

Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 26, 2026



OVERVIEW

Hanover and District Hospital (HDH) remains committed to delivering exceptional patient care. Guided by our vision, "Partnering for Excellence in Rural Health Care," we uphold our core values of integrity, compassion, and collaboration in everything we do. As a small and rural hospital that provides essential 24/7 Emergency and Acue Care services, HDH continues to experience system pressures related to patient flow, fiscal constraints, and regional gaps in emergency service availability. Despite these challenges, HDH has maintained strong patient satisfaction and has demonstrated adaptability, collaboration, and resilience in supporting our community.

For 2026-27, HDH's Quality Improvement Plan (QIP) aligns with Ontario Health's system-wide priorities: Access and Flow, Equity, Patient Experience, and Safety. HDH's QIP indicators, targets and improvement activities are grounded in the organization's Strategic Plan and informed by data from the Emergency Department Pay-for-Results (P4R) Program, patient feedback, and staff and physician engagement.

Key improvement priorities this year include:

- Reducing the 90th percentile ED wait time to physician initial assessment to Ontario Health's recommended 3.4 hours target.
- Reducing the number of admitted patients waiting in the ED at 8 a.m. by the OH – recommended 25% reduction.
- Strengthening oversight and audit-driven improvements to maintain or improve the percentage of patients who leave without being seen (LWBS).
- Supporting equity through Indigenous Canada cultural safety education for executive-level leadership.

- Enhancing patient experience by improving clarity and consistency of discharge information.
- Advancing patient safety through implementation of the Delirium Aware Safer Healthcare (DASH) program.

HDH's approach reflects strong collaboration across teams, reliance on evidence-based practices, and a commitment to improving care experiences and outcomes for patients, families, and staff.

ACCESS AND FLOW

Improving access and flow remains one of HDH's highest priorities and aligns directly with Ontario Health's system requirements for emergency department performance. HDH's QIP includes three ED-related Access & Flow indicators: the 90th percentile ED wait time to physician initial assessment (PIA), the daily average number of admitted patients waiting in the ED at 8 a.m., and the percentage of ED patients who leave without being seen (LWBS). Each indicator includes Ontario Health's recommended targets where required.

Key strategies include strengthening ED documentation accuracy, reinforcing early assessment processes, and optimizing internal patient-flow workflows. HDH will continue to improve the completeness and reliability of time-stamp data and reinforce consistent use of standardized processes to reduce variation in PIA documentation.

HDH's Utilization Committee plays a central role in Access & Flow improvements by reviewing ED P4R data quarterly, analyzing trends, identifying contributing factors, and submitting formal recommendations to the Medical Advisory Committee (MAC) for oversight and follow-up. This governance structure ensures HDH

maintains continuous and transparent monitoring of ED performance and aligns organizational decision-making with P4R metrics.

HDH will also complete 40 Emergency Department Return Visit Quality Program (EDRVQP) audits, including development and implementation of corresponding quality improvement action plans. These audits directly support improvements in ED flow, LWBS mitigation, and provider education related to unplanned return visits.

For admitted patients, HDH will improve overnight flow through policy review, earlier discharge planning processes, and enhanced surge capacity planning. Collaboration with South Bruce Grey Health Centre and regional partners supports timely interfacility transfers and shared resource use, reducing bottlenecks across the system.

Through these targeted, data-driven initiatives, HDH aims to ensure patients receive the right care in the right place at the right time.

EQUITY AND INDIGENOUS HEALTH

Ontario Health has emphasized the importance of reducing health inequities and advancing Indigenous health across care settings. HDH continues to prioritize equity, diversity, inclusion, and anti-racism (EDI/AR) as organizational commitments embedded within both the Strategic Plan and the Health Equity Committee's workplan.

HDH's 2026–27 QIP includes one equity indicator: the percentage of executive-level staff completing relevant EDI/AR training, with a target of 100% completion. This year, HDH has adopted a focused learning requirement using the Indigenous Canada course offered through Coursera by the University of Alberta's Faculty of Native Studies. Completion of this education supports leadership in strengthening cultural safety, improving understanding of Indigenous histories and contemporary realities, and advancing reconciliation within healthcare.

