PROGRESS REPORT: FISCAL YEAR 2025 - 2026

The Quality Improvement Plan (QIP) is a living document, and the change ideas may fluctuate as we test and implement throughout the year. In the progress report we reflect on which change ideas had an impact and which ones we were able to adopt, adapt or abandon. This learning will help build capacity across the province.

Length of Emergency Department (ED) Wait for Bed at 90 Percentile

Indicator from 2025/2026	Performance stated on QIP 2025/26	Target stated on QIP 2025/2026	Current Performance 2025/26	Comments
Length of Emergency Department (ED) Wait for Bed at 90 Percentile	22.0 hours	22.0 hours	20.7 hours	Meeting Target

Change Ideas from 2025/2026 QIP

Continue to create capacity and build on accountability mechanisms to improve patient pull.

Method:

Alternate Level of Care (ALC) Corporate Strategy to reduce variability in ALC approaches between departments and inpatient units. Continuous Improvement of Access and Flow Command Centre.

Process measure and Target:

- LHSC-wide target ALC Rate 5.9 per cent - not met
- Increase compliance with ADD – improvement
- Reduce time between bed status changes- not available

Was this change idea implemented as intended? (Y/N)

YES: This change idea was implemented.

Lessons Learned:

LHSC continued to focus on reducing variability in ALC practices across departments and strengthening the overall Patient Flow strategy. LHSC implemented Ontario Health's Home First operational directions, which helped standardize early assessments and promote consistent discharge planning.

Another key accomplishment was the introduction of proactive surge planning. Anticipating seasonal increases in ED admissions allowed the organization to better support patient flow and manage rising occupancy pressures. This work contributed to more timely movement of patients from the ED to inpatient beds and reduced the impact of high-volume periods on wait times.

The sustained use of the Command Centre model has also been a success. By centralizing inpatient bed assignment, the Command Centre enabled real-time prioritization of patients experiencing long ED waits and provided a more consistent, system-wide view of capacity. This structure supported improved decision-making and contributed to more efficient patient flow across the hospital.

Over the year LHSC continued to improve the performance reporting structures for quality and safety indicators. ED wait to inpatient bed and Average ALC Open cases are monitored on a weekly basis at leadership huddles.

Despite these achievements, challenges remain. Ongoing ED volume pressures highlight the need for continued refinement of surge strategies and real-time flow management. However, the progress made this year established a strong foundation for ongoing improvement in Patient Flow, and ALC processes.

Focused department level improvement strategies

Method:

Mental Health and Medicine programs review performance data and change ideas on monthly basis at improvement teams. EMPATH dedicated Mental Health space at Victoria Hospital ED.

Process measures and Target:

- LHSC-wide target ALC Rate 5.9 per cent- not met
- LHSC-wide target discharges completed by 11a.m. 50.0 per cent - not available

Was this change idea implemented as intended? (Y/N)

YES: This change idea was implemented.

Lessons Learned:

The Mental Health and Medicine programs continue to routinely review performance data and testing improvement initiatives through their monthly improvement team meetings. This structured, ongoing review helped maintain visibility on key flow indicators and supported the timely identification of barriers across both programs. The dedicated EMPATH Mental Health space within the Victoria Hospital ED also continued to provide a more appropriate environment for patients requiring mental health support, helping to reduce pressure on general ED spaces and improve patient experience.

A significant area of progress this year was the continued expansion of the LHSC to Home program. The addition of a respiratory pathway has enhanced the program's ability to safely transition more patients home with appropriate support. Enrollment continues to increase, and the program is on track to meet its target of supporting 600 patients by March 31, 2026. This demonstrates strong system-level impact in reducing inpatient utilization where safe alternatives exist.

LHSC continues to strengthen prioritization of Estimated Date of Discharge accuracy and compliance across clinical areas. This focus has supported better flow out of the ED and strengthened alignment between inpatient units and flow leadership teams. A new indicator has been added to the weekly leadership huddles that will focus on monitoring discharges by noon.

LHSC is evolving its reporting structures to better utilize data across the organization. This includes ensuring consistent use of data to drive decision-making at monthly improvement teams which will remain essential to maintaining momentum and identifying emerging barriers within both Mental Health and Medicine programs.

Emergency Department (ED) Wait time for Physician Initial Assessment at 90 Percentile

Indicator from 2025/2026	Performance stated on QIP 2025/26	Target stated on QIP 2025/2026	Current Performance 2025/26	Comments
Emergency Department (ED) Wait time for Physician Initial Assessment at 90 Percentile	6.3 Hours	6.0 Hours	6.6 Hours	Target Not Met to Date

Change Ideas from 2025/2026 QIP

Continuous improvement of Intermediate Care Zones

Method:

Intermediate Chair Program – efficiently cycle patients through the system. Ongoing Plan-Do-Study-Act (PDSA) cycles of adaptation intermediate care zones.

Process measure and Target:

- Reduce per cent left without being seen – improvement
- Reduce Length of Stay (LOS) of non-admitted patients - not meeting target

Was this change idea implemented as intended? (Y/N)

YES: This change idea was implemented.

Lessons Learned:

The Intermediate Zone Program continues to efficiently cycle patients through the system by using ongoing PDSA cycles to refine processes within intermediate care zones. These rapid-cycle tests of change focused on improving patient flow, with particular attention to physician shift incentives and optimized chair strategies. These interventions have contributed to efforts to reduce Left Without Being Seen (LWBS) rates by enhancing throughput, improving visibility on bottlenecks, and ensuring patients are assessed in a timely and efficient manner.

This year the ED completed the self-assessment and development of action plans for both LHSC's University Hospital and Victoria Hospital in response to Ontario Health's Emergency Department Leading Practices Toolkit. Developing these action plans ensured that both hospitals have a clear roadmap for implementing evidence-informed strategies that support flow, safety, and patient experience.

Both locations completed value stream mapping activities based on the Leading Practices Toolkit. These exercises provided a detailed assessment of the patient journey within each ED, identifying inefficiencies and prioritizing targeted improvements. The value stream maps offer a critical foundation for future PDSA cycles, as they make flow barriers more visible and support data-driven decision-making.

Together, this work demonstrates meaningful progress toward improving system flow through structured improvement methods and enhanced alignment with provincial guidance. Continued focus on testing and refining interventions will be essential for ensuring patients move efficiently through the system.

