Measures								Change			
Quality Dimension	**Measure/Indicator**	**Unit/Pop'n**	**Source/Period**	**Current Performance**	**Target**	**Target Justification**	**Collaborators**	**Planned Improvement Initiative**	**Methods**	**Process Measures**	**Process Measures Target**
Population Focus	**% of clients completing population-specific 'Patient Experience Survey'**	SNGR Community and clients	Patient Experience Survey	204 surveys completed in 2024	Hard to determine because we don't know how many total clients we have due to 'COVID clinic' data skewing #s 15% increase = 235 completed Stretch Goal: 20% increase = 245 completed	A 15% increase (235 surveys completed) is reasonable without overextending due to program capacity and survey fatigue. Stretch goal of 20% (245 survey's completed). Moderately ambitious; aligns with continuous improvement logic from Accreditation Canada. Engagement in continuous data collection to gather community-level input. Demonstrates proactive community engagement.	Data, Analytics and Insight team; Healthcare Together; Health Planning Team	Integrate PES into Routine Care Touchpoints: Offer the survey at intake, discharge, or check-in during survey month Greater staff support: Home care staff, outreach teams, and clinic staff offer it in person or with a tablet Offer Completion Flexibility: Provide paper, online, phone, and oral survey options	Integrate the Patient Experience Survey (PES) into standard client touchpoints (e.g., intake, discharge, check-in). Provide multiple formats to support diverse participation needs (paper, online, tablet, phone, and oral). Engage clinic and outreach staff (e.g., home care, outreach workers) in active survey distribution and support. Track monthly distribution and response trends to identify underrepresented client groups and adapt approaches accordingly.	# of programs routinely offering PES during care touchpoints % of staff trained or oriented on PES administration and engagement strategies % of clients offered the PES during eligible appointments (e.g., intake/discharge/check-in) # of PES completions per month (by format: online, paper, oral, phone)	**80%** of programs offering PES routinely by end of survey month **90%** of clinic/outreach/frontline staff are oriented to PES administration methods **75%** of eligible clients offered the PES during care interactions **Minimum of 20 PES surveys per program (approx. 12 programs) = 235 total**
Accessibility & Efficiency	**# of clients who felt they were provided with timely access to care**	FHT increase # of new client	FHT EMR data	(Being Collected by FHT Admin)	**48 new clients per month**	ON Health guidelines state that FHTs are	FHT physicians	Increase total # of intakes for those physicians who are accepting new	Results will be tracked using the EMR	# of new clients per month	48 new clients per month. 12 per week. Goal of 3200 total.

		intakes to meet Ministry metrics				expected to have 3217 pt's		clients. (1-2 new intakes/day).			
		Iroquois Lodge Residents	Lodge EMR (PointClickCare)	90%	97%	These targets ensure proactive admission planning, reduce occupancy delays, and meet the Ministry's 97% funding threshold by aligning internal workflows (RAI coordination, file readiness, and client contact) with admission frequency	IL Staff (RAI Coordinator)	Increase LTC occupancy rate (%) (Iroquois Lodge) (Indicator)	RAI Coordinator to improve management of waitlist. Increase # of admissions from 1 to 2/week	**# of new LTC admissions per week** # **of waitlist clients contacted and reviewed weekly** **# of admission-ready files completed per week by RAI Coordinator**	**2 admissions per week** consistently maintained (vs. current 1/week) **100% of active waitlist clients reviewed weekly** for eligibility and readiness **2 admission-ready files prepared per week** by RAI Coordinator
Safety	**Increase Hand hygiene compliance rate in the FHT**	Department of Well-Being Family Health Team staff	Hand Hygiene audits (self, 1-1)	79-80%	100%	The current compliance rate of **79–80%** falls below best practice standards and poses a preventable safety risk. **100% compliance** is the gold standard and is achievable through targeted education, routine reminders, visible leadership support, and regular feedback. Aligns with **Ministry of Health, Public Health Ontario, and Accreditation Canada** safety expectations, especially under *Infection Prevention and Control (IPAC)* standards.	Infection Prevention Officer; Professional Practice Coordinator; CL FHT; IPAC FHT reps (Alicia & Angela)	Increase # of hand hygiene education and training sessions provided to all staff by ICO and IPAC committee members and build them into an annual training calendar ICO regularly visiting the FHT and talking with individual staff about importance of hand hygiene Ensure that staff meetings regularly review hand hygiene practices & document activities to boost hand hygiene compliance	Integrate **hand hygiene education and reminders** into regular staff meetings. **Schedule and deliver training sessions** through the LMS (assistance from the PPC), embedded into an **annual training calendar**. Perform **1-on-1 coaching and supportive conversations** during ICO visits to the FHT. Display **visual cues/posters** in clinic spaces reinforcing the 4 moments of hand hygiene.	**# of hand hygiene education sessions delivered per quarter** **# of FHT staff receiving 1-on-1 hand hygiene reminders/visits per month** **% of monthly FHT team meetings with hand hygiene review documented** **# of hand hygiene audits completed monthly (self + peer/IPAC)**	**4 hand hygiene education sessions per year** (quarterly) **5 staff per month** receiving 1-on-1 coaching or reminders from ICO/IPAC **100% of FHT staff meetings** include hand hygiene as a standing agenda item **100% of active clinical FHT staff audited at least quarterly**

