Access and Flow | Timely | Priority Indicator

Indicator #1

90th percentile ambulance offload time (Windsor Regional Hospital)

Last Year		This Year		
117.00	107	104.00	11.11%	83
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

• Consult with external Ontario Health expert on quality assurance strategies for ambulance offload time monitoring and escalation plan for ambulance offload time delays • Weekly meetings and ongoing collaboration with EMS leadership to review data (volumes and trends) and the action plans.

Process measure

- Pay 4 Results (P4R) wait time metrics

Target for process measure

- Target set at 107 minutes

Lessons Learned

Implemented external auditor recommendations on quality assurance strategies to improve times through monitoring and escalation. Weekly meetings with EMS leadership to review data (volumes & trends) and develop real time action plans. This work continues.

Indicator #6

90th percentile emergency department wait time to physician initial assessment (Windsor Regional Hospital)

Last Year		This Year		
8.52	**7.70**	**8.60**	**-0.94%**	**6.90**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

• Work with the physician leads for recruitment and retention strategies to have a full compliment of physicians on the schedule and modify scheduling practices to fit volume demands • Work with the Medical Affairs department for sustainable human resource plan as well as increase funds for physician hours.

Process measure

- Pay 4 Results (P4R) wait time metrics

Target for process measure

- Target set at 7.7 hours

Lessons Learned

Continue to work with physician leads for recruitment and retention strategies. Implement new physician scheduling software.

Comment

Continue to implement the recommended improvement initiatives from the external emergency department review that was conducted in 2025.

	Last Year		This Year		
Indicator #8	**25.38**	**22.80**	**25.24**	**0.55%**	**20.20**
Daily average number of patients waiting in the emergency department for an inpatient bed at 8 a.m. (Windsor Regional Hospital)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

• Continue to work with the inpatient teams and the utilization leadership to improve time to inpatient bed by collaborating with the emergency department patient flow working group and the Utilization Management Committee.

Process measure

- Pay 4 Results (P4R) wait time metrics

Target for process measure

- Target set at 22.80 hours

Lessons Learned

Continue to work with the inpatient teams and internal patient flow working groups to reduce wait times. Emergency Department Quality Improvement Coordinators hired to help assist with patient flow in the emergency department.

Comment

In 2025, the emergency department underwent a review by an external auditor. Recommendations from the review continue to be implemented to improve emergency department patient access and flow.

Access and Flow | Timely | Optional Indicator

Indicator #5

90th percentile emergency department wait time to inpatient bed (Windsor Regional Hospital)

Last Year		This Year		
26.65	**23.70**	**22.80**	**14.45%**	**18.20**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

• Physician Initial Assessment (PIA) action plan will improve the total length of stay as well as continuing to work with the inpatient teams and the utilization leadership to improve time to inpatient bed by collaborating with the emergency department patient flow working group and the Utilization Management Committee.

Process measure

- Pay 4 Results (P4R) wait time metrics

Target for process measure

- Target set at 23.7 hours

Lessons Learned

Continue to implement the physician initial assessment initiatives. Continue to work with inpatient teams to improve time to inpatient bed in collaboration with emergency department and corporate patient flow teams.

Indicator #10

Percent of patients who visited the ED and left without being seen by a physician (Windsor Regional Hospital)

Last Year		This Year		
8.87	**8**	**8.84**	**0.34%**	**7.10**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

• Utilize the Physician Initial Assessment (PIA) action plan to improve left without being seen (LWBS) volume • Create a left without being seen policy with standard work and results of the Emergency Department Return Visit Quality Program (EDRVQP), to help support improvement initiatives • Continue diversion strategies with partner departments and organizations e.g. Nurse Police Team (NPT), Paediatric Emergency Diversion Clinic, Mental Health Assessment Unit (MHAU), and the Nurse Lead Outreach Team (NLOT).

Process measure

- Daily, weekly and monthly reporting of results through various teams and committees

Target for process measure

- Target set at 8.0%

Lessons Learned

Newly created left without being seen policy and standard work will help support improvement initiatives. Continue successful diversion initiatives that include the nationally recognized Nurse Police Team, the Paediatric Emergency Department Diversion Clinic, and the Nurse Led Outreach Team.

Comment

Continue successful diversion initiatives that include the nationally recognized Nurse Police Team, the Pediatric Emergency Department Diversion Clinic, the Mental Health Assessment Unit, and the Nurse Led Outreach Team.

