

Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 9, 2026

North Bay Regional
Health Centre



Centre régional
de santé de North Bay



**Ontario
Health**

OVERVIEW

A Message to Our Patients, Families, and Community,

At North Bay Regional Health Centre (NBRHC), we remain deeply committed to delivering safe, timely, and person-centred care that responds to the evolving needs of our community. As a regional referral hospital serving a growing and aging population, quality improvement continues to be foundational to how we plan, deliver, and evaluate care.

The 2026–2027 Quality Improvement Plan (QIP) reflects our continued focus on preventing avoidable harm, improving access and flow, and supporting patients to receive care in the most appropriate setting, ideally at home. These priorities acknowledge both the increasing complexity of the patients we serve and our shared responsibility to ensure hospital care is purposeful, safe, trauma informed and supports timely recovery and transition.

This year's QIP builds on the strong foundation established through our Quality Framework (2023–2027) and Patient Safety Plan, reinforcing a system-wide approach to quality that integrates safety, effectiveness, access, and patient experience. Our priorities are aligned to key risks and opportunities across the organization, with a particular emphasis on older adults, avoidance of unnecessary hospitalization and Alternate Level of Care (ALC) designation and strengthening transitions across the continuum of care. Central to this work is our continued commitment to patient and family involvement. We believe that quality is best achieved when those with lived experience help shape the care we deliver. By listening, learning, and acting on patient feedback, we ensure our improvement efforts remain grounded in what matters most to the

people we serve. This QIP provides a high-level overview of our quality direction for the year ahead and demonstrates our commitment to transparency and accountability. Achieving meaningful improvement is a shared effort, one that relies on the collective contributions of patients, families, staff, physicians, volunteers, leaders, and community partners.

Together, we continue to strengthen a culture where quality and safety are not initiatives, but expectations supporting better outcomes, better experiences, and better care for our community.

ACCESS AND FLOW

Improving access and patient flow is foundational to patient safety, experience, and system sustainability, particularly for an aging population with increasingly complex care needs. In 2026–2027, we will continue to monitor the 90th percentile wait time from Emergency Department arrival to inpatient bed as a key indicator of overall system flow, patient safety, and timely access to care. Reducing delays to inpatient care supports better clinical outcomes, improves patient experience, and strengthens our ability to care for patients in the most appropriate setting.

Building on the significant progress made to date, this year's work will focus on further embedding a Home First philosophy and reducing avoidable Alternate Level of Care (ALC) days by strengthening coordination, accountability, and early discharge planning across the system. While notable strides have been achieved, continued improvement is required to ensure that flow processes consistently support timely admission, active care, and safe transitions back to home or community. Key initiatives for 2026–2027 include strengthening governance and operational

oversight through the Access and Flow Committee, with a clearly defined workplan and clearly established performance targets. Core flow tools will be refined and standardized, including admission and discharge time expectations, Estimated Date of Discharge (EDD) targets, transfer lists, readiness-for-discharge components, and a comprehensive patient flow dashboard to support real-time decision-making.

Internally, we will redesign the patient flow portfolio by revising Patient Flow Navigator roles and strengthening Hospital to Home and Long-Term Care programs. These actions will ensure timely access to care, reduce delays, and support safe, effective transitions home.

PATIENT/CLIENT/RESIDENT EXPERIENCE

Safe transitions do not end at discharge. Understanding the patient's experience, particularly their confidence in managing care after leaving the hospital, is essential to preventing avoidable readmissions and supporting recovery at home.

In 2026–2027, North Bay Regional Health Centre will build on the progress made in strengthening patient experience measurements and the use of feedback to improve care transitions. Last year's work established a strong foundation for collecting and monitoring patient-reported experience data related to discharge communication. This year, the focus shifts to expanding measurement, strengthening transparency, and using results to drive targeted improvement.

We will expand the implementation of our modernized patient experience measurement program to additional clinical areas,

including Critical Care (CCU/NICU), inpatient maternity and rehabilitation, outpatient services, and Mental Health & Addictions (inpatient and outpatient). This work includes updating and testing Meditech Expanse workflows, building and validating Qualtrics surveys and dashboards, completing staff education and training, and launching new surveys with ongoing monitoring of results and response rates.

To ensure feedback leads to action, we will enhance the dissemination and use of survey results across the organization. Qualtrics dashboards will be optimized to improve access, clarity, and the ability to filter results by unit. We will explore integration of patient experience results into the hospital's internal performance dashboard and standardize quarterly reporting to units and leadership to support accountability and local improvement.

Finally, we will undertake at least one Continuous Quality Improvement (CQI) initiative aimed at increasing the percentage of patients who report they "completely" received enough information about what to do if they were worried about their condition or treatment after discharge. One unit will be selected to participate in a patient involved CQI initiative to understand the current state, review best practices, identify opportunities for improvement, and determine next steps based on findings.

Together, these activities support safer transitions, improved patient confidence following discharge, and more consistent use of patient experience data to inform quality improvement across the organization.

