Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 26, 2026

HALIBURTON HIGHLANDS HEALTH SERVICES

Ontario Health

OVERVIEW

Haliburton Highlands Health Services' 2026/27 Quality Improvement Plan (QIP) reflects our Mission—optimizing health and wellbeing in Haliburton County through growth and innovation—and our Vision: Together – be the model of excellence in rural healthcare. Guided by our Values of Compassion, Accountability, Integrity, and Respect, our Strategic Directions focus on delivering person-centred care, nurturing team culture, strengthening partnerships, and ensuring sustainable resource management. The QIP also aligns with Ontario Health's priorities of Access and Flow, Equity, Patient Experience, and Safety.

This past year brought many achievements. We launched an intergenerational day camp, fostering social connection and mutual growth between younger and older generations. Progress continued on our Master Plan, including planning for an Emergency Department renovation with a Mental Health Crisis Room, improved infrastructure, and donor-funded Diagnostic Imaging upgrades. Staff wellbeing remained central, with new development initiatives, the opening of a Wellness Centre, and Lean improvements to volunteer intake.

Our commitment to Just Culture deepened through digital training and workshops, resulting in greater staff engagement and incident reporting. The 25/26 Worklife Pulse Survey showed significant gains: staff feel safer admitting mistakes (+38%), managers are seen as fair (+21%), and perceptions of growth and workplace quality rose by nearly 50%.

We also advanced sustainability, completing a waste audit, participating in Accreditation Canada's Climate Action Benchmarking Pilot, and achieving a 10% reduction in electricity use compared to 2019. Initiatives included washable linens, reusable sharps containers, EV charging, and environmentally conscious medication practices. Together, these efforts strengthen care delivery, support our team, and build a healthier future for our community.

ACCESS AND FLOW

HHHS operates a fifteen-bed acute care facility, making efficient patient flow essential to ensuring county residents receive timely care. To steward this limited resource, we continue to collaborate and enhance partnerships with local emergency response (Haliburton County Paramedics and OPP) and expand outpatient services so patients can access appropriate care outside our acute and emergency hospital settings. This year, we launched several initiatives focused on increasing local service availability and reducing travel times.

Our Women's Clinic now offers a clinical referral pathway to a gynecologist for unattached patients. "Papapalooza" events provide barrier-free online booking for cervical screening for women aged 25–70, along with evening appointments for those unable to attend during the day. At the Minden Health Hub, new internal medicine and respirology clinics bring specialist care closer to home. In partnership with the Kawartha Lakes Haliburton Ontario Health Team (KLH-OHT), we enhanced our Palliative Care Community Team (PCCT) to strengthen community-based end-of-life support.

We also celebrated the 10-year milestone of our Geriatric Assessment Intervention Network (GAIN) Team, which continues to deliver specialized elder care and expanded its services this year into Wilberforce.

In our Emergency Department, participation in the provincial Pay for Results (P4R) and Emergency Department Return Visit Quality Program (EDRVQP) supported ongoing quality improvement. Our Left Without Being Seen (LWBS) callback program provides valuable insight into how patient flow affects access and patient experience. We achieved our target for 90th percentile ambulance offload time in 25/26 and improved our 90th percentile wait time to physician initial assessment (PIA). In 26/27, we will continue to focus on reducing physician initial assessment (PIA) times and improving our 90th percentile ED wait time to inpatient bed.

EQUITY AND INDIGENOUS HEALTH

At Haliburton Highlands Health Services, we aim to deliver compassionate, high-quality person-centred care to everyone who comes through our doors.

We recognize that every individual is unique, has individual health care needs, and faces individual challenges. In 25/26, we focussed our efforts on developing an educational module for our executive leaders, management and staff about Transgender Visibility and Awareness. The module addresses the unique challenges faced by those who identify as transgender and offers ways to help meet their healthcare needs. This online learning module was developed with input from several community partners including the Nipissing University School of Nursing and Point in Time Centre for Children, Youth and Parents, including those with lived experienced, and we are proud to say that our entire executive leadership and management teams have completed this important training.

For 26/27, we will be advancing equity and inclusion at HHHS by looking beyond learning modules and working to further integrate these principles into practice by establishing a multidisciplinary, collaborative equity, diversity and inclusion committee. The work of this committee will be to enhance inclusivity, equity and diversity at HHHS by identifying barriers, proposing new programs and engaging staff, patients, residents and all partners in further entrenching these principles within the organization.