									Review **audit results monthly** and share with staff to foster awareness and accountability.		
	Increase # of completed safety infrastructure improvement projects for WPWC	White Pines Wellness Centre	Facilities & Maintenance Project Logs and contracts	0	4	Increase safety infrastructure improvements to allow for calling of emergency codes; 'locking down' the building; enabling of a 2-stage alarm system; increased video cameras for enhanced monitoring	Senior Manager of Facilities; Housing Maintenance Manager; DAMAR; SNGR Fire Chief; Health and Safety Manager; Health and Safety committee	Complete Canada Community Securities program application: Install virtual keypad; Increase # of video cameras; install intercom system	Complete and submit funding application to the **Canada Community Securities Program**. Engage Senior Manager of Facilities, Housing Maintenance Manager, and vendor (**DAMAR**) to implement: **-Virtual keypad system** at suite entry points **-Additional video surveillance cameras** for improved monitoring **-Two-stage fire alarm system** **-Intercom and emergency code communication system** -Document and track progress through monthly **project status reports**. Ensure coordination with Health and Safety Managers,	**# of infrastructure projects initiated** (keypad, cameras, alarm, intercom) **% of projects with signed contracts and timelines approved** **# of Health and Safety Committee meetings where WPWC safety upgrades are reviewed**	**100% of 4 priority infrastructure projects** initiated and under contract by Q4 **75% of projects completed** by end of fiscal year (March 2026) **WPWC safety upgrades reviewed at 100% of quarterly Health and Safety Committee meetings**

									and the Health and Safety Committee for alignment with safety protocols and education of staff on infrastructure changes.		
	Increase # of audited client charts that meet documentation standards (80% + of auditing criteria is met)	All active programs (excluding The Lodge and Paramedic Services)	Internal documentation (Q1-Q4). Program chart audits	Collecting baseline data	Establish baseline in Q1–Q2. Aim to increase the % of audited charts meeting ≥80% documentation standards by **15% over baseline** by Q4	This target is designed to drive incremental quality improvement while allowing time to establish a reliable baseline. Using a 15% improvement over the baseline or achieving ≥80% compliance reflects Accreditation Canada standards for documentation accuracy and completeness	Clinical Leads; Managers; Professional Practice Coordinator (LMS); EMR Administrator; Six Nations Polytechnic	Implement targeted training series to improve documentation practices – starting with HCC PSWs Improving EMR custom forms to support consistent, efficient documentation	Implement a **targeted documentation training series**, starting with Home and Community Care PSWs, and expanding to all programs. Improve **EMR custom forms** and templates to promote structured, consistent documentation. Develop and share a **standardized audit tool** with clear scoring criteria across programs. CLs and Managers to regularly provide **individual feedback and coaching** to staff with <80% chart compliance. Track audit outcomes **quarterly** and review trends to identify programs needing additional support	**# of client charts audited per program per quarter** **% of audited charts that meet or exceed 80% compliance with standards** **# of targeted training sessions delivered per program** **% of staff in each program who receive audit feedback within 30 days** **# of EMR form revisions implemented to support documentation**	**Minimum 10 chart audits per program per quarter** **≥80% of audited charts meet documentation standards by Q4** **100% of targeted staff (e.g., PSWs, nurses, clinicians)** attend training sessions **90% of audited staff receive documented feedback within 30 days** **1-3 (as needed) EMR documentation tools/forms** improved or standardized by end of year

	Increase # of Adult Risk Screening Form (Falls Risk Assessment) completed (at any time) for adults 18+	All active programs participating in QIP (except Paramedic Services and Iroquois Lodge)	EMR (PS Suite)	137 completed April 2023-2024 150 completed April 2024-April 2025	<30% increase 200 target Approx 17/month	33% increase over baseline to expand prevention reach; based on estimated client volumes and improvement capacity Falls prevention frameworks (e.g., RNAO Best Practice Guidelines, Accreditation Canada safety standards) emphasize **universal risk screening** for adults upon entry to care—especially older adults. It allows some flexibility (e.g., for client refusal or exceptional clinical situations) while holding teams to a high standard.	EMR Administrator; Falls Prevention Committee Chair; FHT falls committee rep	EMR toolbar(s) – assist with easier access to screening form Offer regular falls reporting training and education opportunities to staff	**EMR Integration:** Development of customized tool bars for easier accessibility to screening tool **Staff Education:** Deliver bi-annual falls screening training sessions, including refresher content and documentation walkthroughs. **Audit & Feedback:** Conduct routine chart audits to monitor compliance and share program-specific feedback with teams. **Team Engagement:** Include fall risk screening completion as a recurring agenda item in program meetings. **Accessible Tools:** Ensure screening tools and reference guides are available in EMR and through team SharePoint drives.	**% of new adult clients (18+) with a completed Adult Risk Screening Form** **# of Adult Risk Screening Forms completed per month** **# of staff trained on falls screening and documentation bi-annually** **# of EMR Toolbars that have been created and contain 'Adult Risk Screening Form'** **% of participating programs integrating falls risk review in regular team meetings**	**80% of new adult intakes** have the Adult Risk Screening Form completed **≥17 screenings per month**, sustained throughout the year to meet the 200 target **100% of relevant frontline staff** receive at least one falls screening training or refresher by Q3 **100% of EMR toolbars contain the 'Adult Risk Screening Form'** **Falls risk screening compliance is reviewed in 100% of program team meetings quarterly**
	% of random chart audits with no privacy breach	Department of Well-Being Staff (excluding Iroquois Lodge, Family Health Team & Paramedic Services)	Electronic Medical Record (EMR) client charts and auditing template	**1 privacy breach reported (April 2024-April 2025)** **47 charts audited per month.**	100% = 560 charts per year	Demonstrates operational compliance with PHIPA, and provides insight into real-world application of privacy principles and identifies trends in	EMR Administrator; Privacy Consultants; Managers; Clinical Leads; Privacy Officer (Director of Well-Being); Senior Manager of PPO;	**Strengthen the existing privacy audit process by formalizing monthly reviews, integrating audit findings into manager-staff feedback loops, and using results to inform privacy training and EMR**	EMR Admin to continue to conduct randomized chart audits **monthly** across all active programs using the current privacy auditing template	**# of random chart audits completed per quarter** **% of audited charts with no privacy breaches** **# of staff requiring follow-up**	**At least 140 charts audited per quarter** **≥95% of charts audited show no privacy breach during baseline year**; increase to 100% by next cycle