SAFETY

1)FALL PREVENTION

Preventing harm during hospitalization requires targeted action in areas of highest risk. Inpatient falls remain the leading cause of preventable patient harm and are our organization's top safety risk. Falls are also a leading cause of harm in Canadian hospitals, accounting for more than half of reported patient safety incidents.

To reduce overall fall-related harm, we will measure the rate of harmful inpatient falls per 1,000 patient days, including falls resulting in mild, moderate, severe harm, or death. The most common severity of harm from falls in our organization is mild, accounting for approximately half of all fall-related harm events. Approximately half of our falls occur when patients are alone, making them unwitnessed. We recognize the importance of encouraging patients to mobilize to regain or maintain strength and support a safe return home. With this philosophy of care comes an inherent risk of falls; therefore, our focus is on reducing harm when falls occur, which is why we have selected harmful falls per 1,000 patient days as our primary outcome measure.

In previous years, several strategies have been implemented to reduce falls, including patient education posters, staff e-learning, Morse Fall Risk Assessments on admission and weekly, and updated falls prevention equipment such as non-slip footwear and audible seatbelt alarms. Despite these efforts, falls rates have remained relatively static since 2021, with an increase observed in 2025. In response, we are implementing a different approach by identifying a group of frontline interdisciplinary staff as Falls Specialists to lead evidence-based change initiatives aimed at reducing fall-related harm.

Purposeful Rounding, defined as in-person, hourly checks to proactively assess patient needs, will be a key intervention. Purposeful rounding enhances patient safety by mitigating fall risk, strengthening team communication, and building staff capacity to deliver efficient, high-quality care. Evidence demonstrates additional benefits, including reduced pressure injuries, decreased call bell use, and improved patient satisfaction.

To measure the effectiveness of purposeful rounding, we will monitor call bell usage and response times to ensure patient needs are addressed promptly and to reduce the likelihood of patients attempting to mobilize without assistance.

We will also implement bedside mobility care plans, visible to all disciplines, that integrate ambulation goals with fall prevention strategies. This will enhance interdisciplinary communication and ensure clarity regarding each patient's mobility needs and safety requirements.

2) DELIRIUM PREVENTION

Delirium prevention is a key patient safety priority at NBRHC, aligned with falls prevention, Senior Friendly Care initiatives, and improving outcomes for hospitalized older adults. Delirium is associated with increased falls, functional decline, longer length of stay, and poorer overall patient outcomes.

Our improvement approach begins with establishing a standardized baseline assessment of cognition and function on admission to support early recognition of changes and targeted prevention

strategies. This work includes interdisciplinary collaboration, workflow integration, education, and documentation standardization.

Subsequent phases focus on implementing standardized delirium screening linked to baseline function, developing a clear escalation pathway, and embedding prevention strategies such as mobility, sleep support, hydration, and orientation into routine care.

Sustainability will be supported through education, documentation practices, clinical decision supports, and interdisciplinary collaboration. While detection rates may initially increase, the long-term goal is improved prevention, earlier intervention, and better patient outcomes.

3)REDUCTION OF SECLUSION AND RESTRAINTS:

Creating a safe care environment also requires proactive, prevention-focused approaches to distress and behavioural escalation, grounded in trauma-informed and recovery-oriented care. NBRHC is committed to the adoption of evidence-informed practices that improve patient outcomes and promote safe, respectful care. A key organizational priority is minimizing the use of seclusion and restraints through prevention-focused, trauma-informed approaches that support recovery and dignity.

Workforce development is a foundational pillar of this work. Creating an environment grounded in recovery-oriented and trauma-informed principles supports safer care, reduces the likelihood of escalation, and improves experiences for both patients and staff. In support of this goal, NBRHC has revised its Nonviolent

Crisis Intervention (NVCi) education to strategically integrate trauma-informed care principles, reinforcing de-escalation as the primary response to distress and behavioural escalation.

Cultivating a culture centred on de-escalation and trauma-informed practice helps reduce coercive interventions and minimizes situations that may trigger conflict in care delivery. Through this initiative, we aim to improve patient safety, enhance staff confidence and competence, foster a more compassionate and therapeutic care environment, and strengthen the overall effectiveness and value of our workforce development efforts.

To further embed this approach, members of the extended leadership team will complete the trauma-informed de-escalation training alongside frontline staff. Leaders will carry this learning into their routine leadership listening and learning rounds across the hospital, creating opportunities for shared reflection and generative dialogue about how trauma-informed principles are applied in practice. This shared learning model supports alignment between leadership and frontline teams and reinforces unified goals related to safety, dignity, and respectful care.

Together, these efforts support a sustainable culture shift toward prevention, de-escalation, and trauma-informed care, strengthening patient safety, staff well-being, and the quality of care delivered across the organization.