PATIENT/CLIENT/RESIDENT EXPERIENCE

For 2025–26, two key experience metrics were selected: whether patients felt they received enough information about what to do if they were worried about their condition after discharge, and whether long-term care residents felt they had a voice and were listened to by staff. This year, we are expanding our approach by asking patients, residents, and clients across all areas of the organization—Acute Care, Emergency, Long-Term Care, and Outpatient Services—to rate their overall experience. This will give us a broader understanding of how well we are meeting the diverse needs of our community.

Work to enhance experience continues across all programs and departments. As highlighted earlier, our intergenerational day camp created meaningful opportunities for children and older adults to connect, play, and learn together. In long-term care, collaboration with resident and family councils remains central to ongoing improvements. Both Hyland Crest and Highland Wood saw upgrades this year, including new cabinetry in their serveries and the implementation of Mealsuite, a modern dietary management system designed to improve accuracy and efficiency in meal planning and delivery. Mealsuite supports residents by aligning meals with dietary needs, preferences, and restrictions in real time, reducing errors and improving communication among staff. Residents can view photos and nutritional information for menu items, while staff benefit from immediate access to allergy and dietary details and streamlined workflows. These enhancements not only reduce food waste but free up more time for direct engagement, strengthening relationships and improving overall quality of life within the homes.

PROVIDER EXPERIENCE

Our comprehensive approach to recruitment, retention, and staff experience is grounded in rural health system realities and aligned with our organizational priorities. To address ongoing staffing pressures, HHHS has implemented multi-pronged recruitment strategies, including participation in provincial workforce incentive programs that support the recruitment of nurses, nursing students, and Personal Support Workers (PSWs). These programs offer financial recruitment and relocation incentives and are actively leveraged to attract candidates to all areas of the organization.

Recruitment capacity has been strengthened through career fairs and enhanced social media outreach. HHHS also collaborates with municipal partners and the County's recruitment coordinator to align community supports—such as housing and integration resources—to improve the long-term retention of new hires.

To build a sustainable local workforce, HHHS re-launched the high school co-operative education program, offering students structured, multi department rotations and a comprehensive clinical orientation. This early pipeline strategy helps cultivate future staff in all disciplines with strong community ties and familiarity with rural care environments.

Retention is further supported through HHHS's commitment to a Just Culture. This, along with staff wellness initiatives, the introduction of "stay interviews," executive rounding—where senior leaders regularly visit frontline areas to listen to staff, understand day-to-day challenges, and reinforce a culture of safety and support—and an organization-wide commitment to timely performance appraisals, contributes to a safer, more supportive, and more collaborative workplace. Through these integrated strategies, HHHS continues to foster a resilient workforce and enhance the quality of care across all programs.

SAFETY

We are deeply committed to ensuring the safety of every patient, resident, client, and staff member. This commitment is grounded in a strong Just Culture framework, which emphasizes fairness, accountability, and learning. In the past year, HHHS strengthened this foundation by providing enhanced Just Culture training—including Systematic Systems Analysis and Just Individual Assessment—to executive leaders, managers, and frontline supervisors, reinforcing consistent and evidence-based safety practices across the organization.

A key indicator of this culture in action is the increased use of HHHS's online incident reporting system, demonstrating higher staff engagement in identifying risks and contributing to safety improvements. From Q2 24/25 to Q2 25/26, we noted an over 260% increase in the use of our incident reporting system. The value of this insight to patient safety is immeasurable. Through this system, all actual and potential patient safety events (regardless of level of harm) are thoroughly reported, reviewed, and investigated using structured processes such as Quality-of-Care Reviews (QCR) and Failure Modes and Effects Analyses (FMEA). This robust approach ensures that learnings are rapidly translated into safer processes.

HHHS is proud to report that there were zero Never Events in 2025/26. Never Events—serious, preventable patient safety incidents that should not occur if appropriate systems and safeguards are in place in Ontario hospitals—remain a key focus of our quality and safety efforts. Preventing these events continues to be a top priority, and proactive safety strategies are being embedded across hospital, long-term care, and community programs. Looking ahead, HHHS will maintain its strong focus on harm prevention, particularly related to falls and pressure injuries. Efforts such as standardized falls-with-harm indicators and the adoption of Comfort Care Rounding in long-term care will further strengthen early identification of risk, promote patient-centred care, and help prevent harm before it occurs.

