2026-2027 Quality Improvement Plan

Improvement Initiatives & Targets

Windsor Regional Hospital (WRH)

Priority	Indicator	Unit of Measure	Source	QIP Reporting Period	WRH Performance for Reporting Period	WRH 2026/2027 Target	2026-2027 Target Justification/ Comments	Planned Improvement Initiatives (Change Ideas)	Method(s)	Process Measure(s)	Target(s) for Process Measure(s)
Access and Flow	90th percentile ambulance offload time (Priority Indicator)	Minutes	NACRS	Dec 2024 - Nov 2025	104	83	Target set at 83 minutes. 20% improvement from current performance	• Continue to implement and monitor the recommendations made by the Emergency Department external auditor/reviewer on quality assurance strategies for ambulance offload time monitoring and escalation • Weekly meetings and ongoing collaboration with Emergency Medical Services (EMS) leadership to review data (volumes and trends) and develop real time action plans • Monitor corporate surge plan with Access and Flow Leadership to ensure offload capacity due to corporate surge.	• Data collection and monitoring of the Pay 4 Results (P4R) reporting • Monitor daily metrics and compliance with leadership and staff • In-person mentoring, training and education (face to face) with staff • Monitor Emergency Medical Services (EMS) transport resource availability and root cause analysis impact, related to all Code Black occurrences.	Pay 4 Results (P4R) wait time metrics	Target set at 83 minutes for this metric
	90th percentile Emergency Department wait time to physician initial assessment (Priority Indicator)	Hours	NACRS	Dec 2024 - Nov 2025	8.60	6.9	Target set at 6.9 hours. 20% improvement from current performance	• Continue to work with the physician leads on recruitment and retention strategies to have a full compliment of physicians on the schedule and to modify the scheduling practices to fit volume demands • Help support the Medical Affairs department with a sustainable human resource plan as well as increase funds for physician hours • Implement new physician scheduling software that will align with Emergency Department volumes and physician performance.	• Monthly physician scorecard evaluation of metrics and action plans • Ongoing physician leadership mentorship • Monthly review of trends in hourly volumes and PIA shift alignment • Medical Affairs human resource development plan for the Emergency Department physicians to support recruitment strategies.	Pay 4 Results (P4R) wait time metrics	Target set at 6.9 hours for this metric
	Daily average number of patients waiting in the Emergency Department for an inpatient bed at 8 a.m.(Priority Indicator)	Number of patients per day	NACRS	Apr 2024 - Mar 2025	25.20	20.2	Target set at 20.2. 20% improvement from current performance	• Continue to work with the hospital's inpatient teams and utilization leadership to improve time to inpatient bed by collaborating with the Emergency Department, Utilization Management Committee and Corporate Flow Committee • Implement the Emergency Department Quality Improvement (QI) Coordinator positions to help support patient flow to monitor barriers to the length of stay (LOS).	• Data collection for Pay 4 Results (P4R) reporting and monitoring of daily metrics and compliance • Utilize daily and monthly scorecards to target discharge before 1100 and 1400 as well tracking estimated date of discharge delays • Ongoing monitoring and tracking of physician scorecards.	Pay 4 Results (P4R) wait time metrics	Target set at 20.2 for this metric
	90th percentile Emergency Department length of stay for nonadmitted patients triaged as low acuity (Priority Indicator)	Hours	NACRS	Dec 2024 - Nov 2025	10.73	8.6	Target set at 8.6 hours. 20% improvement from current performance	• Improvement in Physician Initial Assessment (PIA) time 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 any delays in disposition • Utilize the Quality Improvement (QI) Coordinator position to target improved PIA results and decrease delays in length of stay by overall collaboration with internal hospital partners for process improvements impacting delays in length of stay.	Data collection for Pay 4 Results (P4R) reporting and monitoring daily metrics and compliance.	Pay 4 Results (P4R) wait time metrics	Target set at 8.6 hours for this metric
	90th percentile Emergency Department length of stay for nonadmitted patients triaged with high acuity (Priority Indicator)	Hours	NACRS	Dec 2024 - Nov 2025	12.90	10.3	Target set at 10.3 hours. 20% improvement from current performance	• Improvement in Physician Initial Assessment (PIA) will decrease the Emergency Department length of stay overall and for all high acuity patients • Daily, weekly review of Emergency Department dashboard data to review practice and delays in disposition • Utilize the Emergency Department QI Coordinator position to target improved PIA and decrease delays in length of stay by overall collaboration with internal hospital partners for process improvement impacting delays in the length of stay.	• Daily monitoring of metrics from Emergency Department and Physician performance dashboards • Quality assurance through review and discussions are weekly Emergency Department leadership meetings.	Pay 4 Results (P4R) wait time metrics	Target set at 10.3 hours for this metric