	Last Year		This Year		
Indicator #4	**10.75**	**9.60**	**10.73**	**0.19%**	**8.60**
90th percentile emergency department length of stay for nonadmitted patients with low acuity (Windsor Regional Hospital)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

• Improvement in Physician Initial Assessment (PIA) to decrease length of stay • Daily review of the length of stay for all low acuity patients • Review of Emergency Department dashboard data to review practice and delays in disposition and the Emergency Department Return Visit Quality Program (EDRVQP) results for quality improvement opportunities.

Process measure

- Pay 4 Results (P4R) wait time metrics

Target for process measure

- Target set at 9.6 hours

Lessons Learned

Daily review of wait times for low acuity patients to develop real time action plans. Ongoing review of emergency department dashboard data to review practice and delays in disposition

Comment

in 2025, WRH underwent a comprehensive external emergency department review and the recommendations from that audit continue to be worked on.

Indicator #3

90th percentile emergency department length of stay for nonadmitted patients with high acuity (Windsor Regional Hospital)

Last Year		This Year		
12.88	**11.60**	**12.90**	**-0.16%**	**10.30**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

• Improvement in Physician Initial Assessment (PIA) will decrease the length of stay overall and for all high acuity patients • Review of Emergency Department dashboard data to review practice and delays in disposition and the Emergency Department Return Visit Quality Program (EDRVQP) results for quality improvement opportunities.

Process measure

- Pay 4 Results (P4R) wait time metrics

Target for process measure

- Target set at 11.6 hours

Lessons Learned

Continue to implement improvement strategies recommended by the external auditor. Continued focus on physician initial assessment time. Daily, weekly and monthly review of ED Dashboard data to review practice and delays in disposition.

Comment

In 2025, WRH underwent an external audit of the emergency department. Multiple recommendations to help improve patient flow and wait times continue to be implemented. Ongoing meetings with EMS help support system wide process improvement initiatives. A 20% improvement target has been established for this upcoming year.

Indicator #2

90th percentile emergency department length of stay for admitted patients (Windsor Regional Hospital)

Last Year		This Year		
35.83	**31.90**	**30.20**	**15.71%**	**24.20**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

• Physician Initial Assessment (PIA) action plan will improve the total length of stay • Continue to work with the inpatient teams and the utilization leadership to improve time to inpatient bed by collaborating with the Emergency Department patient flow working group and the Utilization Management Committee.

Process measure

- Pay 4 Results (P4R) wait time metrics

Target for process measure

- Target set at 31.9 hours

Lessons Learned

Ongoing work with professional staff to improve physician initial assessment time. Ongoing work with various internal working groups on strategies to improve time to inpatient bed.

Equity | Equitable | Optional Indicator

	Last Year		This Year		
Indicator #13	**100.00**	**100**	**CB**	**--**	**80**
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education (Windsor Regional Hospital)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

• Provide EIDAR e-learn education & training to leadership: Track compliance and the progress of leadership completing required EIDAR training and education • Provide Indigenous cultural safety training and disseminate to leadership (executive and directors) • Develop EIDAR education to be included in staff orientation and through e-learn • Regional Indigenous Navigator to support development of content across Erie St. Clair hospitals.

Process measure

- Monthly reporting of results

Target for process measure

- Targets set based on staffing group: 100% compliance for executives; 80% compliance for directors, 50% compliance for managers and CB for frontline staff.

Lessons Learned

Roll out of EIDAR education and training at orientation and at front line managers forum

Comment

Continued roll out of EIDAR and Indigenous cultural training initiatives to various staffing groups beyond the executive and director group to front line managers and staff.

Indicator #7

Average ED wait time to physician initial assessment (PIA) for individuals with sickle cell disease (CTAS 1 or 2) (Windsor Regional Hospital)

Last Year		This Year		
109.44	**109.44**	**145.28**	**-32.75%**	**90**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

• Collaborate with professional staff and physician leads/champions to provide sickle cell education and information to the emergency department staff to improve assessment and treatment times and outpatient follow-up • Physician Initial Assessment (PIA) electronic medical record time stamp improvements, Code Medical initiation and overall physician initial assessment improvements will support CTAS 1 and 2 Physician Initial Assessment times.