PALLIATIVE CARE

HHHS delivers integrated palliative care across hospital, long-term care, and community settings, with a strong focus on supporting individuals throughout their illness journey. Committed to advancing compassionate, person centred care, HHHS collaborates closely with regional partners to bring high quality services closer to home, particularly in a rural context.

Although HHHS does not provide chemotherapy or radiation treatment, the organization continues to strengthen local access to cancer related care. Recent initiatives include establishing a Gynecology Clinic to expand cancer screening options and actively exploring participation in the Ontario Lung and Breast Screening Programs, supported by the addition of CT and mammography services.

The Palliative Care Community Team (PCCT) plays a central role in enhancing quality of life for patients and families. Their work includes:

1. Coordinated interdisciplinary support: PCCT members collaborate with care teams across all settings to provide education, navigation, and individualized support aligned with each person's goals of care.

2. Integrated grief and bereavement support: Families receive tailored guidance and resources to navigate loss and maintain well-being.

3. Enhanced communication through EMR integration: PCCT's connection to the hospital electronic medical record system enables seamless referrals from any provider—or from patients themselves—and facilitates timely, coordinated virtual care planning.

Client feedback is collected and utilized in the moment through a customized post intake survey. This survey allows HHHS to make informed, patient centred improvements to a patient's palliative services from the start. The survey also allows us to make improvements to our intake process.

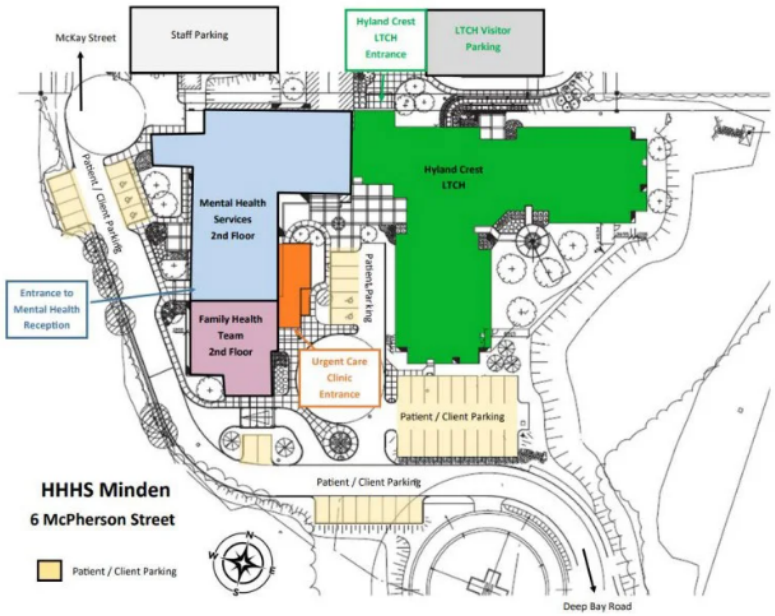
POPULATION HEALTH MANAGEMENT

Optimizing health and well being in Haliburton County through growth and innovation is our mission. Driving this is a steadfast commitment to community engagement. HHHS Community Engagement Sessions, attended by hundreds live and online, have provided a comprehensive platform for advancing population health management by focusing on the needs, priorities, and long-term wellbeing of the community. These sessions routinely highlight HHHS's Master Plan and future system planning, emphasizing sustainable service delivery models that ensure equitable access to care across the county. A strong population health lens is evident in presentations on primary care access and physician recruitment, which address one of the most significant determinants of health in rural communities—consistent, timely primary care. Sessions also provide updates on the development of urgent care services and initiatives that bring care closer to home, reducing barriers such as travel distance and service fragmentation, and improving care continuity for residents.

Population health as a priority is reflected in our commitment to patient navigation. Coordinators in teams such as our Palliative Care Community Team and Geriatric Assessment and Intervention Network (GAIN) Team support individuals in accessing programs, understanding care pathways, and managing transitions—key mechanisms for improving outcomes among older adults and those with chronic conditions.

Our Engagement Sessions have also focussed on building individual and community readiness through presentations on consent, capacity, and advance care planning, including how to establish Powers of Attorney for health and financial decisions—an essential part of proactive health management for an aging population. Every Engagement Session includes opportunities for community input, ensuring patient, resident, client and community voices directly inform organizational planning and service improvements—an essential principle of population-based, person-centered care.