						documentation behaviour	Esadatgehs Committee Chair; CL's	**improvements.** ***Key actions include***: Continue using the existing privacy audit tool developed by the EMR Administrator Conduct monthly random chart audits across programs Provide targeted feedback and follow-up to staff involved in non-compliant charts Use audit data to identify documentation trends and update EMR tools or training accordingly Present monthly summaries to the Ęsadatgęhs Quality Committee and share data in the bi-annual Esadatgehs quality report	Audits conducted by the **EMR Administrator** Document and track breaches or documentation errors in a **confidential privacy audit log** which is shared with Managers for targeted feedback with staff **Flagged charts** are followed up with direct staff coaching and remediation (e.g., 1-on-1 review or refresher training). Summary findings reported to **Ęsadatgęhs Quality Committee** and used to inform **annual privacy training updates**. Use audits to inform updates to EMR workflows or forms that may contribute to privacy risks.	**education/reminders as a result of audits** **# of EMR/documentation improvements initiated as a result of audit trends**	**100% of staff with non-compliance receive follow-up/remediation within 30 days** **100% of audit results summarized for quality committee review monthly and bi-annually for Esadatgehs bi-annual report** **1–2 EMR or privacy (PHI) related improvements identified annually**

	% of active staff who have completed annual privacy training	Department of Well-Being staff participating in QIP	Trainer report of active staff with documented completion of required annual privacy training	322/500 staff (64%)	450/500 staff (90%)	Approx. 480-500 total staff. Target reflects a meaningful and achievable improvement aligned with privacy best practices and regulatory expectations under PHIPA. While the 2024 rate was 64%, reaching 90% demonstrates the organization's commitment to strengthening staff accountability and awareness regarding the protection of personal health information. The 90% threshold accounts for occasional barriers such as staff turnover or leaves, while ensuring that nearly all staff are equipped to uphold privacy standards	Alliance for Healthier Communities; PPO	Increase engagement methods: in-person privacy training sessions (4) with 1 virtual option. Possibility of a recorded session on LMS for those who can't attend in-person/virtual. Incentives or Recognition: Offer department-level recognition for 100% compliance (gift card, etc).	Schedule 4 in-person sessions across accessible times and locations Promote sessions via internal email, posters, and manager reminders Host one virtual session to accommodate remote or off-site staff Record virtual session and post to LMS for later access. Recognize departments that reach 100% with gift cards or acknowledgment in newsletters/team meetings	# of privacy training sessions held and % of staff attending each format # of departments reaching 100% training completion	≥5 total sessions offered and ≥90% of staff have access to at least one session format ≥50% of departments achieve 100% staff compliance by deadline

	# of documents developed for department's 'privacy package'	Department-level privacy infrastructure (policy/procedure) documents maintained and tracked within the Department of Well-Being	Department of Well-Being Privacy documents (Z: Drive) Privacy Policy Tracking Sheet (maintained by PPO and Privacy Consultant) EMR Privacy Audit Data (monthly reports from EMR Administrator)	**100% completion of a prioritized privacy document list** (e.g., 10 of 10 foundational documents developed or updated by March 31, 2026)	1	A complete and current privacy package is essential for **compliance with PHIPA**, supports readiness for **Accreditation Canada's governance and safety standards**, and ensures staff have clear, consistent guidance. This initiative demonstrates organizational accountability and aligns with quality dimensions focused on **risk mitigation and safe care environments**. EMR audit trends will also inform real-time priorities for documentation.	Alliance for Healthier Communities; PPO; Managers; CLs; SLT; EMR Administrator	The Professional Practice Office (PPO), in collaboration with Privacy Consultants (Alliance for Healthier Communities), will conduct a privacy policy and process gap assessment and develop missing or outdated documents. EMR audit findings from the EMR Administrator will also inform ongoing document priorities.	Conduct a **comprehensive gap analysis** of the current privacy package using PHIPA & Accreditation Canada standards. Use EMR Administrator's **monthly privacy audit data** to identify areas of documentation behavior that may signal the need for process or policy clarification. Develop or revise key privacy documents (e.g., policies on consent, lockbox, breach response, mobile device use, access, third-party disclosure, training protocols). Maintain a **master policy tracker** to monitor progress toward the full set of required documents. Integrate finalized documents into **training/orientation materials**, SharePoint resources, and staff reference tools.	**# of new or updated privacy documents developed** **% of identified priority privacy documents completed** (e.g., 8 of 10 = 80%) **# of privacy audit themes used to trigger policy/process revisions** **# of quarterly document review and update checkpoints completed** **# of finalized documents implemented into staff training/orientation packages**	**100% of identified priority documents** completed by March 31, 2025 **At least 2 audit-identified themes** lead to creation or revision of policies/procedures **Quarterly review of policy tracker** with PPO, Privacy Consultant, and EMR Administrator **100% of finalized documents** integrated into staff-facing tools or training (LMS)
	# of clients who report 'knowing who to speak to if I have a complaint or concern regarding	Department clients completing PES	Patient Experience Survey; 2024-2025	63.5 %	**75%** (*An increase of 11.5%*	Target reflects a meaningful improvement of ~18% relative increase from	Yerihwahronkas (They Who Hear the Matters); all department staff;	Increase visibility and clarity of complaint/safety	Run a communication campaign (e.g., posters, brochures,	# of staff trained or oriented on safety	100% of front-line staff complete a refresher by Q3