Physician schedule improvement strategy

Method:

Additional shifts to improve physician scheduling gaps. Utilize coverage to augment emergency department flow.

Process Measure and Target:

- Reduce physician scheduling gaps - not available

Was this change idea implemented as intended? (Y/N)

YES: This change idea was implemented

Lessons Learned:

The ED focused on filling physician scheduling gaps by adding targeted shifts to improve ED flow. A key accomplishment was the implementation and ongoing PDSA testing of the Pod D INT 2.0 zone at Victoria Hospital, supported by a dedicated physician from 2 to 10 p.m. to reduce LWBS rates and Physician Initial Assessment (PIA) times.

Interdisciplinary collaboration also played a major role in improving flow. At University Hospital, health disciplines expanded their coverage to support timely assessments and safe discharge home, helping reduce unnecessary admissions. At Victoria Hospital, the introduction of a Nurse Practitioner in October 2025 added independent clinical capacity and provided a consistent resource for patients and staff. Together, these initiatives improved coverage, enhanced patient progression through the ED, and supported more efficient team-based care.

This year updates were made to the Medical Advisory Committee (MAC) ED Admission Guidelines, accompanied by enhanced reporting processes to support practice change. These updates provided clearer expectations for admission standards and improved accountability.

Health system challenges with increased patient volumes and inpatient capacity constraints continue to impact the ability to move patients through the ED.

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?

Indicator from 2025/2026	Performance stated on QIP 2025/26	Target stated on QIP 2025/2026	Current Performance 2025/26	Comments
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?	64.7%	65.0%	65.0%	Meeting Target

Change Ideas from 2025/2026 QIP

Focused department improvements and sustainment

Method:

Utilize dashboard data to identify areas of improvement. Share and spread actions implemented across departments.

Process measure and Target:

- Increase utilization rate of patient experience dashboard – met target

Was this change idea implemented as intended? (Y/N)

YES: This change idea was implemented.

Lessons Learned:

This year dashboard data was actively used to identify trends and priority areas for improvement. To support staff engagement and spread successful strategies, the QIP indicator was incorporated into LHSC's weekly performance huddles. These huddles created a consistent venue for sharing actions that different departments were testing and supported broader organizational learning. Examples of initiatives shared through the huddles included a new multilingual patient information poster developed by Victoria Hospital Medicine, the introduction of informational TV monitors in EDs, and a corporate level rollout of a redesigned poster by the Patient Experience team.

As this was the second year of the indicator's inclusion on the plan, several working groups, including the Emergency Department, Clinical Neurosciences, and Cardiac Care, continued to meet to evaluate the impact of their strategies. Through this evaluation lessons learned emerged. Teams emphasized the importance of sustained commitment to quality improvement (QI) and the consistent use of QI methods, such as PDSA cycles, to test and refine approaches. Survey response rates improved due to the new email-based methods, though groups noted that access to free text responses specific to this indicator would provide deeper insight into patient expectations.

Teams also acknowledged the inherent subjectivity of patient experience surveys, noting that responses may reflect factors unrelated to discharge communication. Reinforcing the importance of data deep dives to ensure results are interpreted accurately. Feedback was also provided noting that since the survey is only distributed through email certain populations may still be missed. For next year, teams recognized the value of exploring data from multiple perspectives to better understand which strategies are truly driving improvement.

Establishment of Patient Experience Survey Steering Committee

Method:

New committee established to ensure that appropriate processes are in place to support the growth and development of patient experience surveying.

Process measure and Target:

- Completion of committee work plan –not met

Was this change idea implemented as intended? (Y/N)

NO: This change idea was not implemented.

Lessons Learned:

This change idea focuses on establishing a new committee to strengthen processes that support the growth and development of patient experience surveying. Discussions were held to define the purpose and scope of this committee, and while there is value in the development of this structure, it was recommended to delay of the committee given the focus on a broad organizational review.

In 2025/26 LHSC completed a major step in its improvement journey which included a comprehensive organizational review to strengthen operations. As part of this review key working groups were established to deliver on a work plan.

Within the Patient Experience portfolio, LHSC placed particular emphasis on evolving the role of Patient and Family Partners to ensure their contributions are meaningful and impactful. This working group was prioritized as part of the organization review.

LHSC is continuing to strengthen its internal Quality Control structures. A new action is to integrate the review of patient survey results into these existing oversight mechanisms. This approach will ensure ongoing monitoring, more consistent interpretation of the data, and better utilization of the survey to guide improvements.

To support the development of the patient experience survey LHSC remained an active partner in the Ontario Hospital Association's benchmarking table, which supports hospitals in leveraging new benchmarking data and adopting best practices. This partnership will continue to inform the organization's efforts to enhance the patient experience survey program and ensure results drive meaningful improvements.

Discharge Medication Reconciliation

Indicator from 2025/2026	Performance stated on QIP 2025/26	Target stated on QIP 2025/2026	Current Performance 2025/26	Comments
Discharge Medication Reconciliation	74.0%	80.0%	73.3%	Target Not Met to Date

Change Ideas from 2025/2026 QIP

Focused department level improvement strategies

Method:

Utilize data to determine focused areas of improvement. Set up working groups to identify change ideas and monitor performance.

Process measure and Target:

- Number of working groups established - improved
- Best possible medication history – no improvement

Was this change idea implemented as intended? (Y/N)

YES: This change idea was implemented.

Lessons Learned:

LHSC focused on using data to identify priority areas and establishing a dedicated working group to develop and monitor improvement strategies. A detailed Pareto analysis was conducted to identify high impact program areas that would benefit most from targeted interventions. A cross functional working group was formed, bringing together Patient Safety/Clinical Quality, Medical Quality, Surgery, and other key partners to generate new strategies to strengthen processes that impact program areas that would benefit most from targeted interventions.

The team completed engagement with physician partners to understand barriers and opportunities for process optimization. The team also examined best practices from high performing areas, such as Medicine, where standardized use of the Patient Oriented Discharge Summary (PODS) are often embedded into discharge workflows. Medicine does share however that this is a process measure and the connection needs to be made to outcomes.