Process measure

- Daily, weekly and monthly reporting of results to establish baseline

Target for process measure

- Baseline year for collection of data and initiation of services

Lessons Learned

Developed an internal and external work group in collaboration with North York General. Internal working group includes the emergency department where education and training are being conducted in collaboration with the physician sickle cell hospital lead and emergency department champions. Daily weekly monitoring of metrics.

Comment

2025/2026 Fiscal Year to Date Actual PIA result is 101 minutes, an improvement from prior year results. New collaboration with North York General to help support improvement initiatives. Sickle cell working group developed to help track and monitor daily, weekly and monthly sickle cell metrics. In 2026, a patient with lived experience will join the WRH sickle cell working group to better inform care. Code Medical established to include immediate response to patients who present to the emergency department with sickle cell disease

Indicator #15

Rate of ED 30-day repeat visits for individuals with sickle cell disease (Windsor Regional Hospital)

Last Year		This Year		
X	**18.20**	**36.40**	**--**	**NA**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

• Collaborate with professional staff and physician leads/champions to provide sickle cell education and information to the Emergency Department staff to improve assessment and treatment times and outpatient follow-up, to reduce 30-day repeat visits to the emergency department • Review the Emergency Department Return Visit Quality Program (EDRVQP) results for quality improvement opportunities • Where possible, refer paediatric patients to the Paediatric Emergency Department Diversion Clinic or to appropriate paediatric specialist (hematology-oncology) offices.

Process measure

- Daily, weekly and monthly reporting of results to establish baseline

Target for process measure

- Baseline year for collection of data and initiation of services

Lessons Learned

Physician Champions established; Education and training on sickle cell disease for emergency department staff; chart review on all patients visiting the emergency department with sickle cell disease; established a multi-disciplinary sickle cell working group that meets monthly; developed a sickle cell Power BI dashboard; and, collaborate with North York General Hospital in the Evidence to Practice Sickle Cell Program.

Comment

Strategies are focused on lessening wait times, helping to prevent complications, and improving the care provided to individuals with sickle cell disease to address health care disparities and ensure equitable access to treatment.

Indicator #11

Percentage of ED visits for individuals with sickle cell disease triaged with high severity (CTAS 1 or 2) (Windsor Regional Hospital)

Last Year		This Year		
74.07	**74.07**	**82.30**	**--**	**NA**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

• Collaborate with professional staff and physician leads/champions to provide sickle cell education and information to the Emergency Department staff to improve assessment and treatment times and outpatient follow up

Process measure

- Daily, weekly and monthly reporting of results to establish baseline

Target for process measure

- Baseline year for collection of data and initiation of services

Lessons Learned

Physician Champions established; Education and training on sickle cell disease for emergency department staff; chart review on all patients visiting the emergency department with sickle cell disease; established a multi-disciplinary sickle cell working group that meets monthly; developed a sickle cell Power BI dashboard; and, collaborate with North York General Hospital in the Evidence to Practice Sickle Cell Program.

Comment

FYTD 2025/2026 results are 82.3%. Strategies to improve the identification and treatment will be further augmented by implementing patient acute wallet cards to support expedited pain management and improve time to first analgesia; implement a sickle cell alert in the electronic medical record and support the development of a paediatric and adult sickle cell disease clinic and embed a wellbeing coordinator into patient flow.

Experience | Patient-centred | Optional Indicator

Indicator #12

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? (Windsor Regional Hospital)

Last Year		This Year		
79.22	**83**	**67.79**	**-14.43%**	**75.50**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ **Implemented** ☐ **Not Implemented** ☐ **In Progress**

• Monthly reporting of results from patient satisfaction surveys ensuring appropriate contact information including email address has been collected • Ongoing education to registration staff on consent and email collection process • Standardized Leadership Rounding on all in-patient units with leaders asking about concerns or needs • In-room white boards to provide communication to those involved in the circle of care • Utilize the electronic health information management system and discharge huddle process to ensure the care team has provided the appropriate health information to the patient • Roll-out Qualtrics electronic patient experience survey to inpatient areas, select outpatient areas, and the Emergency Department.

Process measure

- % of patients responding completely to this question.

Target for process measure

- Target set at 5% improvement from prior year results. Target of 83% is better than the provincial average of 71.2%

Lessons Learned

Introduction of the Qualtrics electronic survey across inpatient areas, Emergency Department, outpatient clinics, Day Surgery and the Catheterization Lab will result in an increased response rate across a broad range of areas.