	90th percentile Emergency Department length of stay for admitted patients	Hours	NACRS	Dec 2024 - Nov 2025	30.20	24.2	Target set at 24.2 hours. 20% improvement from current performance	• Continue to work with WRH's inpatient teams and patient flow/ utilization leadership to improve time to inpatient bed by collaborating with the Emergency Department, Utilization Management Committee and Corporate Flow Committee • Implement the Emergency Department Quality Improvement (QI) Coordinator position to help support patient flow to monitor barriers to length of stay • Improvement in Physician Initial Assessment (PIA) will also decrease the total length of stay for admitted patients.	Data collection for Pay 4 Results (P4R) reporting and monitoring of daily metrics and compliance.	Pay 4 Results (P4R) wait time metrics	Target set at 24.2 hours for this metric
	90th percentile Emergency Department wait time to inpatient bed	Hours	NACRS	Dec 2024 - Nov 2025	22.80	18.2	Target set at 20% improvement from current performance	• Continue to work with the hospital's inpatient teams and utilization leadership to improve time to inpatient bed by collaborating with the Emergency Department, Utilization Management Committee and Corporate Flow Committee • Implement the Emergency Department Quality Improvement Coordinator positions to help support patient flow to monitor barriers to LOS.	• Data monitoring of P4R metrics reporting and monitoring daily metrics and compliance • In collaboration with the ED Leadership and QI Coordinators, we will evaluate barriers for time to inpatient bed and collaborate with the access and flow leads throughout targeted working groups that report up to the Corporate Flow Committee.	Pay 4 Results (P4R) wait time metrics	Target set at 18.2 hours for this metric

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Access and Flow	Percentage of patients who visited the Emergency Department and left without being seen (LWBS) by a physician	Percentage	NACRS	Apr 2024 - Mar 2025	8.84%	7.1%	Target set at 20% improvement from current performance	• Utilize the Physician Initial Assessment (PIA) action plan to improve left without being seen (LWBS) volume • Newly created left without being seen policy and standard work will help support improvement initiatives • Utilize the Emergency Department QI Coordinator positions to target improved PIA improvements and delays in length of stay overall impacting a decrease in LWBS • Continue successful 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).	• Daily monitoring of emergency department data • Ensure quality assurance through weekly Emergency Department leadership meetings • Daily/weekly monitoring of diversion strategy metrics in consultation with partner departments and organizations.	Daily, weekly and monthly reporting of results through various teams and committees	Target set at 7.1% for this metric
	NEW: Percentage of people who undergo hip fracture surgery within 48 hours of first arrival at any hospital	Percentage	NACRS	Apr 2025 - Sep 2025	43.70%	81.5%	Target set at 81.5% which is consistent with CIHI's YHS Ontario Benchmarking results for FY 2024/2025	• Implement Ontario Health Hip Fracture Quality Standards including: Suspected hip fractures diagnosed within 1 hour of arriving to hospital where preparation for surgery is initiated and patient is admitted and transferred to a bed in an inpatient unit within 8 hours; Individuals with a hip fracture receive surgery as soon as possible within 48 hours of their first arrival; Individuals with suspected hip fracture have their pain assessed within 30 minutes of arriving to hospital and pain managed using a multimodal approach; Specific interventions for stable intertrochanteric fractures, surgery for subtrochanteric or unstable intertrochanteric fractures; and surgery for displaced intracapsular fractures and post operative blood transfusions, in addition to various initiatives post surgery to be reviewed.	• Daily reporting and review of all patients admitted with a hip fracture and removal of process barriers • Weekly reporting on all hip fracture patients not meeting target, with the reason for delay documented and trended • Weekly reporting of trends by campus • Monthly reporting to the OR Committee and OR Executive Committee of the percentage of hip fracture patients sent to the OR within 48 hours • Refinement of current pre-operative power plan for fracture hips to support targeted interventions towards timely treatment for our patients • Development of the hip fracture scorecard for multidisciplinary team to track progress and action plans and interventions.	• Daily, weekly and monthly monitoring of the following indicators: Time to Diagnosis; Time to ED pain assessment; Time to orthopedic consult; Time to Internal Medicine consult; Admit to Bed Time; Time to medical clearance for surgery; overall inpatient length of stay (LOS); and 7 day readmission rate • Review documentation and trend results for reasons for delay	• Target set at 81.5% for this metric • Other metrics include: ED Diagnosis within 1 hour of arrival; ED pain assessment within 30 minutes of arrival; Time to orthopedic consult within 8 hours; Time to internal medicine consult within 8 hrs.; Admit to Bed Time within 8 hours.; Time to medical clearance for surgery within 24 hours; Total length of stay within 7 days; 7 day readmission rate less than 4%.