Several lessons emerged through this work. A root cause analysis identified key barriers experienced by physicians, including administrative burden, misconceptions about process complexity, inconsistent workflows, gaps in resident onboarding, a lack of alignment to organizational goals, and the need for visible physician champions. These findings highlighted the importance of addressing workflow variability and supporting clinicians with clearer processes and expectations. The team noted that improving buy-in requires reinforcing the direct connection between medication reconciliation and patient safety, emphasizing the critical role accurate discharge information plays in preventing harm.

College of Physicians and Surgeons of Ontario (CPSO) Quality Improvement Program spread

Method:

Share successful improvement strategies and identify local physician champions as partners.

Process measure and Target:

- Meeting with all physicians in cohort for feedback – met target
- Themes identified through root cause analysis– met target

Was this change idea implemented as intended? (Y/N)

YES: This change idea was implemented.

Lessons Learned:

LHSC continues to enhance our participation in the College of Physicians and Surgeons of Ontario (CPSO) Quality Improvement Program. This year a major advancement was the development of a physician-focused dashboard, designed to consolidate all professional staff indicators into one accessible platform. By improving visibility into key metrics, the dashboard is expected to empower physicians to more effectively track progress and identify opportunities for improvement.

This work aligned with LHSC's requirements under the CPSO Quality Improvement Program, ensuring that the dashboard and its reporting structures support both organizational priorities and QI expectations.

Once fully implemented, the dashboard and related reporting processes will significantly strengthen physician-led improvement initiatives. By improving access to reliable data, highlighting successful practices, and enabling clearer identification of physician champions, the organization is better positioned to foster a culture of shared learning and continuous quality improvement across clinical programs.

Average Emergency Department Wait Time to Physician Initial

Indicator from 2025/2026	Performance stated on QIP 2025/26	Target stated on QIP 2025/2026	Current Performance 2025/26	Comments
Average Emergency Department Wait Time to Physician Initial Assessment for Individuals with Sickle Cell Disease (CTAS 1 or 2)	70.3 mins	Collecting Baseline	50.0 mins	Not Applicable

Change Ideas from 2025/2026 QIP

Complete a deep dive into the reliability of data to ensure appropriateness in setting meaningful improvement targets.

Method:

Complete consultation with key partners to assess data source for accuracy, completeness, and consistency. Monitor indicator as part of quarterly performance reporting process.

Process measure and Target:

- Internal quarterly data is consistent with Ontario Health e-reporting – met target
- Validated indicator definition added to internal indicator library - met target

Was this change idea implemented as intended? (Y/N)

YES: This change idea was implemented.

Lessons Learned:

As this was the baseline collection year for the metric, LHSC prioritized building a strong internal reporting process that could accurately monitor and track performance. The metric has now been embedded into LHSC's quarterly reporting cycle, and the Emergency Department Continuous Quality Improvement Committee is reviewing results and identifying opportunities for improvement.

Throughout the year, the reporting processes were refined to ensure accuracy, especially given that the baseline year establishes the foundation for target setting. Through this work, it was determined that a one quarter data lag was necessary to ensure all patient encounters were correctly coded and complete, providing reliable volume counts and accurate wait-time data. This adjustment has strengthened data integrity.

Overall, the focus on validating data quality and establishing monitoring structures has created a stronger foundation for understanding the current state of care for individuals with Sickle Cell Disease and for guiding future improvement efforts aimed at reducing time to physician assessment.

To assist in our target setting and to benchmark performance a peer comparison was conducted. We reviewed the results and targets of other peer provincial hospital sites that had this metric on their QIP. Three other sites also included this metric on their FY 2025/26 QIPs, Scarborough Health Network, Humber River Health, and Windsor Regional.

We have started to complete and discuss driver diagrams for this work and look forward to continuing that work into the new fiscal year.

Increase awareness of Sickle Cell Disease (SCD) among ED staff to improve care in the emergency department

Method:

Develop the Hemoglobinopathy/SCD Clinic internal and external website that will include housing local guidance documents to support ED providers in the acute management of SCD patients.

Process measure and Target:

- Launch of education materials – met target
- Utilization of education materials– met target
- Reduce rate of ED 30 day repeat visit for individuals with sickle cell disease - improvement

Was this change idea implemented as intended? (Y/N)

YES: This change idea was implemented.

Lessons Learned:

This improvement work aligned with the broader work of the Lifespan Hemoglobinopathy Program at LHSC, which delivers equitable, state of the art care for equity denied populations by integrating medical, psychological, and social supports for individuals living with Sickle Cell Disease and Thalassemia. The program has continued to establish and implement evidence-based standards of care across all areas of the hospital, including inpatient settings, outpatient follow up, ED care, access to subspecialists, and connection to community resources.

Within the ED specifically, the team implemented new order sets that have led to measurable improvements in the timely administration of appropriate treatments for acute presentations such as vaso-occlusive pain crises and infections. Alongside this clinical work, a current state analysis was conducted with support from Quality Improvement and Project Management Office teams to guide ongoing and planned improvement strategies. Findings from the Quality Standards Gap Analysis project were used to identify priority areas for further development, including enhancing provider education, strengthening pain management practices, and improving the consistent use of data to inform care.

Ongoing efforts continued to improve the inpatient experience for individuals with SCD through the implementation of a new care pathway for admitted patients.

Quality Improvement Plan Narrative

Overview

London Health Sciences Centre (LHSC) is one of Canada's largest research-intensive, academic acute care hospitals. We are committed to collaborating with patients, families, and system partners to deliver excellent care experiences and outcomes, educate the health-care providers of tomorrow, and advance new discoveries and innovations to optimize the health and well-being of those we serve.

In the past year, LHSC has remained committed to quality, safety, and accountability, while navigating the challenges of our health-care system. LHSC completed a major step in its improvement journey through a comprehensive organizational review that has guided how we strengthen our operations and support our people. As part of this improvement journey, we are developing our Quality Blueprint which is our governance framework to streamline

processes into one cohesive system. Our Quality Blueprint is our unified approach to quality which will support us in achieving consistent excellence and improving performance.

