Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 27, 2025

OVERVIEW

Lennox and Addington County General Hospital is dedicated to delivering the highest standard of care to the communities we serve. We aim to embed our core values — Integrity, Respect, Excellence, Patient-Centeredness, Innovation, and Collaboration — into every service we provide.

Our Quality Improvement Plan (QIP) is shaped by our corporate mission: “To be a progressive rural health system, committed to improving the health of our patients and communities.” The 2025-2026 QIP highlights strategic initiatives designed to elevate the quality of care, enhance safety, foster greater patient satisfaction, and achieve better clinical outcomes for both patients and residents.

This QIP has been developed through collaboration with clinical teams, staff, physicians, residents, as well as patient and caregiver representatives from our Patient and Family Advisory Council. We have thoughtfully incorporated feedback gathered from patient and resident surveys, incident reviews, and the patient relations process to inform and guide the creation of targeted change initiatives.

Aligned with our current strategic plan, service accountability agreements, accreditation standards, and best practices, the 2025-2026 QIP is designed to optimize resource allocation where it will have the greatest impact. We have developed this year’s QIP in tandem with the ongoing creation of the 2025-2028 Strategic Plan, ensuring that we address both immediate needs and position ourselves for long-term, sustainable improvements in patient care. By leveraging quality improvement methodologies, we are committed to driving meaningful and measurable outcomes that

will positively impact the health and well-being of the people of Lennox and Addington.

ACCESS AND FLOW

To support patients and residents in accessing the right care in the right place at the right time, our organization has planned a series of strategic improvement initiatives focused on enhancing access, flow, and capacity within our healthcare system. These efforts are designed to improve patient outcomes, streamline healthcare processes, and ensure that care is provided in the most appropriate setting.

Efficient Access and Collaborative Partnerships:
A key component of our strategy is collaborating with a wide range of partners, including primary care, long-term care (LTC), community organizations, OH@Home, community paramedics, tertiary care partners, and virtual care programs with Toronto Grace Hospital and Baycrest Hospital. By strengthening these partnerships, we aim to support keeping patients and residents in their place of comfort—whether at home or in the community—whenever possible. The goal is to provide the right care at the right time in the right place, ensuring that patients are supported throughout their care journey.

Timely Access and Emergency Department Optimization:
Our Emergency Department (ED) plays a crucial role in providing 24/7 care, with annual ED volumes exceeding 26,000 visits at our small rural site. While we see high volumes, the majority of visits fall within the CTAS 3 category, and we have been facing increased pressure due to not only high volume but also challenges with flow and capacity. This has impacted several key ED metrics, including Length of Stay (LOS) for both admitted and non-admitted patients, as well as the time to PIA (Physician Initial Assessment) and the percentage of patients leaving without being seen.

To address these challenges, we recognize that improving efficient access to care requires more than simply reducing wait times. It involves optimizing every stage of the patient journey—from arrival at the ED to discharge, transfer, or admission. In 2025-2026, our approach will focus on several key ED throughput initiatives, including:

- Twice-daily bed awareness rounds to improve internal communication and ensure that all stakeholders are aware of current capacity and patient flow.
- Developing an identification process for system pressures, including staffing issues that may impact flow, and addressing early discharge planning and barriers to discharge.
- Strengthening collaboration with community partners to direct patients to external services when appropriate, improving care efficiency and reducing unnecessary ED visits.

We will also focus on improving several ED performance metrics:
- Ambulance Offload Delay: Maintain a baseline of less than 23 minutes, which is better than the provincial average.
- ED 90th Percentile LOS: Focus on reducing LOS for non-complicated, non-admitted patients (currently 7.28 hours) and complex, non-admitted patients (currently 8.47 hours), both of which are above the provincial targets.
- Admitted patients' ED LOS: Work to reduce the 90th percentile ED LOS for admitted patients (currently 39.5 hours), which is also above the provincial target.

- Time to Physician Initial Assessment (PIA): Dedicate efforts to reduce the 90th percentile PIA time (currently 5.87 hours, above the target of 4 hours).

Enhancing Care Delivery through Regional Health Information System Optimization:
In December 2024, LACGH, in collaboration with five partner healthcare organizations, launched a new Regional Health Information System (RHIS), Lumeo. This system enables the seamless flow of patient electronic medical records across the six participating organizations, enhancing the delivery of care and flow of health information between organizations. Over the course of the 2025-2026 fiscal year, we will continue to collaborate with our regional partners to further optimize the functionality of the Lumeo RHIS, ensuring it better serves both patients and healthcare providers.

Moving Forward: Quality Improvement Model Cells
In April 2025, we will embark on a quality improvement journey with a strong focus on improving both timely and efficient access to care in the Emergency Department. By fostering a collaborative environment between Hospital departments, addressing system pressures, and leveraging community resources, we aim to improve LACGH patient experiences and their healthcare outcomes, ensuring that patients receive the care they need when they need it, in the right place.

EQUITY AND INDIGENOUS HEALTH

In 2024-2025, we continued our commitment to addressing the health needs and disparities faced by Indigenous Peoples in our region. Leveraging Ontario Health's Indigenous Health Framework, we took meaningful steps toward improving access to care and health outcomes for Indigenous communities.

As outlined in the Framework, we began by establishing strong, trusting relationships with Indigenous leaders, communities, and organizations. These relationships are built on the core values of trust, accountability, and mutual respect. This foundational work was supported by our Executive Leaders and Board Members, who participated in an enlightening session led by an Indigenous leader at our September 2024 Board Retreat. The session provided valuable insights and guidance on the next steps in our journey toward reconciliation and equity.

Our efforts were further enhanced by the involvement of a respected local grandmother, who visited our facility. Her thoughtful advice on our policies, display of Indigenous artwork, and land acknowledgment was instrumental in ensuring that our practices are culturally sensitive and aligned with Indigenous values.

In the Winter of 2024, we were pleased to welcome a new Indigenous community member to our Patient and Family Advisory Council (PFAC). Their presence and perspective will be be invaluable in shaping our approach to patient care and indigenous community engagement.

Looking ahead, we recognize that addressing systemic racism requires a continuous and evolving commitment. Over the next year, we will focus on strengthening internal equity, diversity, and inclusion competencies among our leadership staff. This will include increasing awareness of systemic issues, as well as using the Global Workforce Survey to assess cultural safety within our organization.