Equity	Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and antiracism education	Percentage	Local data collection	Most recent 12 month period (Dec 2024 - Nov 2025)	37%	80.0%	Target set at 80% overall for Executive, Directors, and Managers (clinical and operational). Baseline data for front line staff	• Provide EIDAR e-learn education & training to all leadership and track compliance and the progress of leadership completing required EIDAR training and education and utilize e-learn to expand access to education and training • Provide Indigenous cultural safety training and disseminate to leadership (executive, directors & managers) • Provide EIDAR education to front line staff during orientation and through e-learn • Regional Indigenous Navigator to help support the development of content regionally across Erie St. Clair hospitals.	• Leadership at Windsor Regional Hospital to complete EIDAR and Indigenous cultural safety training and expand access to education and training with eLearn's • Include EIDAR and Indigenous cultural safety training in staff orientation process to improve patient experience • Utilize working groups and/or committees and the Regional Indigenous Navigator to plan education roll-out and strategies across staffing groups.	The percent of executive, directors and managers who complete assigned EIDAR education and training.	Target set at 80% of all leadership to complete EIDAR training and education where leadership includes the executives, directors and clinical and operational managers • Establish baseline for front line staff completing EIDAR training and education as part of their onboarding and orientation.
	Average Emergency Department wait time to physician initial assessment for individuals with sickle cell disease (CTAS 1 and 2)	Minutes	NACRS	Apr 2025 - Sep 2025	145.28	90	Target set at the provincial average of 90 minutes.	• Collaborate with staff/physician leads/champions to provide sickle cell education regarding care and medication administration to Emergency Department staff to improve assessment and treatment times and outpatient follow-up • Daily, weekly and monthly monitoring of sickle cell disease metrics via the dashboard • Physician Initial Assessment (PIA) electronic medical record time stamp monitoring and tracking for improvement including Code Medical initiation for patients presenting to the Emergency Department with sickle cell disease • Overall physician initial assessment (PIA) improvements to support wait times for all patients with sickle cell disease, specifically those triaged as CTAS 1 and 2 • Collaborate with North York General Hospital as a member of the Sickle Cell Evidence 2 Practice (E2P) Program • Implement patient acute pain wallet cards to support expedited pain management in ED • Develop and post in ED exam rooms sickle cell disease (SCD) awareness posters • Implement an SCD alert in the regional Electronic Medical Record (EMR) • Implement sublingual fentanyl for medication administration to improve time to first analgesia in ED • Partner with the Sickle Cell Awareness Group of Ontario (SCAGO) to embed a SCAGO Wellbeing Coordinator into the patient workflows • Improve the management and care of patients presenting to ED through frequent education and training.	• Bi-weekly review of sickle cell disease (SCD) Emergency Department metrics to track and monitor waiting time (including Physician Initial Assessment) and overall care • Chart reviews conducted on all sickle cell patients who present to the Emergency Department • Track and monitor delays in care and adherence to medication administration protocols • Track and monitor Code Medical response time • Track/monitor delays in care documented in the risk reporting system to ensure appropriate review and follow-up • Codesign a patient wallet card with patient and health care provider • Provide wallet cards to patients in adult SCD clinic and educate ED staff on its use and contents • Obtain University Health Network (UHN) developed posters, updated to include WRH information and posted in ED triage rooms • Work with Transform Shared Services (TSSO) to create a regional SCD alert that is applied to the electronic medical record to all known SCD patient charts so that the alert will appear when the patient chart is opened • Develop memorandum of agreement (MOA) between SCAGO (Sickle Cell Awareness Group of Ontario) and Windsor Regional Hospital • Conduct regular lunch and learn events, workshops and regional education events that focus on sickle cell disease	• The Sickle Cell Emergency Department dashboard includes the following metrics: Average Emergency Department wait time to Physician Initial Assessment in minutes, for individuals with sickle cell disease (CTAS 1 and 2); the rate of Emergency Department 30 day repeat visits for individuals with sickle cell disease; the % of ED visits for individuals with sickle cell disease (CTAS 1 and 2); and the median time to first dose of analgesic in minutes • Average response time to Code Medical alert (in minutes)	• Target set at 90 minutes • Target for the rate of Emergency Department 30 day repeat visits for individuals with sickle cell disease to be determined as the baseline data being collected this upcoming year • % of Emergency Department visits for individuals with sickle cell disease triaged with high severity (CTAS 1 & 2) to be determined as baseline data being collected • Median time to first dose of analgesic (CTAS 1 and 2) within 30 minutes.