The foundation of our Quality Improvement Plan (QIP) is understanding our current risks by engaging those who give and receive care. These themes along with system priorities identified by Ontario Health shaped our QIP indicators for the coming year. LHSC's Quality Improvement Plan indicators for FY2026/27 are:

1. Length of Emergency Department wait for bed at 90th percentile
2. Emergency Department wait time to physician initial assessment 90th percentile
3. Emergency Department length of stay for non-admitted patients triaged as low acuity 90th percentile
4. Emergency Department length of stay for non-admitted patients triaged as high acuity 90th percentile
5. 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?
6. Discharge medication reconciliation
7. Percent of 4AT delirium screens accompanied by prevention and management interventions
8. Overdue preventative maintenance backlog for non-low risk devices
9. Average Emergency Department wait time to physician initial assessment for individuals with sickle cell disease (CTAS 1 or 2)

Access and Flow

Ensuring good access and flow means individuals receive the right care, in the right place, at the right time across the health-care system. Hospitals in Ontario continue to experience demand that exceeds available capacity, highlighting the need for initiatives that optimize patient flow while maintaining high-quality clinical care. At LHSC, improving access and flow is a core organizational focus, reflected in the Patient Flow and Alternate Level of Care (ALC) Corporate Priorities.

Through the Patient Flow Corporate Priority, LHSC is implementing standardized and disciplined approaches to improve hospital bed utilization and ensure the right patient is placed in the right bed the first time. This includes strengthening centralized oversight of patient flow, enhancing discharge planning and forecasting, and using real-time data to support timely decision-making. These efforts aim to reduce emergency department boarding, avoid unnecessary delays in care, and improve access to inpatient beds.

The ALC Corporate Priority complements this work by reducing avoidable hospital days and supporting patients to remain in, or return to, the community as safely and quickly as possible. LHSC collaborates closely with Ontario Health at Home and Community Support Services through collaborative rounds to develop individualized, wraparound community plans, including Adult Day Programs, transportation supports, respite care, and meal services. ALC rates and open ALC cases will be reviewed at weekly organizational performance huddles in FY27 to strengthen accountability, identify barriers in real time, and drive focused action toward reducing open ALC cases across LHSC.

To support early intervention, LHSC has decided to implement the Emergency Department (ED) interRAI Screener in fiscal year 2026-27 for all patients greater than 65 years of age to identify patients at high risk of frailty and functional decline at Emergency Department presentation. Early identification enables timely connection to community resources, supports admission avoidance where appropriate, and facilitates proactive discharge planning for patients requiring hospitalization.

In November 2024, LHSC launched the LHSC to Home program, providing up to 16 weeks of coordinated home-based supports through partnership with a community service provider. The program targets patients at risk of, or designated as, ALC and supports expedited discharges. LHSC has recently added a respiratory pathway to LHSC to

Home, enabling patients requiring short-term oxygen weaning, who previously remained hospitalized due to lack of community supports, to safely transition home. LHSC has a target to support 600 patients through the program by March 31, 2026, and which is on target to achieve, if not surpass.

Equity and Indigenous Health

Indigenous Health

LHSC is advancing culturally safe care and addressing anti-Indigenous racism through sustained education, relationship building, and system-level change. This work aligns with the Truth and Reconciliation Commission Calls to Action 18–24 and Joyce's Principle, affirming Indigenous Peoples' right to equitable, culturally safe, and discrimination-free health care. Continued, coordinated efforts are required to deepen understanding, measure impact, and translate learning into tangible improvements in patient, family, and staff experiences. This year LHSC is advancing work in this area through three interconnected initiatives:

1. Focusing on Indigenous Youth Career Pathways through continuation of the Indigenous Youth Career Fair, with the second annual event planned for March 2026. Developed in collaboration with the London District Chiefs Council, the Southern First Nations Secretariat, and LHSC Executive leadership, the initiative provides early exposure to health care careers prior to post-secondary decision-making, supporting long-term Indigenous workforce representation and future system sustainability.
2. Strengthening culturally safe spaces by growing the Indigenous Elders Program and Healing Space services. Elders provide cultural, spiritual, and holistic supports for patients, families, and staff, contributing to trust-building with First Nations, Métis, Inuit, and Urban Indigenous communities. Utilization of the Healing Space continues to increase, supported by close collaboration between Indigenous Navigators and Visiting Elders to provide one-to-one culturally responsive supports.
3. Advancing Indigenous-led cultural awareness education through micro-learning, Lunch and Learns, Allyship in Action workshops, targeted departmental sessions, and evaluation to assess reach, impact, and continuous improvement.

Black Health

The Black Health team was established at LHSC in May 2023 and operates as an integral part of the Equity, Diversity and Inclusion team. Black Health was established in recognition of the many inequities that persist within the health-care system. Its purpose is to actively identify and dismantle systemic, institutional and attitudinal barriers in order to improve the health-care experiences and health outcomes of African, Caribbean, and Black (ACB) peoples.

The work of the Black Health team is in direct response to Ontario Health's A Black Health Plan for Ontario and feedback from internal and external sources. Our focus is on:

- Organizational capacity building and culture shifting through the implementation of anti-Black racism training and cultural competence modules and the recruitment of a Learning Specialist, Black Health. Robust, diverse awareness and educational events are offered during Black History Month inclusive of cultural foods, artisans, wellness activities, and speakers.
- Targeted interventions for ACB peoples and communities with mental health outreach partnerships that support the health and well-being of ACB children and youth;
- Black Health patient navigation services to improve health care experiences and health outcomes for ACB patients;
- Collaborating with various teams to advance implementation of Ontario Health's Sickle Cell Disease quality standard;

- Purposeful community engagement, inclusive of Francophone communities, achieved by co-hosting an ACB community feedback session, London's first ACB health and wellness fair, and participating in existing community events where ACB peoples attend; and
- Partnering with students from Western University's Black Leadership University Experience (B.L.U.E.) program to provide Black students and youth with mentorship across various departments at London Health Sciences Centre and other outreach opportunities.

Advancing Accessibility and Inclusion

LHSC is committed to identifying and removing barriers that present a challenge to people when accessing the spaces, information or services they need. Our 2024-2029 Accessibility Plan outlines strategies to improve accessibility and inclusion for patients, families, visitors, members of the community and Team LHSC. Our Accessibility Plan represents the path forward for LHSC to ensure that people of all abilities can access services, spaces, employment, and information in a way that meets their individual needs. It identifies our goals and outlines opportunities to improve accessibility and inclusion.