By gathering this feedback, we aim to measure the cultural safety that LACGH staff and physicians both experience and exhibit in their interactions with Indigenous patients and families.

Our commitment to equity and reconciliation will remain steadfast as we work to create a healthcare environment that is truly inclusive, respectful, and responsive to the needs of Indigenous communities.

PATIENT/CLIENT/RESIDENT EXPERIENCE

COMMITMENT TO POSITIVE CARE IN THE NEXT FISCAL YEAR
At LACGH, we remain committed to ensuring that patients, families, and residents have a positive experience during their time with us. In 2025-2026, LACGH will continue to engage patients, caregivers, and families in both our quality improvement planning and activities through a variety of methods. We will expand and refine our efforts to collect valuable feedback and ensure a comprehensive understanding of patient experiences.

Some of the key methods we will continue to use and enhance include:

- Patient Satisfaction Surveys: These surveys will continue to be collected across various departments to gauge overall patient experience. Moving forward, we plan to refine these surveys to include more targeted questions, allowing us to better identify specific areas for improvement and track progress over time.

- Post-Discharge Phone Calls: We will enhance our post-discharge outreach by introducing additional follow-up steps, ensuring patients are supported during their transition home. This will include deeper inquiries into their post-discharge care experience and more proactive identification of any ongoing needs or concerns they may have.

- Patient and Family Advisory Council (PFAC): The PFAC will continue to be an integral part of our quality improvement initiatives. In the coming year, we plan to expand their involvement by inviting PFAC members to review new programs and policies more proactively. They will also contribute to reviewing patient experience data and developing action plans to address specific issues raised by patients and families.

- Compliments and Complaints: Feedback through both compliments and complaints will remain a critical source of insight. This fiscal year, we will enhance our processes to ensure that all feedback is systematically analyzed and translated into actionable improvements. This will include closer tracking of recurring themes, which will directly inform our Quality Improvement Plan (QIP).

Our focus for the upcoming year is on further strengthening inclusion in care planning and ensuring a seamless transition for patients and families post-discharge:

- Standard of Care for CVC Residents: In the next year, we will continue to build on our successful Standard of Care for Convalescent Care (CVC) residents, which actively involves them in determining and managing their care goals alongside the care team. We aim to increase engagement further, targeting 100% involvement and ensuring that all residents feel empowered and informed about their care.

- Discharge Planning and Education: We will build on our successful implementation of discharge education by expanding the education module for staff to include additional resources on post-discharge support, including information on follow-up appointments, medication management, and community resources. Our goal is to ensure every patient and resident feels confident in managing their health after discharge.

- Patient-Oriented Discharge Summary (PODS): We plan to enhance the PODS process by further improving the clarity and personalization of the discharge summaries. While we have consistently maintained a 93% rate for providing discharge summaries, we will focus on reaching 100% compliance. Our aim is to ensure that all patients receive an informative and easily understandable summary that helps them navigate their post-discharge care.

Through these efforts, we aim to continue improving patient and family engagement, enhance care planning, and ensure a positive experience throughout the entire care journey.

PROVIDER EXPERIENCE

LACGH has committed to actions to improve the overall work experience related to professional development, trust, inclusion and a sense of belonging among our workforce. This is critical to not only deliver on excellence, but also recruit and retain a strained healthcare workforce. Given the current competition for healthcare workers, we must ensure a welcoming and inclusive environment to attract talent from beyond our region. To support retention and drive engagement, we must also look at strategies to support the health and well-being of our people and pay attention to their needs.

With an intentional focus on recruiting and retaining top talent, examples of current initiatives to enhance LACGH's position as an employer of choice include: engaging both internal and external stakeholders in the development of a new corporate strategic plan and a new branding strategy which will serve to provide renewed vision and direction and to promote LACGH as an innovative and leading organization; follow with revitalized social media presence highlighting the benefits of working in an innovative and welcoming organization who cares about the people it serves, as well as those who work and learn here; increasing the profile of LACGH as a Learning Health Organization offering varied professional development opportunities for staff; and increasing conversations with staff to hear directly from them (i.e. focus groups, targeted surveys) with the goal to improving their overall work experience on topics such as how to enhance a psychologically safe workplace, how to foster a culture of trust and respect and how to create a more inclusive workplace for all. LACGH has also committed to completing a quality review of the complete life cycle of employees starting from the initial contact with a prospective candidate through to the end of their employment with the organization and their continued advocacy of LACGH as a place to work, learn and seek health services.

SAFETY

At LACGH, safety is a top priority, and we are committed to creating and sustaining a culture of safety to prevent and reduce patient safety incidents. One of our key quality improvement projects for 2025-2026 focuses on delirium prevention and management, especially in our acute inpatient areas where older adult patients

are the primary demographic. Delirium is a common and serious condition affecting older adults, particularly those aged 65 and above. Clinical data shows that 10-30% of older adults experience delirium during their hospital stay, which can lead to longer hospital stays, increased risk of complications, and poorer long-term outcomes.

To address this, we are enhancing targeted strategies in the acute care setting to prevent, identify, and manage delirium early. These efforts will be integrated into our 2025-2026 Quality Improvement Plan (QIP), and we will use clinical protocols, education, and screening tools to ensure that delirium is identified promptly, and appropriate interventions are put in place. Additionally, we will focus on staff education around recognizing the signs of delirium, and strategies to prevent its onset, such as promoting early mobilization, adequate hydration, and sleep hygiene.

A system-wide approach to safety also includes our ongoing use of the electronic Incident Reporting System (RL6) to document all incidents, including Patient Safety Incidents (PSIs). RL6 allows for real-time tracking and immediate review of safety incidents, ensuring that actionable items are reviewed and addressed by the relevant team members. Daily reviews of PSIs ensure that any patterns or trends are identified early, and follow-up investigations are conducted by appropriate managers and directors. Root cause analysis and corrective actions are implemented to prevent recurrence. These findings are shared with our Working Groups, who work collaboratively to implement system improvements to mitigate further risks.

These efforts are aligned with Healthcare Excellence Canada's Rethinking Patient Safety report, which emphasizes the importance of a systematic approach to reducing all forms of harm, including both physical and psychological harm, through comprehensive incident reporting, learning from adverse events, and promoting a culture of safety at every level.

Through these initiatives, we are not only working to reduce the incidence of delirium and PSIs but also creating a culture where patient safety is deeply embedded in everyday practices. We remain committed to improving patient outcomes by continually monitoring, learning from, and improving our safety processes across the organization.