Expansion of our Volunteer Services and community support programs help address social determinants of health by reducing isolation and strengthening local support networks. This year, the number of volunteers at HHHS has increased by almost 13% and the number of hours they work has grown even more. Our volunteers are an absolutely integral part of our team and we are so thankful for their commitment to care in Haliburton County.



EMERGENCY DEPARTMENT RETURN VISIT QUALITY PROGRAM (EDRVQP)

In our inaugural year participating in the Emergency Department Return Visit Quality Program (EDRVQP), our team gained valuable experience in conducting structured chart audits and translating findings into meaningful quality improvement actions. Our interdisciplinary approach—bringing together a collaborative working group to review return-visit cases with diagnostic discrepancies or unexpected outcomes – worked particularly well. The standardized audit templates and case review methodology also supported consistent analysis and helped build comfort with a learning-focused rather than punitive review model.

In our first year, we learned a great deal. Although we faced challenges such as limited staffing capacity—which affected our ability to complete audits within ideal timelines—and occasional gaps in information when patients received follow-up care at external sites, the experience ultimately strengthened our processes. As a small centre (7,000 to 17,499 annual ED visits), we did not encounter any of the program's sentinel diagnoses (subarachnoid hemorrhage, acute myocardial infarction, or pediatric sepsis). Instead, we focused on return visits for abdominal pain, chest pain, respiratory symptoms, or urinary tract symptoms. These adaptations allowed us to participate meaningfully.

The program has provided valuable insight into our physician assessment and discharge processes and made evident areas for improvement. In 26/27, we will be improving our discharge process by requiring that vital signs be taken, when clinically appropriate, at the time a discharge order is written. These vitals will be assessed by a physician prior to departure. Physicians will conduct a final discharge discussion with their patients, present their After Visit Summary (AVS) and answer any questions they might have. We will also be tightening the process for the review and follow up of diagnostic results received post discharge. Collectively, these initiatives will strengthen provider awareness, enhance care consistency, increase patient satisfaction and reduce preventable return visits—supporting safer, more reliable emergency care for Haliburton County.

EXECUTIVE COMPENSATION

The Board of Directors holds the President and CEO responsible to ensure delivery of goals and objectives and to improve quality of care, by establishing clear performance expectations and accountabilities. As per the Excellent Care for All Act, a portion of executive compensation is linked to achieving the performance improvement targets set out in our QIP.

For each indicator tied to executive compensation, the percentage of the goal achieved will be accordingly rewarded. Performance on indicators will typically be evaluated on an annual basis, either fiscal or calendar year. In some cases, quarterly results may be considered in the assessment of performance achievement.

Targets for indicators are outlined in the table below. Achievement of all targets would result in 100% payout; partial achievement of targets will result in a partial payout as determined by the Board of Directors, based on an assessment of the degree to which the targets are achieved.

Priority Issue	Indicators	Source	Baseline	Target
ACCESS & FLOW	90th Percentile ED wait time from admission to inpatient bed	CIHI - Apr 2025-Dec 2025	53.5 hrs	-5% (**50.825 hrs**)
	90th Percentile ED wait time to physician initial assessment	CIHI - Apr 2025-Dec 2025	2.91 hrs	-5% (**2.76 hrs**)
EQUITY	Creation of a committee for the promotion of Equity, Diversity and Inclusion at HHHS	NA		**First meeting and TOR by end of Q2**
EXPERIENCE	Percentage of residents, clients and patients who answered eight, nine or ten on a ten point scale asking them to rate their care.	ED & Acute (Community and LTC to be added in this QIP Cycle)	80.70%	+5% (**84.74%**)
SAFETY	Organizational falls with harm per 1000 patient days	Incident Reporting System, Q1-3 Acute, ED, HC, HW	2.71	-5% (**2.5745**)
	Long Term Care - Implement Comfort Care Rounding	NA	NA	**Quarterly Milestones**
	Reduce the frequency of *new* stage two, three and four pressure ulcers acquired in hospital and long-term care.	HC - CIHI (Percent new wounds/residents)	5.28%	-5% (**5.02%**)
		HW - CIHI (Percent new wounds/residents)	6.76%	-5% (**6.42%**)
		Acute/ED - EPIC Report 9768320 (Percent new wounds/total discharges)	1.37%	-5% (**1.30%**)

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

_____

_____
Board Chair

_____
Board Quality Committee Chair

_____
Chief Executive Officer

_____
EDRVQP lead, if applicable

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