	my safety or the quality of care I received'		fiscal year (baseline: 63.5%)		*from baseline)*	baseline (63.5% to 75%). Improved signage, staff education, and visibility of the "They Hear the Matters" role are expected to raise awareness. This aligns with Accreditation Canada's emphasis on clearly communicated safety processes and client engagement.	Communications Officer; CLs; PPC	procedures across all client-facing areas. Add or update signage and materials throughout program areas explaining the "They Hear the Matters" role (Yerihwahronkas) Educate front-line staff on the client complaint process and how to support and guide clients with concerns. Embed this messaging in client intake & welcome materials, and staff orientation materials (LMS)	digital signs, staff badges). Short LMS training module created and in-service refreshers for staff on complaint navigation and the complaint policy (PPC and CLs). Distribute client-facing handouts that describe the complaint/safety process and "They Hear the Matters" contact.	complaint procedure # of client-facing areas displaying signage about 'They Hear the Matters' # of programs that include safety complaint guidance in client welcome materials	100% of public-facing locations have updated signage by Q3 At least 80% of programs update client handouts by Q3
	% of incident reports to be completed electronically	All incidents occurring within the Department of Well-Being, across all staff and programs	Internal reporting data extracted from the **AtWorkCare incident management system** (Tracked monthly and summarized quarterly by HR or PPO)	0%	100% of all incident reports are submitted electronically using the AtWorkCare platform by Q4 of the 2025–26 fiscal yea	Moving to 100% electronic reporting ensures improved accuracy, timeliness, and standardization in incident management. It supports faster follow-up, allows trend analysis, and aligns with Accreditation Canada's expectations for a coordinated approach to safety monitoring and risk management. Electronic systems reduce reporting gaps and delays and facilitate organizational learning.	Health and Safety Manager (HR); HR Special Projects Coordinator; PPO; Administrative Lead; Managers; All staff; Director of HR; COO; CEO	Full implementation of the **AtWorkCare** electronic incident reporting system, supported by: -System rollout with access across all relevant departments -Staff education on how and when to report electronically -Integration of system access into onboarding and orientation procedures -Regular reminders to reinforce reporting expectations	Provide training sessions (virtual) through AtWorkCare & create own training module (PPO) available on LMS Distribute one-page quick reference guides and system access instructions to all staff Ensure all Managers can assist staff with completing their incident report via AtWorkCare Monitor incident submission methods monthly and provide program-level feedback	# of Managers trained on using AtWorkCare % of incidents submitted via AtWorkCare each quarter # of departments that have fully transitioned to electronic reporting (some programs may require additional time based on infrastructure limitations)	**100% of relevant staff trained by end of Q3** **≥ 90% of incident reports submitted electronically by end of Q4** **100% department adoption of AtWorkCare by end of Q4**

									Troubleshoot system access issues with ITS or HR as needed Phase out paper or verbal reporting methods entirely by Q3		
	# of staff who have completed the Workplace violence survey	Department of Well-Being Staff	Health and Safety Manager data	Baseline TBD (audit not yet implemented)	75% of department staff complete the workplace violence audit by March 2026	A 75% completion target reflects a significant and achievable improvement from the current baseline. It acknowledges operational realities such as staff turnover, part-time schedules, or leaves, while ensuring strong organizational participation. Completion of the audit promotes safety awareness, helps identify workplace risks, and supports compliance with occupational health and safety standards	Health and Safety Manager (HR); Health and Safety Officer; Workplace Health & Safety committee; staff; Professional Practice Coordinator (LMS)	Deliver a workplace violence awareness module through HR, followed by staff completion of an individual violence risk audit. Results will inform both training needs and workplace safety planning.	Develop and deliver a training module in collaboration with the Health and Safety Manager Provide staff with access to the audit (paper or digital) Monitor completion rates monthly Follow up on gaps with managers and targeted reminders	# of staff completed workplace violence training module # of completed individual surveys submitted % of staff completing both components	≥75% of all Department of Well-Being staff complete the training module and the workplace violence survey by March 2026 All new hires complete audit within 30 days of start date
	% of medication occurrences resulting in a near miss	Medication occurrence reports involving Department of Well-Being staff (excluding Paramedic Services and Iroquois Lodge)	Internal medication occurrence reporting template; 2024-25 reporting year	2 near misses reported in 2024-2025 2 near misses reported in Q1 & Q2 (2025)	Increase the # of reported medication near misses to **at least 8 for the 2025–26 fiscal year.**	This is a **300% increase** from the previous year, but the **absolute number (8)** is realistic and achievable with proper training and awareness. The goal is not to increase the actual errors, but to increase **staff recognition and reporting** of *near misses* — which are key learning opportunities.	Medication Management Committee Chair and committee reps; Six Nations Polytech (SNP); PSWs (HCC)	Deliver targeted **Medication Administration Training for PSWs**, emphasizing error prevention, "5 Rights," and near-miss recognition. Training to begin with HCC PSWs. Share quarterly/bi-annual de-identified medication occurrence summaries with SM of PPO for tracking and monitoring (QIP); also shared with Esadatgehs	Coordinate PSW training sessions (SMP and CLs) Integrate near-miss case examples into training materials (Ethical Decision Making tool) Promote reporting through visual reminders and	**# of PSWs who complete Medication Assistance refresher training** **# of reported near miss medication incidents (monthly or quarterly)** **% of medication incidents that include near miss analysis during**	100% of active PSWs have completed Medication Assistance refresher training by Q3 **Increase total near miss reports to at least 8 for the 2025–26 fiscal year** (*This is a meaningful jump from 2/year and aligns with a culture of improved detection/reporting.*