Patient Experience

London Health Sciences Centre (LHSC) continues to gather feedback from patients who complete our survey within two weeks of leaving the hospital. From April to December 2025, we achieved a strong 35 per cent response rate, with 5,387 surveys completed out of 16,467 sent. Throughout the past year, we reviewed patient experience results every week to understand how our improvement efforts were affecting our Quality Improvement Plan (QIP) indicator. To support progress, we introduced targeted quality initiatives both within specific clinical areas and across the organization. These actions contributed to an overall improvement in our QIP measure. In the first year that this indicator was included in the QIP, performance was 62.6 per cent. This has since increased to 66.1 per cent. We also examined all response options for the QIP question ("Did you receive enough information from hospital staff about what to do it you were worried about your condition or treatment after you left the hospital?") and saw a shift toward more patients selecting "completely" or "quite a bit," showing improvement in the information patients receive at discharge.

To make providing feedback even easier, we are preparing to introduce several new surveys. We are collaborating with the Ontario Hospital Association to develop and launch the new ICU survey, which will replace five older versions and be used in intensive care units. Additional surveys in development include a shorter Pediatric Outpatient survey and a Youth Mental Health and Addictions survey. In April 2025, LHSC joined a pilot benchmarking project that allows us to compare our performance with other large hospitals.

To better hear and understand a broader range of patient and family perspectives, we have introduced new feedback platforms:

- SPEAK: A tool that brings together patient feedback with safety and risk management data. This integrated view helps us understand the full patient journey, prevent harm, and enhance care.
- Great Moments: A platform where patients can share positive experiences and stories of exceptional care.

These tools were promoted through internal signage, Community Update Meetings, and participation in community events such as the City of London's Newcomer Day, Black Health Day, and engagement activities with Indigenous communities. We have refreshed our posters and communication plans to ensure patients remain informed about opportunities to share their voice.

We are strengthening how Patient and Family Partners are engaged within LHSC. We are developing a policy to formalize and reinforce the importance of incorporating patient perspectives in our work. Additionally, we are

designing an evaluation process to measure the impact of their involvement. Our goal is to ensure Patient and Family Partners have meaningful roles and that their contributions directly influence the quality of care we provide.

Provider Experience

LHSC is committed to continuous innovation in recruitment/retention, workplace culture and staff experience.

Strategic Recruitment

- LHSC has prioritized internal movement in its recruitment strategy, reducing external postings, which are now largely focused on hard-to-fill roles. The Employee Referral Program (launched September 2025) supports this need with a $1,500 incentive and has resulted in one hire to date, with one candidate in progress.
- LinkedIn remains a key recruitment channel for external talent attraction, with a 28 per cent increase in followers over the past year and evidence that one in five hires were influenced by LinkedIn engagement.
- Ministry-funded programs to support nursing recruitment have been realigned to meet organizational needs, with the New Graduate Guarantee prioritized for all eligible RNs and RPNs, and the Community Commitment Program for Nurses targeted to out-of-province and travel nurses to support experienced nurse recruitment and retention.

Workplace Culture and Employee Experience

- 62 per cent of the leadership team has completed The Working Mind training, strengthening leader capability to support mental health, reduce stigma, and embed a culture of wellness. In addition, a new leadership development program was introduced to strengthen core management fundamentals, including HR, Finance, and Operations.
- LHSC launched the Mayo Clinic's Well-Being Index, a validated tool providing confidential individual insights and system-level baseline data to inform and adapt the organization's well-being strategy.
- The Attendance Support program was refreshed to better support staff attendance, success at work, and a culture of care and accountability.

Safety

Ontario Health's Never Events Hospital Reporting initiative

LHSC has been monitoring Never Events internally on a quarterly basis as a measure of preventable patient harm since July 2020. With the introduction of the provincial Never Events reporting project, LHSC has a well-defined process for identifying and reviewing all Never Events.

As part of the roll-out of LHSC's new incident management system "SPEAK" (System Promoting Excellence, Accountability and Knowledge) in December 2024, the team uses a Root Cause Analysis module within the system as a means of documenting all reviews, including Never Events. Centralizing the documentation for Never Event reviews allows for the identification of trends and themes, and for broader dissemination of recommendations within the organization for others to learn from. All events that meet the definition of a Never Event are reviewed by the clinical leader of that area to identify contributing factors and opportunities for improvement.

A process is currently being established for all Pressure Injury-related Never Events to be presented to LHSC's Pressure Injury Steering Committee. This committee consists of subject matter experts from across the organization and allows for more robust discussion and further dissemination of learnings.

Palliative Care

Palliative Care at LHSC provides nearly 2,000 consultations annually across University and Victoria Hospital sites, with an average response time of 14 hours. Our interprofessional team, including dedicated social work support, specializes in managing complex pain and symptoms associated with life-threatening illness, with a strong focus on quality of life. Care is guided by the Ontario Palliative Care Network Quality Standards and the Ontario Health Palliative Care Health Services Delivery Framework.

Patient and family engagement is central to our model of care. Our broad presence across the organization enables timely, responsive support, with care delivered through a multidisciplinary approach that emphasizes shared decision-making and individualized care planning.

The program is advancing digital integration to improve information exchange. This spring, the My Care Portal is expected to launch for all LHSC patients, supporting both ambulatory and inpatient care. Patient and provider feedback, alongside performance dashboard data, will guide continuous quality improvement.

Education in grief, bereavement, and palliative care is strengthened through ongoing professional development, including participation in the Learning Essential Approaches to Palliative Care (LEAP) program. Care closer to home is supported through strong partnerships with community providers, outreach teams, and hospice services, enabling seamless transitions and care aligned with patient preferences.

Culturally appropriate care is promoted through targeted education, language-concordant consultations, Indigenous Navigator training, and initiatives to support equitable access for marginalized populations. Ongoing patient and family feedback informs continuous improvement across inpatient and ambulatory settings.

Together, these efforts ensure LHSC Palliative Care delivers timely, equitable, and high-quality care that responds to the evolving needs of patients and families across the continuum of illness.

Population Health Management

LHSC is committed to transforming health in partnership with our community and system partners. We collaborate across the health and social care system to identify populations requiring additional support as demographics evolve, co-design person-centred models of care, and evaluate outcomes to drive continuous improvement.

A recent example is our partnership with Youth Opportunities Unlimited (YOU) to launch a community youth hub at Victoria Hospital for young Londoners experiencing homelessness. The need for this hub was identified through engagement with multiple community partners, who highlighted limited resources for youth, a group representing 26 per cent of people experiencing homelessness in our region. The hub enables young people to access coordinated health and social supports while transitioning toward stable housing. Since opening in November 2024, the hub has supported 72 youth, including 15 who have transitioned to permanent housing.