This focused, mandatory education enhances leadership competency and informs policy, resource development, and organizational decision-making, contributing to an increasingly equitable and culturally safe care environment for patients, families, and staff.

PATIENT/CLIENT/RESIDENT EXPERIENCE

Ontario Health requires hospitals to demonstrate how patient experience feedback informs quality improvement. HDH collects experience data through the Ontario Hospital Association's patient satisfaction surveys and unit-based feedback mechanisms. One of HDH's strengths is the active participation of the Patient and Family Advisory Committee (PFAC), who co-design and review patient communication materials, processes and policies.

The patient experience indicator for 2026–27 is the percentage of respondents who report "Completely" to the question: "Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?"

HDH's target is 95%, consistent with prior QIP targets and reflective of the hospital's commitment to clear, consistent, and patient-centred discharge communication.

Planned improvement activities will support patients in understanding their care, managing their recovery at home, and knowing when and how to seek follow-up support.

PROVIDER EXPERIENCE

HDH recognizes that creating a positive workplace culture is essential for delivering high-quality, safe care and supporting staff retention. Ontario Health encourages organizations to describe initiatives that address recruitment, retention, workplace culture, and staff experience.

We prioritize staff education and development, offering training, workshops, and continuing education opportunities to ensure our team has the tools and knowledge needed to deliver exceptional care. This investment in professional growth not only enhances care quality but also cultivates a culture of continuous learning, making our staff feel valued and empowered.

SAFETY

At HDH, ensuring safety is integral to our mission of delivering exceptional care. Our approach is guided by Healthcare Excellence Canada's Quality Care and Patient Safety Framework, which supports alignment with evidence-informed safety practices across all care settings. HDH continues to participate in Ontario Health's Never Events program, reinforcing our commitment to preventing avoidable, serious incidents through focused education and shared learning.

Our incident management system remains a critical tool for ensuring timely reporting and follow-up of all safety events. Each report triggers a structured review, enabling early identification of contributing factors and supporting targeted quality improvement actions. The Patient and Medication Safety Committee review all medication-related, falls, and miscellaneous incidents to identify opportunities for improvement and prevent recurrence. HDH also

maintains robust patient safety policies, subject to annual review to ensure their effectiveness.

Furthermore, HDH's active Joint Health and Safety Committee continues to play a key role in maintaining a safe workplace environment. Regular safety inspections and follow-up processes help safeguard both staff and patients and reinforce proactive hazard identification.

A key enhancement of this past year was the introduction of a new security services provider, which strengthened safety practices throughout the hospital. This upcoming year, working with this security provider, HDH will implement MORB (Management of Resistive Behaviour) training and PINEL restraint training for staff. This partnership will enhance staff competency, confidence, and preparedness when managing behavioural escalations, ensuring responses prioritize patient dignity, therapeutic communication and staff and patient safety.

Together, these initiatives demonstrate HDH's strong commitment to fostering a safe, supportive, and high-quality environment for patients, staff, physicians and visitors.

EMERGENCY DEPARTMENT RETURN VISIT QUALITY PROGRAM (EDRVQP)

In its inaugural year participating in the Emergency Department Return Visit Quality Program (EDRVQP), Hanover and District Hospital (HDH) gained meaningful experience conducting structured return-visit audits and integrating findings into quality improvement activities. During the audited period, HDH had 19,219 ED visits, with 56 return visits within 72 hours meeting criteria for review and one

sentinel event, which was audited thoroughly and found to have no quality-of-care concerns, with the patient experiencing a positive outcome.

HDH successfully completed the required 40 return-visit audits, strengthening staff familiarity with the program's methodology and reinforced a consistent approach to case review, documentation, and learning. Audit findings are shared with the Patient Safety Committee, Utilization Committee, Medical Advisory Committee, and the Board Quality Governance and Risk Management Committee, enhancing organizational oversight and promoting shared learning across departments.

Two themes consistently emerged through the audit process. The first involved seniors living alone, who comprised 60% of return-visit patients, often experiencing challenges with follow-up care or managing symptoms independently. In response, HDH will implement the Identification of Seniors at Risk (ISAR) tool at triage and develop standardized pathways for engaging community partners in earlier intervention.