EMERGENCY DEPARTMENT RETURN VISIT QUALITY PROGRAM (EDRVQP)

At LACGH, we are enhancing the care of patients diagnosed with sepsis through an Emergency Department (ED) Return Visit Quality Program (EDRVQP). This initiative, part of our Quality Improvement Plan (QIP), focuses on adult and pediatric sepsis cases and integrates data collection, process improvement, staff education, and continuous monitoring.

Our approach includes the following:

Data Collection: We audit ED records quarterly, tracking return visits within 72 hours for sepsis patients. Key indicators such as mortality rates, sepsis severity, and treatment timeliness are monitored.

ED Quality Review Task Force: A team consisting of ED physicians, nurses, leadership, and decision support meets quarterly to review

sepsis cases, return visits, and overall performance.

Root Cause Analysis and Action Plan: We perform root cause analyses for return visits, identifying common issues like improper discharge instructions, delayed symptom recognition, or inadequate follow-up. Discharge instructions are then improved to include detailed follow-up steps and educate patients on warning signs of relapse.

Sepsis Care Protocols and Staff Education: We ensure early sepsis recognition and management protocols are followed, providing regular training for ED staff on identifying and treating sepsis, including pediatric-specific education.

Continuous Monitoring and Feedback: We use audit data to adjust protocols, providing regular feedback to staff and leadership on the program's progress.

Our goal is to reduce sepsis-related return visits and improve the timeliness of treatment, ultimately enhancing patient care and satisfaction. Through ongoing evaluation and refinement, we aim to sustain the program and ensure adherence to Best Practice Guidelines.

EXECUTIVE COMPENSATION

It is mandatory under the Excellent Care for All Act (ECFAA) to link compensation for the Chief of Staff (COS), Chief Executive Officer (CEO) and other executives reporting to the CEO to the achievement of performance targets in our organizations Quality Improvement Plan (QIP). Performance-based executive compensation is linked to achieving specific QIP targets, as well as achieving success on selected corporate goals and objectives. The amount of compensation that is performance-based for the executive team has been set at 3% for 2025/2026 year. The payment of performance-based compensation occurs following the fiscal year end evaluation of results. The amount awarded is based on the Board of Directors and the President & CEO's evaluation of performance against the specific thresholds listed below:

1. Achieve a 1.87hr reduction in the 90th percentile emergency department wait time to physician initial assessment.
2. The percentage of leaders who have completed the equity, diversity and inclusion education created in the 2025-2026 fiscal year (FY) will be at or above 80%.
3. During the final development stage of the 2025-2028 Strategic Plan, leaders will co-create one or more indicators with front-line staff to assess perceptions of how leaders demonstrate the new organizational value related to communication. During the 2025-26 fiscal year, these indicators will be regularly monitored to evaluate the impact of implemented change initiatives, aiming to achieve a majority of positive responses.

CONTACT INFORMATION/DESIGNATED LEAD

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Access and Flow

Measure - Dimension: Timely

Indicator #9	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile ambulance offload time	P	Minutes / Patients	CIHI NACRS / For ERNI hospitals: Dec 1, 2023, to Nov 30, 2024 (Q1 and Q2)	23.00	21.00	Reduce by 10%	

Change Ideas

Change Idea #1 All Charge Nurses to prioritize off load navigation within the ED

Methods	Process measures	Target for process measure	Comments
1. Quarterly meetings with EMS will be organized to review offload data 2. Education will be provided to all Charge Nurses regarding off load ED flow	1. Count of times EMS is onsite due to off load delay >21 min 2. Number of staff educated on EMS off load flow priority	1. Collecting baseline 2. 100% of ED staff educated on off load priority and ED flow	OH target is 30 min. SE 90th percentile is 29 min.

Measure - Dimension: Timely

Indicator #10	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department wait time to inpatient bed	O	Hours / ED patients	CIHI NACRS / For ERNI hospitals: Dec 1, 2023, to Nov 30, 2024 (Q1 and Q2)	28.67	24.00	Reduce by relative percentage	

Change Ideas

Change Idea #1 Improve collaboration between the Inpatient Unit and Hospitalists to prioritize flow			
Methods	Process measures	Target for process measure	Comments
Collaboration efforts will include: - Charge Nurse (CN) huddles twice daily - Utilization of hallway beds when required - Prioritization of early discharge identification in daily tasks - leveraging Catalysis to assist with root cause of discharge delays in inpatient unit	1. Count of twice daily CN huddles occurring 2. Count of ED discharges identified by the Hospitalist prior to 0830 3. Count of days that hallway beds are utilized 4. Count of patients in the ED waiting for ICU > 90 mins 5. Percentage of patients transferred to an inpatient bed within 24 hours	1. 2/day 2. Collecting Baseline 3. Collecting Baseline 4. Collecting Baseline 5. 80%	Utilize a safety cross.

Change Idea #2 Focus on early discharge preparation			
Methods	Process measures	Target for process measure	Comments
- Create a three space Discharge Lounge area - CN Huddles twice daily - Optimize Patient/Family Discharge Handbook	1. Count of days with discharges after 1100hrs 2. Count of times huddles occurring twice daily 3. Count of days utilizing Discharge Lounge space 4. Count of patients in the ED waiting for ICU>90mins 5. Percentage that twice daily CN huddles occurring 6. Percentage of discharges occurring prior to 1100hrs 7. Count of days used for hallway beds/ month 8. Percentage of patients admitted to ICU pulled within 90 mins	1-4: Baseline 5. 85% 6. 65% 7. <15 8. 80%	

Measure - Dimension: Timely

Indicator #11	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 / Apr 1 to Sept 30, 2024 (Q1 and Q2)	11.10	8.33	Reduce by 25%	

Change Ideas

Change Idea #1 1. Focus on visibility of nursing staff and patient education 2. Implement a NP Diversion Clinic

Methods	Process measures	Target for process measure	Comments
- Clerk to instruct patients to follow up with triage nurse prior to leaving - Develop a ED patient handbook - Implement Nursing rounding in the waiting room (q 2-3 h) - Leverage Catalysis to improve with ED work flow - Implement a NP ED Diversion Clinic- 4 days / week	1. Count of patients that LWBS that did not report to triage 2. Count of times the waiting room has a nurse round through 3. Count of patients referred from the ED to the NP Clinic 4. Percentage of calendar days the department met the LWBS target of 8.33 5. Develop a ED patient handbook "What to Expect While Waiting"	1. Collecting baseline 2. Collecting baseline 3. Collecting baseline 4. Collecting baseline 5. By September 2025	

Measure - Dimension: Timely

Indicator #12	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department length of stay for nonadmitted patients with low acuity	O	Hours / ED patients	CIHI NACRS / ERNI hospitals: Dec 1, 2023, to Nov 30, 2024/Non-ERNI hospitals: Apr 1, 2024, to Sept 30, 2024 (Q1 and Q2)	7.28	4.00	OH Target	

Change Ideas

Change Idea #1 We will focus on flow for lower acuity patients and implement a daily fast track pathway.