LHSC is also an active participant in the Health and Homelessness Whole of Community System Response, a multi-sector, multi-organization initiative focused on helping the most marginalized Londoners move safely indoors, become stabilized and supported, connect to appropriate housing, and remain housed. This work is critical as Ontario has experienced a 25 per cent increase in homelessness since 2022. Early results of the system response include more than 400 supportive housing units planned or completed, two hubs built and launched, and a 20 per cent decrease in reported deaths among people experiencing homelessness between 2022 and 2024.

Together, these initiatives demonstrate LHSC's commitment to co-designing solutions with local health, social service, and community partners, working collectively to improve health outcomes across our region.

Emergency Department Return Visit Quality Program (EDRVQP)

Status update on LHSC's quality improvement priorities from the preceding year's EDRVQP audit:

1. **Physician Scheduling & Metric Improvement Strategy:** This initiative funds additional shifts to improve physician scheduling gap coverage to augment emergency department flow and improve our Physician Initial Assessment (PIA) and Length of Stay (LOS). The initiative launched November 4, 2024, including additional shifts: University Hospital Intermediate Zone 12-8 pm; Victoria Hospital Intermediate Zone 12-8 pm.
2. **Left Without Being Seen (LWBS):**

- High Volume/High Return Visit Strategy: Increasing social work engagement; triage/charge nurse collaboration on determining care pathway, implemented new E Chairs Zone (Victoria Hospital) for Mental Health concerns and ENT Chair Zone (University Hospital) rapid access spot for low acuity; continued plan, do, study, act (PDSA) cycles for intermediate zones at both Hospitals for improved departmental flow.
- Low Acuity/Low CTAS/LOS Strategy with a focus on abdominal pain presentations: Investigating opportunities for expanding Medical Directives, implementing a triage flow strategy for monitoring waiting room length of stay

Quality issues identified during this year's audit and the quality improvement initiatives that are being planned or worked on to address these issues:

1. Long wait times which lead to patients LWBS, and an increased requirement for triage reassessment of high-risk patients or those with abnormal vital signs.
2. Education and training. This was specific to the care needs and disposition of the gynecological presentations, multiple Emergency Department visits, reassessment/documentation of abnormal vital signs.

- Intermediate Zone: continue PDSA cycles to optimize space and flow for both University and Victoria Hospitals to flex with departmental needs.
- Implemented a second Intermediate 'Pod D' Zone at Victoria Hospital: to assist with afternoon/evening volumes and decrease the LWBS population. Staffed by a Nurse Practitioner who started October 2025. Plans to implement a Nurse Practitioner at University Hospital April 2026.
- Ambulance Triage/Offload Process: Continue PDSA cycles to optimize space and flow to achieve a 30-minute target.
- Escalation and Code Gridlock Policy: Relaunch December 2024, The Escalation and Code Gridlock procedure is designed to ensure effective patient flow during periods of high occupancy. This procedure ensures that resources are allocated efficiently, and patient safety is prioritized.
- Physician Scheduling & Metric Improvement Strategy: Continue to fund additional shifts to improve physician scheduling gap coverage to augment emergency department flow and improve our PIA and LOS.
- LWBS High Volume/High Return Visit Strategy: Increasing social work hours of coverage (University Hospital); triage/charge nurse collaboration on determining care pathway, implemented new E Chairs Zone (Victoria Hospital) for Mental Health concerns and ENT Chair Zone (University Hospital) rapid access spot for low acuity.
- Low Acuity/Low CTAS/LOS Strategy: Focus on abdominal pain presentations: investigating opportunities for expanding Medical Directives, implementing a triage flow strategy for monitoring waiting room length of stay.

Executive Compensation

The 2026/2027 QIP is linked to executive pay for performance and is consistent with the Excellent Care for All Act. The link to performance establishes how leadership will be held accountable for achieving targets set in the QIP. The performance-based compensation allows senior executives and CEO to have an opportunity to earn a percentage of their bonus. The two quality improvement indicators selected for the executive pay for performance include:

1. Length of Emergency Department wait for bed at 90th percentile
2. Emergency Department wait time to physician initial assessment 90th percentile

These performance indicators are incorporated into our corporate scorecard and are updated weekly, monthly and/or quarterly with ongoing tracking and monitoring.

Contact Information/Designated Lead

Krista Muncaster
Director, Quality, Risk and Privacy Officer
E: krista.Muncaster@lhsc.on.ca

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

_____ DATE: MARCH 12, 2026
DAVID MUSYJ
SUPERVISOR
LONDON HEALTH SCIENCES CENTRE

Quality Improvement Plan FY2026/27 Work Plan

Measure: Length of Emergency Department (ED) Wait for Bed at 90 Percentile

Priority Issue: Access & Flow

Unit/Population	Source/Period	Current Performance	Target
Hours/Emergency Department patients	Hospital collected data /December 1, 2024, to November 30, 2025	20.7 hours	20.5 Hours

Target Justification: Performance is trending positively and remains better than peer organizations. The target is informed by recent internal data and peer benchmarking and reflects a realistic yet ambitious goal, considering ongoing system capacity and flow pressures.

LHSC utilizes internal data for QIP target setting because it is reliable and available at the outset of the target setting cycle. Establishing appropriate targets requires a collaborative process involving engagement with key partners, and timely access to internal data supports this work.

External Collaborators: Private-Public partnerships for transitional care units in collaboration with Home and Community Care and local retirement homes, City of London Homeless Hub Strategy and partners and continued coalition with Emergency Medical Services (EMS).