						Encouraging near miss reporting improves early detection of systemic issues in medication safety and supports targeted prevention An increase in the % of near misses reflects greater staff awareness, proactive reporting, and a culture of safety. Staff are identifying issues before harm occurs, which aligns with Accreditation Canada's goals around medication safety and incident learning. PSW-targeted education can significantly reduce risk during high-volume administration tasks.		committee & all staff (Quality Report) to promote transparency and reflection. Clinical Leads to clarify and reinforce with staff how and when to report near misses	leadership modeling.	**monthly Medication Management meetings**	*Aim for ~2 per quarter.*) 100% of medication management committee meetings include at least one near miss case review (utilization of ethical decision making toolkit)
Work Life	**% LMS training module completion rates by program**	All Department of Well-Being Staff excluding Iroquois Lodge	Learning Management System database - tracked monthly and reported by the Professional Practice Coordinator (PPC)	**June 2025** (baseline): CYH 42% CHW 46% MH 59% HCC 15% FHT 65% WB Admin 53% Paramedics 94% IL (requested report) TBD	Achieve **at least 75% LMS training completion rate** across all programs by end of fiscal year (March 2026), with a min of **60%** in each individual program.	Setting a 75% organizational average ensures strong uptake of required learning and supports staff safety, clinical competency, and regulatory compliance. A minimum 60% target per program accounts for variations in leave, onboarding delays, or shifts in staffing, while still encouraging consistent staff participation. This aligns with best practices in healthcare training standards and Accreditation Canada's expectations for a learning organization.	Professional practice coordinator; HLT; DAI	PPC will create and distribute an **annual training calendar** to support proactive staff registration PPC will **share monthly completion rate data** with managers for team-level follow-up and performance discussions PPC Collaborate with Managers/Clinical Leads to troubleshoot access or time barriers Promote learning completion with **monthly staff reminders**, Q&A drop-ins, and **highlighting programs that reach 100%**	Monthly LMS data sent to managers Embed training expectations into staff performance reviews and checklists Provide department-level dashboards or quick-glance charts to monitor progress (DAI) Offer open office hours for staff to ask questions Identify "training champions" in each program to help increase uptake – could also be the	# of monthly data reports shared with managers by PPC # of staff who complete LMS modules each month per program and cumulatively % of programs achieving ≥60% completion rate by Q4	**100%** of managers receive monthly LMS completion reports **100%** of programs have access to a training calendar by Q3 **Minimum 10% increase in LMS completions per program per quarter** **100%** of programs meet or exceed 60% LMS completion rate by Q4 **Organization-wide average of ≥75%** LMS completion by March 2026

									LMS Peer Supporters		
	Increase % of staff who report feeling valued at work	All Department of Well-Being staff	Annual Global Workforce Survey (GWS): #12 I have opportunities for personal growth and development #14 (immediate supervisor) Provides me with feedback on how well I do my job #15 (I.S) provides me with positive recognition #34 How satisfied are you with your job	#12 = 76.5 % positive #14 = 65.7% positive #15 = 67.3% positive	80% 75% 75%	**4-5%** increase reflects steady progress and aligns with internal quality improvement capacity and comparable benchmarks in healthcare staff engagement and wellness indicators. This incremental gain helps build momentum toward long-term goals of high staff satisfaction and retention, and supports a psychologically safe, engaged workforce—central to high-quality, client-centered care. **8-10%** increase (**65–67% to 75%)** reflects a strategic and evidence-informed improvement goal. A **target of 75%** demonstrates the organization's commitment to addressing key worklife concerns (staff engagement, well-being, psychological safety, and professional	SLT; all staff	Staff regularly included in review of annual framework updates (Esadatgehs Committee). Monthly meetings – sharing information -'Quality Champions' and 'accreditation champions' – regular incentives provided ($) -Annual Staff Appreciation Day (recognition opportunities) Regular performance evaluations – receiving feedback (occurring every year) Increase department wide learning opportunities/professional development Consistent engagement of **SLTs** with **HLT** to help implement and reinforce recognition, feedback, and learning practices within teams	Share survey results with managers - Senior Managers involved with helping teams create small team-level action plans Track performance review completion rates and staff development plans Embed recognition moments into staff meetings, newsletters, or internal communications Use "You Matter" appreciation cards, internal shout-outs, or spot-recognition methods Evaluate access and participation in learning sessions by department	% of staff who receive a completed annual performance evaluation with documented feedback # of staff recognized through formal mechanisms (e.g., Quality Champion, shout-outs, Staff Appreciation events) # of departmental staff who participate in learning/development opportunities each quarter # of teams that receive and review their own GWS results and identify improvement opportunities	**≥ 90%** of staff receive a completed annual performance evaluation with feedback by Q4 **≥ 100 staff** formally recognized across all mechanisms throughout the year **≥ 30% of staff per program** participate in at least one learning session by Q3 **100% of programs** receive their GWS results and identify at least one action item for local improvement by Q3