Methods	Process measures	Target for process measure	Comments
1. Charge Nurse (CN) to identify a fast track area suitable for 4 spaces daily at huddles 2. CN will identify a fast track assignment for nursing staff on a daily basis 3. Physicians will complete scheduling optimization from 1300-1500 and 1800-2000 to promote fast track utilization PA to focus on fast track	1. Count of days per month fast track utilized from 1300-1500 and 1800-2000 daily 2. Count of days fast track does not have a MRP assigned	1. Collecting Baseline 2. Collecting Baseline	

Measure - Dimension: Timely

Indicator #13	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department length of stay for nonadmitted patients with high acuity	O	Hours / ED patients	CIHI NACRS / ERNI hospitals: Dec 1, 2023, to Nov 30, 2024/Non-ERNI hospitals: Apr 1, 2024, to Sept 30, 2024 (Q1 and Q2)	8.47	7.00	OH Target	

Change Ideas

Change Idea #1 1. Deployment of Catalysis QI Project 2. Leverage ED roles (Charge Nurse (CN), Triage Nurse and ED Physician) to promote CTAS 2 ED flow

Methods	Process measures	Target for process measure	Comments
We will be taking a multifaceted approach - CN, Triage Nurse, & ED Physician huddle to develop early care plans for CTAS 2 patients - Triage Nurse to utilize comment section of new HIS to document/ highlight concerns - Staff to complete education regarding assigning CTAS if higher or lower level required - Leverage the Catalysis Project to help identify delays in discharge processes	1. Percentage of staff that have received CTAS education 2. Number of CTAS 2 patients meeting LOS target of 7 hours	1. 100% by October 2025 2. Collecting baseline	

Measure - Dimension: Timely

Indicator #14	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 / ERNI hospitals: Dec 1, 2023, to Nov 30, 2024/Non-ERNI hospitals: Apr 1, 2024, to Sept 30, 2024 (Q1 and Q2)	5.87	4.00	OH Target	

Change Ideas

Change Idea #1 Optimize Physician scheduling in the ED

Methods	Process measures	Target for process measure	Comments
Implementation of: - Overlapping physician coverage daily from 1300-1500 and 1800-2000 - Daily utilization of Fast Track area - Direction for the Physician Assistant to focus on lower acuity patients - Leverage Catalysis to assist with ED work flow	1. Count of days per month fast track utilized 2. Count of days fast track does not have a MRP assigned 3. Percentage of patients with a PIA of 4 hours or less	1. Collecting baseline 2. Collecting baseline 3. 80%	Utilize a safety cross

Measure - Dimension: Timely

Indicator #15	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 / Apr 1 to Sep 30, 2024 (Q1 and Q2)	2.28	2.28	Return and maintain Sep 2024 performance.	

Change Ideas

Change Idea #1 Focus on patient flow and placement in collaboration with Inpatient Unit and Hospitalists.

Methods	Process measures	Target for process measure	Comments
Initiate: - Charge Nurse (CN) huddles twice daily - Utilize hallway beds when required - Prioritize early discharge identification	1. Count of admitted patients in the ED at 0800 daily 2. Count of hallway beds utilized at 0800 3. Percentage of time there are 2 or less patients admitted in the ED at 0800	1. Collecting baseline 2. Collecting baseline 3. 75%	Utilize Safety Cross

Measure - Dimension: Timely

Indicator #16	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department length of stay for admitted patients	O	Hours / ED patients	CIHI NACRS / ERNI hospitals: Dec 1, 2023, to Nov 30, 2024/Non-ERNI hospitals: Apr 1, 2024, to Sept 30, 2024 (Q1 and Q2)	39.50	25.00	OH Target	

Change Ideas

Change Idea #1 Collaboration with Inpatient Unit/ Hospitalists on rounding and ED discharge priority

Methods	Process measures	Target for process measure	Comments
A multi-faceted improvement approach will be implemented including: - Charge Nurses (CN) (ED/Inpatient) will Huddle 2x per shift (0800 &1530) to discuss staffing/flow - ED CN and Hospitalist will connect at 1000 for a post rounds update - Improve implementation of Overcapacity Policy and create a companion checklist for huddle discussions - Prioritize moving ICU patients from the ED to the ICU within 90 mins - Enhance early discharge identification through Hospitalist collaboration, improvement of ED rounding times, and prioritizing ED discharges. - Engage experts (like Catalysis) to help identify barriers to discharge (i.e. DI/Home Care) and monitor data related to these barriers daily for 6 weeks to look at pressures - Consider the creation of a discharge lounge	1. Percentage of the time CNs participate in two huddles per day 2. Percentage of patients identified for discharge from the ED prior to daily rounds 3. Count of days used for hallway beds/ month 4. Percentage of patients admitted to ICU pulled within 90 mins	1. 85% 2. 80% 3. <15 days/month 4. 80%	Safety Crosses will be used.

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 (Lennox And Addington County General Hospital)	O	% / Staff	Local data collection / Most recent consecutive 12-month period	41.38	80.00	Percent Increase	Kingston Health Sciences Centre

Change Ideas

Change Idea #1 Facilitate a leader education event focused on equity, diversity and inclusion.

Methods	Process measures	Target for process measure	Comments
Facilitate blended learning of an in-person event, supplemented with on-line resources and education, to facilitate new equity, inclusion and diversity knowledge or skills for our leaders	Percentage of leaders who have completed the required equity, diversity and inclusion education	80% to be completed by end of Q4	Total LTCH Beds: 22 This indicator is focused on the leadership cohort of staff. We rely on and expect our leaders to play a pivotal role in creating a diverse, inclusive and welcoming environment.

Measure - Dimension: Equitable

Indicator #2	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	31.00	80.00	Percent Increase	Kingston Health Sciences Centre

Change Ideas

Change Idea #1 Facilitate a leader education event focused on equity, diversity and inclusion.