The second theme involved patients who left without being seen (LWBS). Audit findings identified the need for deeper analysis of LWBS characteristics and underlying causes. HDH will undertake a comprehensive review of LWBS patterns and develop a follow-up process for highest-risk LWBS patients, supporting safe transitions and timely care re-engagement.

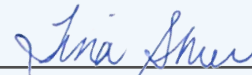
EXECUTIVE COMPENSATION

Ontario Health requires clarity on how executive compensation is linked to QIP performance. At HDH, this includes tying 5% of the President & CEO's base salary to achievement of QIP targets, in alignment with Board Policy #502. This linkage supports strong accountability for quality improvement at the senior leadership level.

SIGN-OFF

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

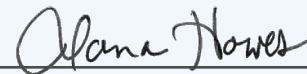
I have reviewed and approved our organization's Quality Improvement Plan on **March 26, 2026**



Tina Shier, Board Chair



Pamela Matheson, Board Quality Committee Chair



Dana Howes, Chief Executive Officer



Saskia MacMillan, EDRVQP lead, if applicable

Access and Flow

Measure - Dimension: Timely

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percent of patients who visited the ED and left without being seen by a physician	O	% / ED patients	CIHI NACRS / April 1, 2024, to March 31, 2025 (i.e., FY 2024)	4.16	4.16	LWBS in Ontario was 5.3%. HDH will strive to maintain or improve as this rate is below the Ontario average.	

Is this indicator related to:	
Emergency Department Return Visit Audits	Yes
Executive Compensation	Yes
Pay-for-Results Action Plan	Yes

Change Ideas**Change Idea #1 Strengthen ED Oversight, Early Assessment and Audit-Driven Improvements to Reduce LWBS**

Methods	Process measures	Target for process measure	Comments
- Complete 40 audits including the development and implementation of a Quality Improvement action plan as part of the Emergency Department Return Visit Quality Program (EDRVQP) requirements. - The Utilization Committee will conduct quarterly analyses of LWBS patterns using P4R data to help guide the implementation of mitigation strategies.	- Number of EDRVQP audits completed and % of audit-generated action items implemented. - Completion of quarterly Utilization Committee review of ED P4R indicators, included recommendations to Medical Advisory Committee.	- 40 audits completed with 100% corresponding QI action plans and Quarterly review of LWBS cases with flagged return visits. - 100% completion of all four quarterly Utilization Committee meetings.	

Measure - Dimension: Timely

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department wait time to physician initial assessment	P	Hours / ED patients	CIHI NACRS / December 1, 2024, to November 30, 2025, in alignment with the Pay for Results program	3.70	3.40	Ontario Health recommended target for ED PIA is 3.4 hours or less.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	Yes
Pay-for-Results Action Plan	Yes

Change Ideas

Change Idea #1 Ensure the accuracy, completeness, and timeliness of data regarding ED wait times to Physician initial assessment.

Methods	Process measures	Target for process measure	Comments
- Continue to conduct regular data audits to identify inaccuracies or missing data in ED wait time logs. - Utilize standard process for recording wait times to reduce data entry errors.	- Data Accuracy - Audit frequency		- Data accuracy: Collect baseline accuracy in recorded ED wait times to physician initial assessment. - Audit frequency: Target quarterly audits to review and correct data entry issues.

Change Idea #2 Reinforce the importance of accurate data and reducing wait times to ensure consistent adherence to timeliness guidelines for initial assessments.

Methods	Process measures	Target for process measure	Comments
The Utilization Committee, reporting to MAC, will review P4R data quarterly, identify contributing factors to delays, and recommend actions to improve PIA timelines.	Completion of quarterly Utilization Committee review of ED P4R indicators, included recommendations to Medical Advisory Committee	100% completion of all four quarterly Utilization Committee meetings.	

Measure - Dimension: Timely

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Daily average number of patients waiting in the emergency department for an inpatient bed at 8 a.m.	P	Number / ED patients	CIHI NACRS / April 1, 2024, to March 31, 2025 (i.e., FY 2024)	0.44	0.33	Ontario Health recommended target is a 25% reduction from baseline.	South Bruce Grey Health Centre

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	Yes
Pay-for-Results Action Plan	Yes

Change Ideas

Change Idea #1 Optimize internal processes for overnight admissions to ensure timely patient placement and reduce wait times in the ER.