				#34 = 75.8% positive	80%	development)—while remaining attainable given current resources and initiatives. This 8–10% increase is significant enough to indicate real cultural or operational improvement, yet achievable within one planning cycle. It also aligns with national healthcare benchmarks that often identify 75% as a threshold for "positive" workplace experience or engagement levels.					
	% of staff who have completed cultural safety training	Department of Well-being staff (current and new hires)	Internal scheduling and attendance template managed by the **Professional Practice Coordinator (PPC)** and **Cultural Safety Facilitators**	Collecting baseline data (June, 2025-June 2026)	100%	A 100% target reflects the Department's commitment to embedding Haudenosaunee values, trauma-informed care, and culturally responsive practice into every aspect of service delivery. Cultural safety training promotes psychological safety, respectful communication, and better client-provider relationships—supporting Accreditation standards and Indigenous-specific policy guidance (e.g., TRC Calls to Action). Given the training is offered monthly and integrated into orientation, full participation is both	Professional practice Coordinator; Cultural Safety Facilitators; Michelle Thomas	Monthly delivery of a **community-specific, 2-day cultural safety training series** Mandatory attendance for **all existing staff** over the next 12 months Inclusion of training as a **core part of staff onboarding/orientation** for all new hires Reminders and follow-up coordinated by the PPC in collaboration with managers and supervisors Cultural Safety Facilitators (in partnership with Michelle Thomas) to facilitate sessions	PPC maintain a **centralized training attendance tracker** for each session Work with managers to ensure staff are registering for upcoming sessions and track completion Use orientation checklists to confirm new staff registration Provide quarterly progress summaries to Esadatgehs committee, SLT for accountability Ensure session delivery includes feedback surveys to monitor effectiveness and	# of 2-day cultural safety training sessions delivered monthly # of current staff who have completed training % of new hires who complete the training within 60 days of start date # of programs with 100% staff completion	**At least 1, 2-day training session per month** delivered from July 2025 to June 2026 **100% of current staff** complete training by end of June 2026 **100% of new hires** complete training within 60 days of hire **100% of programs** have full staff participation by the end of Q4

						feasible and mission-critical.			inform improvement		
Client Centered Services	% of clients who report being treated with dignity and respect	Department of Well-Being clients participating in PES; FHT, MH and CYH clients completing feedback survey	Patient Experience Survey (PES) – Question #8: *"I was treated with dignity and respect during my visit"* FHT client feedback survey (same or equivalent measure if available) MH Survey – Client feedback. (Talk to Eve) CYH Program Survey	**Total respondents**: 202 "**Always**": 162 "**Usually**": 32 "**Sometimes**": 8 "**Never**": 0 **Current Positive Response Rate ("Always" only):** 162 / 202 = **80.2%** (*A broader positive score including "Always" + "Usually" would be 194 / 202 =* ***96%***)	**85% 'Always' response** rate on dignity and respect (PES Q8)	The current "Always" score of 80.2% is strong, but an **85% target** reflects an intentional step toward excellence in trauma-informed, respectful, culturally safe care. Maintaining a high score while increasing the percentage who report the highest level of dignity ("Always") aligns with both community expectations and Accreditation standards. This small but meaningful increase supports the organization's commitment to equity, listening to client voice, and building trust	All Department Staff (SLT, HLT, staff); Communications Officer; PPC	Share PES results annually with all program teams Managers incorporate discussions about respect and dignity into team huddles, reflective practice sessions, and onboarding Develop short **scenario-based micro-trainings** to support respectful, client-centred interactions (patient-centered care) Ensure **welcome practices** are consistently upheld across programs Embed **reminders about respectful care** in client spaces (e.g., posters, welcome boards) and reinforce in supervision Share positive feedback from PES surveys with teams to celebrate success and reinforce what's working	Analyze "Usually" and "Sometimes" responses to understand improvement opportunities Use onboarding and ongoing education to embed respectful care practices as standard expectations Collect patient experience feedback (client comment box, FHT survey, 'Yerihwahronkas' data to monitor shifts in client experience	# of staff completing dignity/respect or trauma-informed care micro-training PES Q8 tracked on next PES (2026) to gauge improvement. Results are reviewed and discussed annually # of PES surveys completed with valid Q8 responses (to ensure robust sample) # of client-facing areas with visual indicators of respectful care commitment	**90%** of client-facing staff complete dignity/respect refresher training by June 2026 **100%** of program teams review PES Q8 results **100%** of client-facing program areas display a visual commitment to respectful care by Q3 **≥ 200 completed PES surveys** with valid Q8 responses annually (to maintain year-over-year comparability)
	Increase the number of client and family engagement opportunities per year	Clients and families who access Department of Well-Being programs and services	Structured engagement sessions (e.g., leadership-hosted meal & discussion events) **Develop a client feedback survey for**	Baseline data collection began in 2025. Feedback mechanisms are currently being expanded and formalized	Document and review **at least 3 distinct client/family advisory opportunit**	A target of 3 advisory opportunities is intentionally modest to reflect current organizational capacity, while acknowledging the importance of strengthening client	SLT; HLT; PPO	Programs to host at least one **leadership-client engagement session** by Q4 (e.g., meal or talking circle format)	**Centralized Tracking:** Professional Practice Office (PPO) to develop & maintain a centralized log of all client engagement opportunities, including	% **of programs** hosting at least one leadership-client engagement session by Q4. # **of completed centralized department client**	Centralized client feedback survey developed, launched, and available for use within **6 months** of QIP launch.