Methods	Process measures	Target for process measure	Comments
Facilitate blended learning of an in-person event, supplemented with on-line resources and education, to facilitate new equity, inclusion and diversity knowledge or skills for our leaders.	Percentage of leaders who have completed the required equity, diversity and inclusion education.	80% to be completed by end of Q4.	This indicator is focused on the leadership cohort of staff. We rely on and expect our leaders to play a pivotal role in creating a diverse, inclusive and welcoming environment.

Experience

Measure - Dimension: Patient-centred

Indicator #3	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	90.00	95.00	Relative increase	

Change Ideas

Change Idea #1 Focus on patient education

Methods	Process measures	Target for process measure	Comments
- Completion of PODS discharge summary for all patients - Utilize education materials in Cerner - Round on patients who are readmitted within 7 days	1. Count of of Patients receiving PODS on D/C 2. Count of Patients admitted within 7 days who are rounded on 3. Percentage of patients who respond they received enough information through D/C phone surveys 4. Percentage of discharged patients who receive PODS	1. Collecting baseline 2. Collecting baseline 3. 100% 4. 100%	Total Surveys Initiated: 10

Measure - Dimension: Patient-centred

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents responding positively (yes) to: "Do staff involve you in decisions about your care?" (Lennox And Addington County General Hospital)	C	% / LTC home residents	In-house survey / April - March	79.20	100.00	Ideal Target	

Change Ideas

Change Idea #1 Residents will be engaged in setting personal goals upon admission.

Methods	Process measures	Target for process measure	Comments
Staff will lead care planning with residents at time of admission and document these Goals of Care on the white boards in resident's rooms. Complete weekly audits of white boards.	1. Rate of residents who are aware of care goals (Number of residents who are engaged/participate in care planning or rounds/total number of residents) 2. Rate of residents who have white boards completed with written and visible goals of care through weekly audits.	100% of residents are aware of care goals 100% of residents have white boards completed	Staff will use the safety cross as a tracking tool.

Measure - Dimension: Patient-centred

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents who responded positively to the statement: "Do you feel you can express your feelings and opinions around here?" (Lennox And Addington County General Hospital)	C	% / LTC home residents	In-house survey / April - March	88.70	100.00	Best Practice	

Change Ideas

Change Idea #1 Increase weekly resident rounding

Methods	Process measures	Target for process measure	Comments
Implement weekly rounding of 5 residents and any opportunities for improvement that come from resident feedback	1. # of residents rounded on weekly 2. Rate of changes implemented based on resident feedback	1. 5/week 2. 80%	Use the safety cross tool to monitor implementation.

Safety

Measure - Dimension: Safe

Indicator #6	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, 2024 (Q1 and Q2), based on the discharge date	X	0.00	Absolute Target	

Change Ideas

Change Idea #1 Focus on staff education and data monitoring.

Methods	Process measures	Target for process measure	Comments
- Completion of CAM - Staff education regarding Prevention of Delirium	1. Count of patients who are identified as having a positive CAM 2. Percentage of staff educated regarding Delirium Prevention 3. Percentage of patients developing Delirium within 24 hours of admission	1. Collecting baseline 2. 100% by December 2025 3. Collecting baseline	

Measure - Dimension: Safe

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of ED Revisits for Adult Sepsis	C	Other / ED patients	CIHI NACRS / April - March	19.00	10.00	Relative Reduction with ultimate target = 0	

Change Ideas

Change Idea #1 Utilize Sepsis Indicator to drive improvement

Methods	Process measures	Target for process measure	Comments
- Review quarterly revisits data for adult sepsis - Provide staff with education regarding sepsis Early Warning Signs - Educate staff on Goal Directed Treatment	1. Percentage of sepsis reviews completed quarterly 2. Percentage of staff completing education 3. Count of recommendations from reviews implemented	1. 100% 2. 100% by November 2025 3. Collecting Baseline	

Measure - Dimension: Safe

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of ED Revisits for Pediatric Sepsis	C	Other / Other	CIHI NACRS / April - March	0.00	0.00	Status Quo	

Change Ideas

Change Idea #1 Utilize Sepsis Indicator to drive improvement

Methods	Process measures	Target for process measure	Comments
- Review quarterly revisits data for pediatric sepsis - Provide staff with education regarding sepsis Early Warning Signs - Educate staff on Goal Directed Treatment	1. Percentage of sepsis reviews completed quarterly 2. Percentage of staff completing education 3. Count of recommendations from reviews implemented	1. 100% 2. 100% by November 2025 3. Collecting Baseline	

Access and Flow | Timely | Optional Indicator

Indicator #1

90th percentile ambulance offload time (Lennox and Addington County Gen Hospital)

Last Year		This Year		
26.00	25	23.00	11.54%	21
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Change Nurse to facilitate ambulance offload flow.

Process measure

- 1. Develop Fit to Sit criteria 2. Provide staff education regarding Fit to Sit protocol by October 2024 3. Count of times offload Paramedic is on-site due to offload delays

Target for process measure

- 1. Develop Fit to Sit criteria by July 2024 2. Provide staff education regarding Fit to Sit protocol by October 2024 3. # of times offload Paramedic on site due to offload delays does not exceed 4 (baseline 0)

Lessons Learned

Overall this change idea was successful. Dedicating the charge nurse to work with with Community Paramedics reduced offload delays for fit-to-sit program appropriate patients. 1. Develop Fit to Sit criteria developed in April 2024 2. Staff education regarding Fit to Sit protocol initiated and ongoing since May 2024. 3. There were 21 offload delays between November 2024 and Feb 2025 due to RHIS implementation compared to 0 per month prior to November 2024.A challenge to the program occurred in December 2024 with the implementation of a new regional Health Information System (HIS) that, temporarily, increased the time to triage and delayed access to QI metrics. This challenge has since improved with familiarity and HIS development.

Comment

In December 2024, LACGH successfully launched a new Regional Health Information System (RHIS), marking a significant advancement in care delivery. As teams acclimate to the new system, there are some unavoidable delays in data availability, stemming from the learning curve, system optimization, and the development of data reports. However, notable improvements in data access were achieved by the close of Q4 in the 2024-2025 fiscal year.