Comment

The Qualtrics electronic survey was introduced in November 2025 across a broad range of areas representing inpatient, outpatient, day surgery, emergency department and outpatient clinics and the catheterization lab resulting in an increased response rate from 3% to 37%.

Safety | Safe | Optional Indicator

Indicator #9

Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged. (Windsor Regional Hospital)

Last Year		This Year		
90.40	**96**	**87.73**	**-2.95%**	**96**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

• Continue to monitor the medication reconciliation process at both campuses utilizing Cerner (electronic health information system), with identified reporting responsibilities for nursing, professional staff (physicians in the Emergency Department and Most Responsible) and pharmacists/pharmacist technicians

Process measure

- % of patients with medication reconciliation completed at discharge

Target for process measure

- Target set at 96%, which is better than the provincial average of 83.4%

Lessons Learned

Standardize medication reconciliation process across both campuses of WRH.

Comment

Improved from previous year results. Ongoing education and training utilizing the electronic health record system with identified reporting responsibilities for nursing, physicians and pharmacy (pharmacists & pharmacy technicians)

Indicator #14

Rate of delirium onset during hospitalization (Windsor Regional Hospital)

Last Year		This Year		
1.11	**1.03**	**0.95**	**--**	**0.90**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

• Review hospital acquired delirium documentation with the physician teams in the Departments of Medicine and Family Medicine • Establish and review hospital acquired delirium case studies with the Departments of Medicine and Family Medicine physician teams • Review hospital acquired delirium cases through the Departmental Quality Review (DQR) process where applicable • Ensure the on-site Behavioral Nursing Specialist continues delirium education and training with frontline staff.

Process measure

- % of patients diagnosed with hospital acquired delirium

Target for process measure

- Target set at 1.03%, which is the provincial average

Lessons Learned

Review hospital acquired delirium cases as part of department quality review process for improvement opportunities.

Comment

Work closely with medical affairs, decision support and health records for monthly review of cases for improved documentation and coding opportunities.

Indicator #16

Rate of workplace violence incidents resulting in lost time injury (Windsor Regional Hospital)

Last Year		This Year		
0.14	**0.13**	**0.17**	**-21.43%**	**0.15**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ **Implemented** ☐ **Not Implemented** ☐ **In Progress**

• Safe Workplace e-learn: Continue with enforcement of Safe Workplace e-learns as part of training protocol for all staff • Workplace Violence Weekly Reports: Highlight incidents resulting in harm at Monday Morning Huddles • Continue to provide Code White/De-escalation training to all staff • Safe Workplace Indicator Team: Maintain cross-department representation • Enhanced Flagging Protocol: Enhance and implement patient/visitor flagging with known risks • Incident Follow-Up Process: Introduce a standardized approach to follow-up on workplace violence incidents with debriefings and actionable recommendations • Environment Safety Audits: Conduct monthly safety audits in high-risk areas to identify potential hazards and ensure compliance with safety standards • Staff Support Resources: Expand availability of support resources for staff exposed to workplace violence • Risk Assessment Tools: Integrate risk assessment tools into workflows to proactively identify and mitigate potential workplace violence threats • Department specific safety working groups.

Process measure

• • % of staff completing Safe Workplace e-learn monthly • % of incidents reported and reviewed by the care team and leadership within 48 hours • % of staff from high-risk areas completing Code White training • % of Post-Incident Debrief completed with involved staff and leadership • the number of workplace violence incidents reported compared to total number of incidents observed or flagged

Target for process measure

• • 95% of staff complete the Safe Workplace e-learn • 100% of reported incidents reviewed by care teams and leadership within 48 hours • 95% of staff in high-risk areas complete Code White training • 100% of incidents resulting in lost time injury or harm hold post incident debrief sessions • 100% of high risk areas complete environmental safety audits monthly with actionable follow-up within two weeks of incident • Workplace Violence Trends Report distributed monthly to 100% of leadership teams.

Lessons Learned

WRH set an ambitious target at .15%. Safe workplace initiatives including Code White training to all staff in high-risk areas, enhanced policies and mock drills and ongoing monitoring and tracking support this metric overall

Comment

WRH results for last year (.17%) remains well below provincial average at 3.3%.