			the department (e.g., satisfaction forms, post-visit evaluations, event feedback) collected and shared with leadership (SLT, HLT)		**ies** by the end of the fiscal year, across any combination of sources listed above.	voice and responsiveness. The inclusion of diverse feedback methods—such as program surveys and culturally grounded complaint submissions—ensures that both informal and formal input is captured. This aligns with Accreditation Canada's expectations for client involvement in shaping services and supports trauma-informed, culturally safe quality improvement efforts.		Program surveys: FHT, CYH, Senior Support Hub surveys Develop centralized client feedback survey for department use	leadership-client sessions and program surveys. **Survey Development:** PPO to develop and launch a centralized department client feedback survey for use across department. **Promotion:** Use multiple channels (posters, newsletters, social media, community boards) to promote leadership-client sessions, surveys, and other engagement activities. **Data Compilation:** Track number of engagement opportunities, number of client feedback surveys completed, and participation rates for leadership-client sessions. **Committee Review:** Share engagement data and trends quarterly with the Ęsadatgęhs Quality Committee to inform service planning and quality improvement.	**feedback surveys** (per month after launch) Development and launch of the centralized department client feedback survey by target date. **% of engagement opportunities** (sessions + centralized survey) with participation data recorded in the centralized log	**100%** of programs host at least one leadership-client engagement session by Q4. **100%** of engagement opportunities documented with participation data in the centralized log
	# of client complaints received	Clients and families who access Department of Well-Being	All complaints collected centrally by the Professional	Collecting baseline data	Establish baseline in first 12 months of tracking;	Baseline tracking is essential before setting volume or resolution-based targets; this ensures realistic, data-	Professional Practice Office; Managers; Staff; Yerihkwahronkas	Develop and implement a standardized process for documenting and	PPO to develop and maintain centralized complaint log to track client	% **of complaints received by the Yerihkwahronkas role or via the Non-Employee**	**100%** of complaints (from any source) entered into the centralized complaint log within

		programs and services who have made a concern/complaint utilizing the 'Non-employee Complaint Form'; Yerihkwahronkas program; or client feedback box/QR code	Practice Office (PPO). Includes complaints received: Verbally or in writing to the Yerihkwahronkas role Via Non-Employee Complaint Form (usually completed by a Manager with the client) Through physical complaint box submissions Through QR code submission form (to be developed)		set future improvement targets once baseline data is available Ensure new QR code submission form is developed and complaint box usage is tracked within 6 months.	driven improvement goals		coding complaints across all sources Train staff on documentation of complaints, and reporting process Introduce a centralized log to capture and monitor all complaints. Develop and implement QR code feedback/complaint submission form. Promote use of **QR code–enabled digital feedback forms** in common spaces Promote awareness of all complaint submission methods to clients/families.	feedback - Yerihkwahronkas role to share monthly data (non-employee complaint form submission #s) to the PPO for tracking & analysis: -Create or adapt an electronic complaint tracking tool. - Categorize complaints (e.g., service quality, safety, communication) to enable future trend analysis. -Educate managers and front-line staff on the process. Quarterly review of complaint data at the Ęsadatgęhs Quality Committee – include trends by collection method	**Complaint form that are entered into the central complaints log** within a defined timeframe (e.g., 5 business days). **% of complaints with all required fields completed** in the log (to ensure completeness and enable analysis). # of client complaints submitted through 'complaint box/QR code' % of managers and front-line staff trained on the standardized complaints documentation and reporting process (through LMS)	**5 business days** of receipt. **100%** of complaint records complete at time of entry (all required fields filled in). **QR code complaint submission form** developed and live within **6 months** of QIP launch. **100%** of complaint box submissions collected and logged monthly. **90%** of managers and front-line staff trained on the standardized complaints documentation and reporting process within the first 6 months of implementation.
	% of departmental policies reviewed and updated to reflect trauma informed principles	All programs participating in the QIP	Policy document log (monitored through Policy working group)	Relationship Agreement updated; other departmental documents pending review	75% of departmental policies reviewed and updated by March 2026	Trauma-informed care is a foundational standard in mental health and community services. The target of 75% reflects a meaningful and achievable step toward full alignment with trauma-informed principles, while accounting for the time required for collaborative, inclusive review processes. This approach supports culturally safe, client-	SLT; HLT; community consultants; CAMH	Work with program staff, clinical leads, and community partners to co-review and update departmental documents, ensuring alignment with trauma-informed principles.	Review policies at Policy review working group and Esadatgehs committee (where relevant) Develop & use a trauma-informed care policy review tool or checklist to ensure consistency Develop and track policy updates via	# of policies reviewed using trauma-informed lens - # of documents updated based on feedback - Completion of working group meetings or review sessions	100% of newly created departmental documents incorporating trauma informed principles 100% of core departmental policies reviewed and updated by Q4 2027 50% of current department