	Last Year		This Year		
Indicator #5	**11.80**	**6.99**	**11.10**	**5.93%**	**8.33**
Percent of patients who visited the ED and left without being seen by a physician (Lennox and Addington County Gen Hospital)	**Performance (2024/25)**	**Target (2024/25)**	**Performance (2025/26)**	**Percentage Improvement (2025/26)**	**Target (2025/26)**

Change Idea #1 ☐ Implemented ☑ Not Implemented

Increase compliance with nursing standards regarding reassessment of patients.

Process measure

- 1. Percentage of staff provided education regarding standards and protocols for reassessment 2. Percentage of patients who are reassessed according to standards with documentation

Target for process measure

- 1. 70% of staff provided education regarding standards and protocols for reassessment by July 2024 2. 80% of ED patients charted with correct disposition by October 2024

Lessons Learned

1. 100% of staff provided education regarding standards and protocols for reassessment by May 2024 2. 45% of ED patients charted with correct disposition by October 2024. 3. Employed a wait rom nurse where possible to review wait room patients and assigned triage nurses to follow-up with patients and educate them on what to do if their condition changes.

Change Idea #2 ☐ Implemented ☑ Not Implemented

Improve time to physician initial assessment (PIA).

Process measure

- Percentage of patients meeting PIA 90th percentile times per standards

Target for process measure

- 75% PIAs meeting standards by December 2024

Lessons Learned

Data Collection issue with PIA time. Capture is when documentation occurs vs. first seen. This data collection is expected tp improve with the implementation of the RHIS.

Comment

In December 2024, LACGH successfully launched a new Regional Health Information System (RHIS), marking a significant advancement in care delivery. As teams acclimate to the new system, there are some unavoidable delays in data availability, stemming from the learning curve, system optimization, and the development of data reports. However, notable improvements in data access were achieved by the close of Q4 in the 2024-2025 fiscal year.

Indicator #2

90th percentile ED length of stay (Lennox and Addington County Gen Hospital)

Last Year		This Year		
8.68	**5.81**	**8.83**	**-1.73%**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Maximize use of medical directives for triage and in the ED where indicated.

Process measure

- 1. Upload Medical Directives to Moodle 2. Current staff to complete Medical Directive education 3. New ED staff complete Medical Directive education at time of hire. 4. Track the percentage of ED patients who have a Medical directive applied.

Target for process measure

- 1. Medical Directives uploaded to Moodle by February 2024 2. 100% of current staff complete education by July 2024 3. 100% of new ED staff complete Medical Directive education during onboarding orientation. 4. 75% of appropriate patients will have an applied Medical Directive by October 2024

Lessons Learned

1. Medical Directives uploaded to Moodle in April 2024 2. 100% of current staff completed education by October 2024 3. 100% of new ED staff complete Medical Directive education during onboarding orientation was facilitated by May 2024 and is ongoing. 4. 91% of appropriate patients had an applied Medical Directive by September 2024

Change Idea #2 ☑ **Implemented** ☐ **Not Implemented**

Improve accuracy of the documentation of departure status and patient disposition.

Process measure

- 1. Number of Chart Audits completed per month 2. Percentage of patients meeting LOS for complex (CTAS 1-2) and uncomplicated (CTAS 3-4-5) non-admits 3. Percentage of staff educated through huddles

Target for process measure

- 1. 10 Chart Audits completed per month 2. 80% of patients meeting LOS for complex (CTAS 1-2) and uncomplicated (CTAS 3-4-5) non-admits 3. 100% Percentage of staff educated through huddles by June 2024

Lessons Learned

1. 30 Chart Audits completed per month until December 2024 with feedback provided to staff. The documentation was updated in December 2024 and qualitative assessment reveals that the new RHIS allows improved accuracy of disposition and departure status 2. Data not analyzed beyond November; however, target percentage was not achieved 3. 100% Percentage of staff were educated through huddles by June 2024

Change Idea #3 ☐ **Implemented** ☑ **Not Implemented**

Maximize stretcher utilization

Process measure

- Occupancy in the ED versus patients waiting in the waiting room

Target for process measure

- 100% occupancy in the ED when ED waiting area has patients 80% of the time by July 2024

Lessons Learned

Data and space were not available to implement this change idea; however, 4. our manual data review showed a higher volume of CTAS 2 and 3 patients affecting LOS, with 30-35% of ED visitors being unattached, leading to longer follow-up and diagnostic tests, which has been determined as one of the root caused to prolonged ED LOS.

Comment

In December 2024, LACGH successfully launched a new Regional Health Information System (RHIS), marking a significant advancement in care delivery. As teams acclimate to the new system, there are some unavoidable delays in data availability, stemming from the learning curve, system optimization, and the development of data reports. However, notable improvements in data access were achieved by the close of Q4 in the 2024-2025 fiscal year.

Access and Flow | Efficient | Optional Indicator

	Last Year		This Year		
Indicator #3 Alternate level of care (ALC) throughput ratio (Lennox and Addington County Gen Hospital)	**0.93** Performance (2024/25)	**1** Target (2024/25)	**0.94** Performance (2025/26)	**1.08%** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Improve consistency of follow-up when a delay to LTC occurs.

Process measure

- 1. Count of number of delayed transfers to LTC per month 2. Percentage of patients designated ALC with delayed transfers to LTC that have a follow up review completed. 3. Percentage of patients designated ALC with a Home First meeting documented

Target for process measure

- 1. Collect baseline of number of delayed transfers to LTC per month. 2. 100% of patients designated ALC with delayed transfers to LTC will have a follow up review completed. 3. 100% of patients designated ALC with a Home First meeting documented.

Lessons Learned

1. There were a total of 3 delayed transfers to LTC from April 2024 to January 2024 which would indicate that delayed transfers are not the root cause of throughput concerns 2. 100% of patients designated ALC with delayed transfers to LTC did have a follow up review completed. 3. 100% of patients designated ALC had a Home First meeting documented.

Change Idea #2 ☐ Implemented ☑ Not Implemented

Mitigate functional decline of patients designated ALC.

Process measure

- 1. Percentage of patients who have been "up to eat" at least twice per day who meet eligibility criteria. 2. Percentage of patients who have experienced a functional decline while in hospital

Target for process measure

- 1. >80% of eligible patients have been "up to eat" at least twice per day 2. <5% of patients frailty score will decrease while in hospital as calculated by the frailty score.

Lessons Learned

1. 100% of eligible patients were "up to eat" at least once per day and 75% of eligible patients were "up to eat" at least twice per day 2. The frailty score was not able to be assessed with available data/resources; therefore, we are unable to quantitatively assess patients for functional decline.