EMERGENCY DEPARTMENT RETURN VISIT QUALITY PROGRAM (EDRVQP)

Emergency Department return visit audits provide a critical lens into early clinical decision-making, system responsiveness, and

opportunities to reduce downstream harm and unplanned returns to care. Findings from the Emergency Department Return Visit Quality Program (EDRVQP) audit directly informed the selection of the following quality improvement priorities.

Priority 1: Timely ECG Acquisition for CTAS 2 Chest Pain with Cardiac Features

Last year's EDRVQP audit identified inconsistent compliance with medical directive use for CTAS 2 patients presenting with chest pain and cardiac features (n = 24). In response, targeted improvements were implemented, resulting in meaningful reductions in door-to-ECG times, despite occasional delays related to extended waits to triage.

Average door-to-ECG time: 17 minutes (improved from 27 minutes)

Median time: 10 minutes (improved from 22 minutes)

Mode: 10 minutes (unchanged)

Cardiac bloodwork was ordered in 100% of audited cases.

Acetylsalicylic acid (ASA) was administered at triage in 60% of applicable cases (6 of 15). In the remaining cases, patients had self-administered ASA or received ASA prior to arrival by Emergency Medical Services.

These findings demonstrate improved reliability in early cardiac assessment and support continued monitoring to ensure consistent application of medical directives.

Priority 2: Nursing Documentation and Vital Sign Reassessment

The EDRVQP audit also identified nursing documentation and reassessment practices in high-volume Emergency Department exam areas as an opportunity for improvement. Of the 38 audited return visits, 95% had documented nursing activity, including vital signs, rounding, medication administration, or therapeutic

interventions.

However, 18% of visits (7 of 38) did not have repeat vital signs documented within four hours, with the longest interval being 11.5 hours. Timely reassessment and documentation are essential to detecting clinical deterioration and supporting safe, responsive care.

These findings highlight the need to strengthen consistency in reassessment practices, particularly during periods of high volume and competing demands.

What Worked Well and Challenges:

Targeted ECG education for new staff, buddying with ECG technicians, and the introduction of a competency “passport” supported improved compliance. Enhanced closed-loop communication between triage and ECG technicians also contributed to performance gains. Persistent challenges included triage congestion during peak volumes.

Planned and Ongoing Initiatives:

A January 27, 2026, ED flow event informed upcoming staffing model changes planned for March 2026. Key improvements include nursing-led escorting of patients from triage to exam spaces to enable real-time reassessment, and collaboration between the triage lead and the newly introduced Nurse Navigator role to optimize patient flow and safety.

EXECUTIVE COMPENSATION

North Bay Regional Health Centre has selected a compensable performance metric for the 2026–2027 fiscal year that reinforces senior leadership accountability for advancing safe, respectful, and trauma-informed care across the organization.

Leadership participation in trauma-informed de-escalation is intended to model expected behaviours, build shared understanding, and support consistent application of de-escalation practices.

Leaders will carry this learning into leadership learning and listing rounds across the hospital, creating opportunities for shared reflection and generative discussion with frontline teams about how trauma-informed principles are applied in daily practice. This shared learning approach strengthens alignment between leadership and frontline staff and reinforces unified goals related to patient safety, dignity, and respectful care.

By linking senior leadership compensation to active participation and visible application of this learning, NBRHC demonstrates its commitment to sustained culture change and leadership accountability. These efforts support improved patient safety, staff confidence, and the overall quality and effectiveness of care delivered across the organization.

The following executives will participate in the QIP Executive Compensation Program:

1. Chief Executive Officer
2. Chief of Staff
3. Vice President, Corporate Services and Chief Financial Officer
4. Vice President, Mental Health Services
5. Vice President, Clinical & Chief Nursing Executive

The calculation model for executive compensation is summarized below:

The percentage of performance-based pay will be a maximum of 1% of base salary for each eligible executive as determined by the Board of Directors. Allocation of executive performance-based compensation is at the discretion of the CEO and the Board. Consideration may be given to special circumstances that present a barrier to achievement of the targets for some or all of the indicators. Allowances for special circumstances will require CEO and Board approval.

The performance of each executive is linked to the achievement of key objectives, including 100% of Senior Leadership Team members' completion of trauma-informed de-escalation training and 10 Leadership learning and listening rounds.

CONTACT INFORMATION/DESIGNATED LEAD

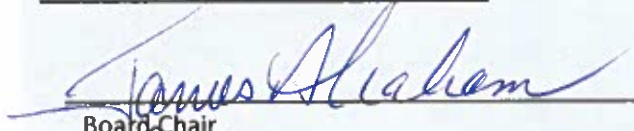
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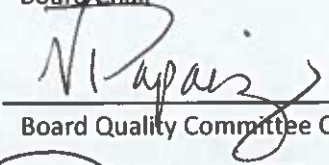
SIGN-OFF

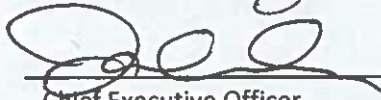
It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan on

18/03/2026


Board Chair


Board Quality Committee Chair


Chief Executive Officer

EDRVQP lead, if applicable