Indicator Related to:

- Emergency Department Return Visit Audits
- Executive Compensation
- 2026/2027 Pay-for-Results (P4R) Action Plan

Change Ideas

1. **Continue to build on accountability mechanisms to improve patient pull.**

Method:

- Advance ALC Corporate Strategy to reduce variability in ALC approaches between departments and inpatient units
- Continue to strengthen the LHSC to Home Program as part of the LHSC's Home First Strategy
- Implementation of consistent Patient Flow Command Centre leadership to support real-time decision-making and system coordination

Process Measures

- ALC Rate
- Number of patients sent home through LHSC to Home program
- Occupancy Escalation Status Tracking

Target for Process Measure

- LHSC-wide target ALC Rate 5.9 per cent
- LHSC annual target 600 patients
- Minimize the occurrence and duration of Gridlock events over the reporting period

2. **Continuous improvement of proactive surge planning**

Method:

- Apply standardized surge triggers and escalation protocols
- Coordinate staffing, bed capacity, and operational responses during periods of increased ED demand

Process Measures

- Weekly 7 a.m. census
- Weekly admissions
- Weekly number of ALC patients
- Weekly discharges
- Weekly admit no bed in ED compared to available beds

Target for Process Measure

- Weekly monitoring triggers appropriate Surge Plan

Measure: Emergency Department (ED) wait time for physician initial assessment at 90 percentile

Priority Issue: Access & Flow

Unit/Population	Source/Period	Current Performance	Target
Hours/Emergency Department patients	Hospital collected data /December 1, 2024, to November 30, 2025	6.6 hours	6.0 hours

Target Justification: Results trending and peer benchmarks. Currently not meeting internal target.

LHSC utilizes internal data for QIP target setting because it is reliable and available at the outset of the target setting cycle. Establishing appropriate targets requires a collaborative process involving engagement with key partners, and timely access to internal data supports this work.

External Collaborators: None

Indicator Related to:

- ED return visit audits
- Executive compensation
- 2026/2027 Pay-for-Results (P4R) Action Plan

Change Ideas

1. **Intermediate zone nurse practitioner**

Method:

- Nurse practitioner independently practicing within the intermediate zone to support physicians

Process Measures

- EED Length of Stay (ED LOS)

Target for Process Measure

- Reduce ED LOS for patients

2. **Continue physician schedule improvement strategy**

Method:

- Optimize schedule to match hours of coverage

- Continuously review and optimize patient flow
- Regular review of metrics at huddles
- Utilize updated MAC ED Admission guidelines to support practice change

Process Measures

- ED LOS for non-admitted patients

Target for Process Measure

- Reduce ED LOS for non-admitted patients

Measure: Emergency Department length of stay for non-admitted patients triaged as low acuity (90th Percentile)

Priority Issue: Access & Flow

Unit/Population	Source/Period	Current Performance	Target
Hours/Emergency Department patients	Hospital collected data /December 1, 2024, to November 30, 2025	9.5 hours	5.8 hours

Target Justification: Results trending and peer benchmarks. Currently not meeting internal target.

LHSC utilizes internal data for QIP target setting because it is reliable and available at the outset of the target setting cycle. Establishing appropriate targets requires a collaborative process involving engagement with key partners, and timely access to internal data supports this work.

External Collaborators: London Police Services

Indicator Related to:

- ED return visit audits
- 2026/2027 Pay-for-Results (P4R) Action Plan

Change Ideas

1. **Extended social worker coverage**

Method:

- Dedicated social work intervention to address psychosocial barriers for safe discharge
- Review social work caseload to optimize coverage and identify peak demand periods

Process Measures

- ED return visits within 30 days
- Connection to community resources

Target for Process Measure

- Reduce ED return visits within 30 days
- Enhanced access to community resources

2. **Continue Nurse Police Response Team**

Method:

- LHSC ED nurses support London Police Officers in the community providing minor patient care, health teaching in the community

Process Measures

- ED Diversion

Target for Process Measure

- Increased community engagement

3. Value Stream Mapping (VSM) workflow optimization

Method:

- Continued partnership with Pathology and Laboratory Medicine and Medical Imaging to optimize ED patient flow and enhance workflows

Process Measures

- Overall Patient Experience
- Labs and Diagnostic Imaging request turnaround time

Target for Process Measure

- Increased patient experience
- Consistent and timely turnaround times

Measure: Emergency Department length of stay for non-admitted patients triaged as high acuity (90th Percentile)

Priority Issue: Access & Flow

Unit/Population	Source/Period	Current Performance	Target
Hours/Emergency Department patients	Hospital collected data /December 1, 2024, to November 30, 2025	10.4 hours	7.7 hours

Target Justification: Results trending and peer benchmarks. Currently not meeting internal target.

LHSC utilizes internal data for QIP target setting because it is reliable and available at the outset of the target setting cycle. Establishing appropriate targets requires a collaborative process involving engagement with key partners, and timely access to internal data supports this work.

External Collaborators: None

Indicator Related to:

- ED return visit audits
- 2026/2027 Pay-for-Results (P4R) Action Plan

Change Ideas

1. Extended social worker coverage

Method:

- Dedicated social work intervention to address psychosocial barriers for safe discharge
- Review social work caseload to optimize coverage and identify peak demand periods

Process Measures

- ED return visits within 30 days
- Connection to community resources

Target for Process Measure

- Reduce ED return visits within 30 days

- Enhanced access to community resources

2. **Medicine strategies for enhanced access and flow**

Method:

- Dedicated nurse practitioner to provide target, post-discharge follow-up for patients at highest risk of readmission

Process Measures

- 30-day readmission rates

Target for Process Measure

- Reduce 30-day readmission rates

Measure: 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?

Priority Issue: Experience

Unit/Population	Source/Period	Current Performance	Target
%/Survey Respondents	OHA Patient Experience survey**/** Most recent consecutive 12-month period	65.0%	65.0%

Target Justification: Maintain current target and continue progress toward sustaining the improvement goal. Clear discharge information improves safety, reduces confusion, prevents avoidable complications or readmissions, and improves overall patient experience.

External Collaborators: Ontario Hospital Association (OHA)

Change Ideas

1. **Integrate patient experience survey reviews into department Improvement Team meetings**

Method:

- Develop reporting resources for Improvement Teams that layer provincial benchmarking results, internal complaints, patient stories and patient survey comment trends

Process Measures

- Department utilization of patient experience survey dashboard

Target for Process Measure

- Demonstrate increased use of the dashboard at the department level to inform and support patient experience improvement

2. **Strengthen linkage between provincial patient experience benchmarking and internal improvement actions through internal and external learning**

Method:

- Connect provincial patient experience scores with internal complaint categories and survey trends to identify priority improvement areas

- Participate in provincial patient experience survey tables to learn from peer organizations and apply relevant best practices locally

Process Measures

- Frequency of provincial benchmarking review and reporting

Target for Process Measure

- Regular quarterly review of provincial benchmarking completed and documented at quality and risk performance sessions

Measure: Discharge Medication Reconciliation

Priority Issue: Safety

Unit/Population	Source/Period	Current Performance	Target
%/Discharged patients	Hospital collected data CERNER/most recent 3-month period	75.4%	80.0%

Target Justification: Results trending and peer benchmarks. Currently not meeting internal target. Focusing on discharge medication reconciliation helps prevent medication errors, reduces readmissions, and keeps patients safe after discharge.