3. Despite implementing ALC-leading practice strategies, including Senior Friendly Care (mobilization, dedicated Home First meetings, interdisciplinary team meetings), daily rounding (including OH@Home), and additional staff resourcing, we were unable to maintain our target of 0.93 ALC Throughput. Case review indicated that a significant increase in ALC numbers in November 2024 placed strain on the organization's overall capacity to meet our ALC throughput target. Nevertheless, we successfully implemented the following strategy, which will have a lasting positive impact on flow and will be sustained moving forward:

Consistent Rehabilitation Therapy Assistant Hours - Weekend support for patients/residents to prevent functional decline and enhance their care journey.

Comment

In December 2024, LACGH successfully launched a new Regional Health Information System (RHIS), marking a significant advancement in care delivery. As teams acclimate to the new system, there are some unavoidable delays in data availability, stemming from the learning curve, system optimization, and the development of data reports. However, notable improvements in data access were achieved by the close of Q4 in the 2024-2025 fiscal year.

Equity | Equitable | Optional Indicator

	Last Year		This Year		
Indicator #11	**CB**	**80**	**41.38**	**--**	**80**
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education (Lennox and Addington County Gen Hospital)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Facilitate a corporate equity, inclusion and diversity training program.

Process measure

- 1. DEI Education availability on Moodle 2. Management Training through External Resource 3. DEI Staff Survey Released.

Target for process measure

- 1. DEI Education on Moodle by end of April 2024 2. Management Training completed by August 2024 3. DEI Survey released by January 2025 4. 50% Staff & 100% executive completion of education by March 31, 2025

Lessons Learned

1. DEI Education was on Moodle by end of April 2024 2. Management Training completed was by August 2024 3. DEI Survey was included in the Global Workforce Survey released in February 2025 4. 36% Staff & 100% executive completed Moodle education by March 31, 2025. During he data audit process it was found that Moodle does not capture all staff's completion status. We are working with the vendor to resolve. This gap results in the percent completion presenting as lower than actual.

Comment

Education was provided to staff via several streams including online and in-person. An in-person session for the Board of Directors and executive staff was facilitated on building relationships with indigenous peoples. The leadership staff engaged in general DEI training in person over the summer of 2024. All staff were provided with access via Moodle to The Ontario Human Rights Commission e-course called “Call It Out: Racism, Racial Discrimination and Human Rights”.

Equity | Equitable | Optional Indicator

Indicator #10

Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education (Lennox and Addington County Gen Hospital)

Last Year		This Year		
CB	**80**	**31.00**	**--**	**80**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Facilitate a corporate equity, inclusion and diversity training program.

Process measure

- 1. DEI Education availability on Moodle 2. Management Training through External Resource 3. DEI Staff Survey Released.

Target for process measure

- 1. DEI Education on Moodle by end of April 2024 2. Management Training completed by August 2024 3. DEI Survey released by January 2025 4. 50% Staff & 100% executive completion of education by March 31, 2025

Lessons Learned

1. DEI Education was on Moodle by end of April 2024 2. Management Training completed was by August 2024 3. DEI Survey was included in the Global Workforce Survey released in February 2025 4. 36% Staff & 100% executive completed Moodle education by March 31, 2025. During he data audit process it was found that Moodle does not capture all staff's completion status. We are working with the vendor to resolve. This gap results in the percent completion presenting as lower than actual.

Comment

Education was provided to staff via several streams including online and in-person. An in-person session for the Board of Directors and executive staff was facilitated on building relationships with indigenous peoples. The leadership staff engaged in general DEI training in person over the summer of 2024. All staff were provided with access via Moodle to The Ontario Human Rights Commission e-course called “Call It Out: Racism, Racial Discrimination and Human Rights”.

Experience | Patient-centred | Optional Indicator

Indicator #9

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? (Lennox and Addington County Gen Hospital)

Last Year		This Year		
84.00	**88.20**	**90.00**	**7.14%**	**95**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Improve the consistency in the use of PODs

Process measure

- 1. Percentage of patients who were discharged who received a PODS 2. Staff education to be included at orientation/onboarding 3. Implement a PODS learning module on Moodle

Target for process measure

- 1. 80% of patients who were discharged received the PODS by November 2024 2. PODS education to be accessible on Moodle by May 2024 3. 100% of staff received PODS education by October 2024

Lessons Learned

1. 54% of patients who were discharged were chart audited to had been given a PODS by November 2024; however, 92% of patients who were asked via telephone survey if they received their PODS responded yes in the same time period. 2. PODS education was accessible on Moodle by April 2024 3. 100% of staff received PODS education by October 2024 4. The implementation of our new RHIS integrates PODS regionally; therefore, optimization and compliance work will continue.

Comment

All discharged patients received a discharge phone call. About half of all discharge calls made are answered. 85% of patients surveyed via telephone indicated yes, that received enough information from hospital staff about what to do if they were worried about their condition or treatment after they left the hospital. This high volume data can be used to validate the electronic survey data received where the denominator is very low.

Experience | Patient-centred | Custom Indicator

	Last Year		This Year		
Indicator #8 Percentage of residents responding positively to the question, "do staff involve you in decisions about your care?" (Lennox and Addington County Gen Hospital)	**63.64** Performance (2024/25)	**80** Target (2024/25)	**79.75** Performance (2025/26)	**--** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Focused effort on supporting residents to provide input into their care plan/care goals and any changes/updates to their care plan

Process measure

- 1. Resident surveys to be done with or completed by residents 2. Percentage of residents rounded on who report receiving their Care Plans

Target for process measure

- 1. Number of residents surveyed on discharge 2. Number of residents surveyed ad hoc 3. 100% of residents rounded on who report receiving their Care Plans