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Experience	Did patients feel they received adequate information about their health and their care at discharge?	Percentage	Local data collection	Most recent 12 month period (Dec 2024 - Nov 2025)	67.79%	75.5%	Target set at 75.5% which is the provincial average	• Phase 2 implementation of the qualtrics surveys to critical care areas (adult and paediatric) • Monthly reporting of results from patient satisfaction surveys ensuring that appropriate contact information including email address has also been collected • Standardized Leadership Rounding on all in-patient units with leaders asking about any concerns or needs the patient has about going home • In-room white boards designed to provide communication to those involved in the circle of care • Leverage the electronic health information management system and discharge huddle process to ensure that the care team has provided the appropriate health information to patient prior to discharge.	• Monthly reporting of results from patient satisfaction surveys and leadership rounding across the organization ensuring that appropriate contact information including email address has been collected from patients; • On-going monitoring of completion of in-room patient white boards • Leverage new electronic information management system and discharge huddle process to confirm that appropriate health information has been provided to patient prior to discharge	% of patients who respond positively to this question on the patient satisfaction survey	Target set at 75.5% for this metric.
Safety	Rate of delirium onset during hospitalization	Percentage	DAD	Apr 2025 - Sep 2025 (discharge date)	0.95%	0.9%	Target set at .9%, which is better (lower) than the provincial average of 1.2%	• Review hospital acquired delirium documentation with medicine and family medicine physician teams on an ongoing basis • Establish and review hospital acquired delirium case studies with medicine and family medicine physician teams • Review hospital acquired delirium cases through the department quality review process where applicable • Behavioral Specialist to continue Delirium education with frontline staff as part of WRH's Senior Friendly Program.	• Review coded data related to hospital acquired delirium; • Audit the results from the Confusion Assessment Method (CAM) screening tool completed on inpatient units as part of WRH's Senior Friendly Program.	% of patients diagnosed with hospital acquired delirium	Target set at .9% for this metric
	Rate of medication reconciliation at discharge	Percentage	Hospital collected data (Cerner)	Most recent 12 month period (Dec 2024 - Nov 2025)	87.73%	96%	Target set at 96% which is consistent with prior year target. Current performance is better (higher) than the provincial average of 75.5%	• Standardize the medication reconciliation process across both campuses of Windsor Regional Hospital • Utilize the electronic health information system with identified reporting responsibilities for nursing, physicians (ED and MRP) and pharmacists/pharmacist technicians.	• On a weekly and monthly basis, audit the compliance and accuracy of the medication reconciliation process completed on all patients at discharge	% of patients with medication reconciliation is completed at discharge.	Target set at 96% for this metric
	Rate of workplace violence incidents resulting in lost-time injury	Percentage	Hospital collected data (RL6)	Most recent 12 month period (Dec 2024 - Nov 2025)	0.17%	0.15%	Target set at .15% which is better (lower) than the provincial average of 3.3%.	• Safe workplace eLearn emphasizes code white policy, safe workplace policy, domestic violence/ intimate partner protocol, professional staff conduct and flagging patients/visitors • Workplace violence results reported weekly at Monday Morning Huddle highlighting incidents resulting in harm • Code White/de-escalation training provided to all staff in high risk areas • Safe Workplace Indicator Team has cross department representation including high risk areas such as the Emergency Department and Mental Health units.	• Ongoing monitoring of E-learn compliance • Standard work created for prevention, investigation and debriefing • Weekly monitoring of results with clinical leadership team at Monday Morning Huddle and review of every incident in real time with leadership, the process improvement team and the bargaining unit leadership as required • Monitoring staff completion of Code White/de-escalation training program.	• Monthly rate of E-learn compliance • % of incidents reported and reviewed by care team and leadership • % completing code white training from high risk areas	Target set at .15% for this metric