External Collaborators: None

Change Ideas

1. **Implement a new Physician Dashboard that includes Discharge Medication Reconciliation performance**

Method:

- Develop and launch, with an education video, a standardized physician dashboard with access for all physicians

Process Measures

- Number of physician leaders who access and review the dashboard, unique dashboard views

Target for Process Measure

- Collect baseline

2. **Leverage the CPSO Quality Improvement Program to include Discharge Medication Reconciliation as a formal Quality Improvement initiative**

Method:

- Share successful improvement strategies across the physician cohort and identify local physician champions to support peer-to-peer engagement

Process Measures

- Percentage of physicians in the CPSO QI cohort engaged through meetings or feedback sessions

Target for Process Measure

- 100 per cent of physicians in the cohort contacted for input and feedback

Measure: Overdue Preventative Maintenance backlog for non-low risk devices

Priority Issue: Safety

Unit/Population	Source/Period	Current Performance	Target

Number/Non-Low Risk Devices	Internal reporting/most recent 3- month period	922	862

Target Justification: 10 per cent reduction from the historical six-month baseline. Focusing on addressing the Preventative Maintenance backlog for non-low risk devices protects patient safety, maintains accreditation compliance and ensures operational reliability.

External Collaborators: None

Change Ideas

1. **Continuously improve asset data quality, preventative maintenance (PM) planning, and workload management for non-low risk devices**

Method:

- Standard asset tagging, validate risk classification, and refine PM scheduling to ensure accurate inventory and prioritization
- Balance PM workloads across Biomedical Engineering staff

Process Measures

- Percentage of scheduled PM work completed on time for non-low risk devices

Target for Process Measure

- Sustained improvement in on-time PM completion, contributing to a reduction in the overdue PM backlog

2. **Strengthen oversight of overdue PM backlog trends**

Method:

- Review backlog data regularly to identify trends, bottlenecks, and opportunities for targeted intervention

Process Measures

- Frequency of backlog review and reporting to leadership

Target for Process Measure

- Regular monthly review of overdue PM backlog completed and documented

Measure: Percent of 4AT delirium screens accompanied by prevention and management interventions

Priority Issue: Safety

Unit/Population	Source/Period	Current Performance	Target
Percentage/Medicine, Surgery & Clinical Neurosciences patients	CERNER/most-recent 3 month period	72.0%	90.0%

Target Justification: The target represents an approximately 25 per cent improvement and is ambitious yet achievable. Focusing on at least one intervention supports early, consistent action and builds a foundation for broader implementation across all delirium intervention domains.

External Collaborators: Ontario Health Delirium Aware Safer Healthcare (DASH) campaign

Change Ideas

1. Increase Delirium 4AT screening rates

Method:

- Expand screening beyond first three departments by September 2026
- Development of a Delirium Dashboard for data dissemination and continuous improvement
- Education - in person and virtual via ilearn. Iterative PDSA and process to utilize survey feedback from front line users

Process Measures

- Percent of Patients over 65 years of age and older screened for delirium using the validated 4AT screening tool on admission and the first four days upon admission

Target for Process Measure

- Target: 90 per cent

2. Increase availability of delirium intervention resources

Method:

- Improve access to cognitive stimulation tools, seeing and hearing supports
- Support early mobility and toileting using the Ontario Health Delirium Toolkit
- Improve hydration, nutrition, and oral care supports
- Promote sleep through comfort resources
- Provide delirium education materials for patients and care partners
- Strengthen interdisciplinary collaboration

Process Measures

- Completion of environmental scans assessing availability of delirium prevention resources
- Qualitative Patient Experience Survey

Target for Process Measure

- Environmental scan conducted by fall of 2026
- Baseline data results in 2025 demonstrated that patients feel personal belongs are not safe in hospital such as hearing aids and dentures

3. Tailor Multicomponent Delirium Intervention Bundle to high-risk patients

Method:

- Analyze data to assess which delirium prevention and management interventions are provided to patients at high risk for delirium

Process Measures

- Percent of positive 4AT delirium screens for "possible delirium" accompanied by documented prevention and management interventions for all six delirium interventions

Target for Process Measure

- 60 per cent for all six delirium interventions, for positive screens

4. Adherence to the Ontario Health Hip Fracture Quality Standard

Method:

- Increase the percentage of orthopedic surgery patients undergoing nerve block for hip fracture
- Increase the percentage of orthopedic surgery patients Weight Bearing as Tolerated (WBAT) on POD 1

Process Measures

- Percent of orthopedic surgery patients undergoing nerve block for hip fracture
- Percent of orthopedic surgery patients WBAT on POD 1

Target for Process Measure

- Nerve Blocks - Target: 50 per cent
- WBAT on POD 1 - Target: 90 per cent

Measure: average Emergency Department wait time to physician initial assessment for individuals with Sickle Cell Disease (CTAS 1 or 2)

Priority Issue: Equity

Unit/Population	Source/Period	Current Performance	Target
Minutes/Emergency Department patients	Hospital collected data /April 1 to September 30, 2025 (Q1 and Q2)	52 mins	45 mins

Target Justification: Results trending and peer benchmarks. Last year collected baseline data for this indicator and this target reflects a realistic and focused improvement from our baseline data.

External Collaborators: None

Change Ideas

1. **Detailed chart review and analysis**

Method:

- Detail chart review and analysis for those patients not being seen timely

Process Measures

- Detail chart review and analysis for those patients not being seen within target

Target for Process Measure

- 100 per cent of chart review completed for patients not seen within 45-minute target

2. **Continued education improvements and enhancements**

Method:

- Education provided to staff and patients and care partners, LHSC includes a Patient and Family Advisor with lived experience in Sickle Cell Disease improvement projects

Process Measures

- Percent of new Triage nurses who receive education that includes health equity and Anti-Black Racism education

Target for Process Measure

- 100 per cent of triage nurses receive education as part of their onboarding process