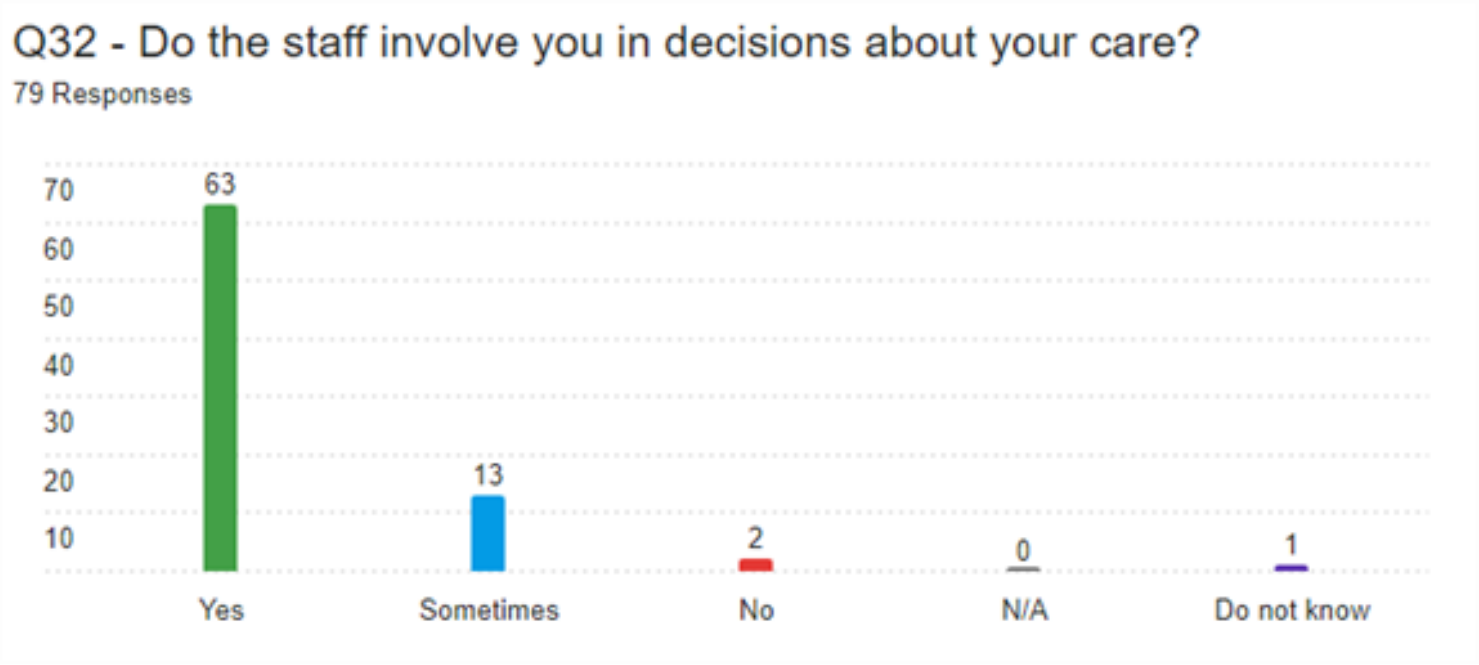
Lessons Learned

1. 79 residents were surveyed on discharge 2. 66 residents surveyed ad hoc 3. 91% of residents rounded on who report receiving their Care Plans

Comment

Note: we considered "Yes" as positive and did not include "sometimes" as positive. The current performance when we include both "Yes" and "sometimes" as positive is 96.20%

Results



Safety | Safe | Custom Indicator

Indicator #4

Count of falls on CVC that resulted in moderate to severe harm to the resident. (Lennox and Addington County Gen Hospital)

Last Year		This Year		
1.00	0	0.00	--	NA
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Ensure that all residents are assessed at time of admission for falls risk and anytime following a fall or change in condition.

Process measure

- 1. Staff education and associated fall policy updated. 2. Compliance falling star signage. 3. Compliance with completion of falls risk assessment. 4. Compliance with post fall assessments

Target for process measure

- 1. Staff education and associated fall policy updated by May 2024 2. 100% of residents who have signage posted at time of admission who are identified as high risk by June 2024 3. 100% of residents will have a falls assessment completed on admission by June 2024 4. 100% of residents will have weekly falls assessments updated weekly by June 2024 5. 100% of residents will have post fall assessments completed and documented by September 2024

Lessons Learned

1. Staff education and associated fall policy was updated in April 2024 2. 100% of residents had signage posted at time of admission who were identified as high risk by May 2024 3. 96% of residents had a falls assessment completed on admission by Feb 2025 4. 77% of residents had falls assessments updated weekly by Feb 2025 5. 94% of residents had a post fall assessment completed and documented by Feb 2025

Safety | Safe | Custom Indicator

	Last Year		This Year		
Indicator #6 Percentage of Patients in the ACU and ICU with new or worsening Pressure Injuries (Lennox and Addington County Gen Hospital)	**31.00** Performance (2024/25)	**12** Target (2024/25)	**22.00** Performance (2025/26)	**--** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

All staff will assess patient's skin for pressure areas daily, document any changes, and make appropriate referrals.

Process measure

- 1. Percentage of patients that have a skin assessment documented daily 2. # of consults seen by OT and Dietician 3. # of consults received by WCT for treatment of a wound

Target for process measure

- 1. 100% of patients that have a skin assessment documented daily by June 2024 2. Collecting Baseline 3. 100% of patients who have a pressure injury will be consulted by the WCT by July 2024 4. Staff education implemented by June 2024

Lessons Learned

1. Wound care committee was reengaged with prevalence studies now being done routinely. 4 2. 46% of patients with pressure injuries were consulted by OT and a Dietician 3. 78% of Patients from June 2024-Feb 2025 had a consult to the wound care team if they had a PI. With 100% of patients consulted since December 2024 4. Staff education implemented in May 2024

	Last Year		This Year		
Indicator #7	**50.00**	**5**	**14.00**	**--**	**NA**
Percentage of Residents in CVC with new or worsening Pressure Injuries (Lennox and Addington County Gen Hospital)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

All staff will assess patient's skin for pressure areas daily, document any changes, and make appropriate referrals.

Process measure

- 1. Percentage of residents that have a skin assessment documented daily 2. Percentage of residents with a PI that have a photo on record 3. The removal of liners in incontinent products and from supply carts will be completed 4. Count of months that the chart audits are completed.

Target for process measure

- 1. 100% of residents will have a skin assessment documented daily 2. 100% of residents with a PI has a photo on record 3. Liners in incontinent product will be removed by July 2024 4. 12/12 months chart audits for PIs will be completed.

Lessons Learned

1. 87% of residents had a skin assessment documented daily 2. 93% of residents YTD with a PI had a photo on record with 100% of patients since December 2024 3. Liners in incontinent product were removed by April 2024 4. 12 chart audits for PIs were completed 3/12 months. CVC implemented a new Point Click Care module that helps with capturing PI data.