Methods	Process measures	Target for process measure	Comments
Review patient flow process daily	Continue to reinforce internal policies	Education and implementation of policy and process.	

Change Idea #2 Continue to expand and enhance internal surge capacity to accommodate a higher number of patients during peak periods, reducing ER wait times for inpatient beds.

Methods	Process measures	Target for process measure	Comments
- Regularly review surge protocols to quickly increase inpatient capacity during periods of high ED patient volume. - Increase flexibility in bed assignment.	- Surge protocol review - Flexibility in bed usage.	- Target activation of surge protocol within 4 hours of identifying high patient volume.	

Change Idea #3 Work with regional partners to coordinate bed leveling efforts and share resources, improving bed availability across the system and reducing ER wait times.

Methods	Process measures	Target for process measure	Comments
- Work with the SW Situational Surge Group - Continue collaboration with South Bruce Grey Health Centre in meeting regularly around interfacility transfers	Frequency of meetings	- SW Situational Surge Group meetings attended (Meetings occur weekly during surge.) - Bi-weekly interfacility transfer meeting touch bases with South Bruce Grey Health Centre	

Change Idea #4 Ensure the accuracy, completeness, and timeliness of data on inpatient bed availability to enable better decision-making and more efficient bed management.

Methods	Process measures	Target for process measure	Comments
- Standardize data collection practices across departments and facilities to improve consistency. - Reinforce with staff on the importance of accurate data entry and the impact it has on patient flow. - The Utilization Committee, reporting to MAC, will review admission related P4R metrics for recommended improvements.	- Data Accuracy - Staff Training - Completion of quarterly Utilization Committee review of ED P4R indicators, included recommendations to Medical Advisory Committee	- Target quarterly audits to ensure accurate data. - Target 95% of relevant staff trained on data entry protocols. - 100% completion of all four quarterly Utilization Committee meetings.	

Equity

Measure - Dimension: Equitable

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	O	% / Staff	Local data collection / Most recent consecutive 12-month period	100.00	100.00	% of executive-level staff	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	Yes
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1 Support equity and reconciliation through Indigenous Canada Training for Executive-level Staff

Methods	Process measures	Target for process measure	Comments
Executive-level staff will participate in Indigenous Canada online course with Coursera offered by the Faculty of Native Studies at the University of Alberta.	Documentation of training completion submitted.	100% of executive-level staff completing required training components by fiscal year-end.	

Experience

Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of respondents who responded "completely" to the following question: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?	O	% / Survey respondents	Local data collection / Most recent consecutive 12-month period	92.11	95.00	Consistent with HDH prior QIP target	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	Yes
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1 Audit and improve discharge information materials with the guidance of the Patient and Family Advisors.

Methods	Process measures	Target for process measure	Comments
- Work with PFAC to develop standardized discharge packages to support informational needs. - Continue to monitor patient responses/satisfaction surveys indicating that they have received sufficient information prior to discharge.	- Completion status of standardized discharge packages. - Monitoring of Patient Satisfaction survey responses.	- Completion of standardized discharge packages with the input of PFAC. - Achieve 95% positive "Completely" responses for the patient satisfaction survey question, "Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital."	Total Surveys Initiated: 1128

Safety

Measure - Dimension: Safe

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of delirium onset during hospitalization	O	% / Hospital admitted patients	CIHI DAD / April 1 to September 30, 2025 (Q1 and Q2), based on the discharge date (Discharge Date/Time)	2.57	2.57	The Ontario Hospital average is 8.2% of all hospitalizations. HDH is striving to improve or maintain current performance.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	Yes
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1 Utilize the Health Quality Ontario Delirium Aware Safer Healthcare (DASH) program to improve delirium screening, documentation, and early intervention practices across the hospital.

Methods	Process measures	Target for process measure	Comments
- Utilize the DASH (Delirium Assessment Screening and Hospitalization) program into daily clinical practices for all hospitalized patients, especially those at higher risk for delirium. - Participation in DASH Community of Practice (CoP) to engage Care Partners in recognizing early signs of delirium.	- Screening completion rate - Implement 1-2 DASH CoP ideas	- Collect the number of at-risk patients screened for delirium using the DASH tool within 24 hours of admission. - Completion of 1-2 CoP changes.	