						centered practice and staff wellness.			shared document log		documents reviewed and updated by March 2026 100% of updated documents include trauma-informed language or guidance
	Increase the number of Home and Community Care (HCC) program processes developed to improve client accessibility to services	Clients of the Home and Community Care (HCC) Program; HCC staff and Jay Silverheels Centre (JSC) staff	Internal documentation and program review by the HCC Health Leadership Team (HLT), with input from HCC and Jay Silverheels staff	Baseline = 0 documented access processes as of June 2025	Develop and implement 2 formalized processes to improve service accessibility: Access to footcare services Eligibility and prioritization criteria for high-demand HCC programs	With limited staff and resources, HCC must make strategic, client-centred decisions around who receives services and when. Implementing clear access and prioritization processes ensures transparency, fairness, and improved navigation for both staff and clients. This target also aligns with Accreditation Canada's expectations for equitable access and respectful, responsive care planning.	HCC HLT; HCC & JSC staff	Collaborate with HCC/JSC staff to co-develop a **footcare access process**, including screening and referral Create **eligibility criteria** for one or more HCC service streams (e.g., home support, transportation, wellness checks) Develop and distribute process maps, checklists, or simple workflow guides Provide staff training and track implementation progress	Conduct needs assessment through staff discussion and service request data Draft process documents in collaboration with frontline teams Collect qualitative feedback from staff for change management strategies Track consistency in how new referrals are processed using the new criteria	# of access/prioritization processes documented and implemented # of HCC and JSC staff trained/oriented on new processes % of applicable referrals reviewed using the new tools % of Staff satisfied with the clarity and usefulness of new processes	**2 access processes** finalized and in use by Q1, 2026 **100% of HCC and JSC staff** oriented to new tools by Q2, 2026 **≥ 80%** of new referrals are screened using the new access criteria (Q3, 2026) **1 staff feedback summary** reviewed at HCC staff meeting (Managers, CL) by Q3, 2026)
Continuity of Care	# of staff who are utilizing the EMR schedule to book client appointments	Active Department of Well-Being staff responsible for scheduling client appointments in the Electronic Medical Record (EMR), including clinical and administrative	**EMR usage data** pulled by the EMR Administrator (reporting staff-specific and program-level use of the scheduling tool) **Program chart audits** conducted by Managers and Clinical Leads, verifying whether client appointments	Baseline data collection is underway. Current use of the EMR schedule for booking appointments is inconsistent across staff and programs. Some rely on alternate calendars, paper logs, or	Achieve 100% EMR schedule use for booking client appointments by all staff in at least 3 key programs by Q4	Using the EMR schedule ensures that client appointments are centrally documented, visible to all relevant staff, and can be reliably tracked for service coordination. It reduces the risk of missed appointments, double-booking, or inconsistent follow-up. For programs with multiple staff or	EMR Administrator; Managers; Clinical Leads	Conduct a **baseline scan of EMR schedule usage** across programs Deliver **targeted training or refreshers** for staff not currently using the scheduling tool Collaborate with the **EMR Administrator and HLT** to address workflow issues or scheduling barriers	Regular reporting from the EMR (Administrator) showing scheduling activity by staff/program Include EMR scheduling compliance checks in monthly chart audits Cross-reference booked appointments in	# of active staff using the EMR schedule for booking appointments # of programs with 100% EMR scheduling usage # of refresher training sessions held on EMR scheduling	**100% of active scheduling staff** in 3 programs using EMR schedule to schedule client appointments by Q4, 2025 **All chart audits** to include a scheduling compliance check by Q2, 2025 **At least 2 training/refresher**

		staff across programs	were booked in the EMR schedule	verbal scheduling.		interdisciplinary teams, this is essential for ensuring continuity. A phased, program-based rollout is realistic and allows time for training, troubleshooting, and staff adjustment.		Integrate EMR scheduling as a standard in **chart audits** and administrative reviews Develop **tipsheets or quick guides** for staff on how and when to use the EMR schedule Share progress with teams and recognize programs that meet 100% compliance	EMR with program service delivery logs or visit records Collect staff feedback on barriers to using the EMR schedule and adjust workflows accordingly	# of chart audits that include EMR scheduling review # of staff identified as needing follow-up for scheduling compliance	**sessions** offered for staff by Q3, 2025 **Quarterly usage reports** shared with program managers (EMR Administrator) **100% of non-compliant staff** receive follow-up and support within 30 days
Appropriateness (Do the Right thing to achieve the best results)	# of practice based scenarios being reviewed at Esadatgehs Committee meeting using the Ethical Decision-Making Tool	Members of the Esadatgehs Quality Committee, including departmental leadership, clinical staff, and invited program representatives. Practice-based scenarios may involve real (de-identified) or hypothetical cases from across Department of Well-Being programs.	Esadatgehs Committee meeting agendas and minutes Completed Ethical Decision-Making Tools (stored by the Senior Manager of Professional Practice)	Inconsistent. While ethical decision-making discussions are encouraged, there is currently no formal tracking of how many scenarios are reviewed or whether the tool is used systematically at each meeting.	11-12/year	This initiative promotes consistent, values-based, and culturally grounded decision-making across programs and leadership discussions. It aligns with Accreditation Canada's *Ethics Framework* expectations and supports professional and organizational accountability. Using the tool regularly encourages reflective practice, team learning, and a proactive culture of ethical awareness. By embedding it into routine committee functioning, the Department strengthens both its ethical culture and its responsiveness to complex client, staff, and system dilemmas.	PPO; Clinical Leads; Esadatgehs Committee Members	**Integrate Ethical Decision-Making Tool use** into every Esadatgehs meeting agenda Establish a **rotating responsibility** among committee members to bring a relevant scenario for review Offer a **brief refresher** or mini-learning session annually on utilization of the tool Develop a **tracking template** to document each reviewed scenario and reflect on follow-up actions or insights Encourage program leads to submit cases from the field (real or hypothetical) to build capacity and surface practice tensions	Include "Ethical Scenario Review" as a **standing agenda item** at each committee meeting Use a **standardized template** to guide and record each tool discussion Capture themes from discussions and share anonymized learnings with teams as part of ongoing quality and cultural safety conversations Review aggregate themes annually to identify common dilemmas, gaps in policy, or training needs	# of Esadatgehs meetings where at least one scenario is reviewed using the Ethical Decision-Making Tool # of unique staff or programs contributing cases for review # of themes identified across ethical discussions that inform practice or policy # of follow-up actions documented after ethical scenario discussions	**11–12 ethical scenarios** reviewed (1 per meeting) **At least 6 different programs or teams** contribute scenarios over the year **100% of scenarios** documented using the Ethical Decision-Making Tool template **At least 1 follow-up action** or reflection shared back to staff or incorporated into QI planning bi-annually