Access and Flow | Timely | Optional Indicator

Indicator #1

90th percentile emergency department wait time to inpatient bed (Orillia Soldiers' Memorial Hospital)

Last Year		This Year		
22.43	**22**	**23.35**	**-4.10%**	**22**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☐ Implemented ☑ Not Implemented

Corporate philosophy change from push to pull of inpatient units from the ED

Process measure

- Number of patient to inpatient bed from time bed was assigned - 30 minutes

Target for process measure

- 75% of all patients to inpatient bed from time bed was assigned within 30 minutes.

Lessons Learned

Piloted ICU and Pediatric pull philosophy - improved Time to inpatient bed and quality of transfer of accountability. We did not spread to other medical units as our Transfer of Accountability process is under review. Challenges with change management and impact of the pull philosophy on unit operations.

Change Idea #2 ☐ Implemented ☑ Not Implemented

Implement unit scorecards for monitoring compliance for 30 min pull time adherence.

Process measure

- total number per unit

Target for process measure

- Scorecards developed and shared with units by end of Q2

Lessons Learned

Unable to pull individual medical/surgical unit data at this time. ED Quality and Utilization scorecard currently tracks Mental Health, Medical/Surgical, Pediatrics, ICU, and Pediatric Mental Health (non-admitted).

Change Idea #3 ☑ Implemented ☐ Not Implemented

Monitoring transfer time to inpatient unit on ED tracker.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

The admitting department consistently enters the time the bed is assigned on the ED tracker. Wait time is monitored by the Manager of Patient Flow and Manager of ED to support barriers to transfers.

Change Idea #4 ☑ Implemented ☐ Not Implemented

Patient flow strategies to improve throughput including Geriatric Medicine.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Geriatric Emergency Medicine Nurse hired in March 2024 to support admission avoidance, overall reducing hospital occupancy and increasing available beds. Processing Mapping of patient journey from ED to each clinical program completed to identify inefficiencies. Reviewing Bed Management program and surge protocols.

Change Idea #5 ☑ Implemented ☐ Not Implemented

Implement Novari on Inpatient Mental Health

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Implemented Novari tool on inpatient mental health to improve bed utilization. Challenges including change management from paper based to electronic system, and education of staff.

Comment

Continuing to work on data driven quality improvement initiatives, maintaining this indicator on next year QIP.

Access and Flow | Timely | Custom Indicator

Indicator #4

Reporting the number of new coordinated care plans(CCP's) created for CHF and COPD patients in the CHIS HPG system to be accessed/utilized by COHT partners. (Orillia Soldiers' Memorial Hospital)

Last Year		This Year		
CB	100	178.00	--	NA
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Education events to promote the utilization of CCP's for CHF and COPD

Process measure

- Led and tracked by OHT lead/ED

Target for process measure

- 1 session per quarter

Lessons Learned

Education completed that included two separate lunch and learn sessions for staff at the HUB as well as OSMH to support coordinated care planning. Included key staff such as GEM/PT flow navigator/CHaH and external partners including helping hands. Education successful overall. Challenges included care plans are only "viewed only" on connecting Ontario, therefore data doesn't fully reflect accuracy; not all partners able to add to plan (helping hands)

Change Idea #2 ☑ Implemented ☐ Not Implemented

Creation of COHT chronic disease HUB

Process measure

- Monitored by COHT leadership (transfer payment agreement).

Target for process measure

- HUB to be in place for Q2.

Lessons Learned

Launched June 17, 2024, streamlining the development and launch integrated clinical pathways. Challenges related to ongoing funding commitment.

Comment

Target achieved, OSMH will continue to work with the OHT on further aspects of enabling successful patient transitions and integration.

Equity | Equitable | Custom Indicator

Indicator #3

Percentage of staff (executive-level, senior management, board) who have completed relevant equity, diversity, inclusion, and anti-racism education
(Orillia Soldiers' Memorial Hospital)

Last Year		This Year		
CB	100	76.20	--	NA
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Partnering with the IHC to provide a full day training on indigenous cultural safety

Process measure

- Planning done through HR

Target for process measure

- Completion end of Q1

Lessons Learned

Partnership developed with the Indigenous health circle, 9/12 board members attended and 7/9 members of senior team. Further education is being planned for other leaders including managers. Biggest challenge for this change indicator was ability to coordinate one day for all participants to attend fully.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Develop a tracking tool to monitor compliance

Process measure

- Compliance reporting will be shared with Senior team quarterly.

Target for process measure

- tool developed for end of Q1.

Lessons Learned

Developed and implemented using excel.

Change Idea #3 ☑ **Implemented** ☐ **Not Implemented**

Create a full education plan with the IHC to provide to the broader team.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Partnered with the IHC to develop focused education for all levels of learners. Challenges included: balancing priorities for work and time to learn and aligning on what level and type of learning is adequate to confidently say that indigenous cultural competency is understood.

Comment

This indicator will remain on the QIP with some adjustments based on learning to support broader education to a broader team.

Experience | Patient-centred | Custom Indicator

Indicator #2

Patient experience: Did you receive enough information when you left the hospital? (Orillia Soldiers' Memorial Hospital)

Last Year		This Year		
CB	**75**	**82.00**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Design, develop and implement internal and external communication plan.

Process measure

- Number of huddles, committees met with.

Target for process measure

- All impacted clinical areas, Leadership council and PFAC will receive a minimum of 2 communication/education touch points by June 30th.

Lessons Learned

Completed.
Engaged multidisciplinary group to collaborate with all aspects of discharge including medical staff.

Change Idea #2 ☐ Implemented ☑ Not Implemented

Ensure every patient discharged received written communication for discharge instructions

Process measure

- Automated electronic documentation option to demonstrate written instruction provided.

Target for process measure

- 80% of discharged patients.

Lessons Learned

Not yet complete, leveraging depart tool within EMR. Currently reviewing how to accurately measure use of current tool. Challenges include difficulty obtaining data on usage of current tool; limitations within current EMR including units that use paper documentation and uptake of usage. Successes include heightened awareness through patient surveys and through rounding with staff importance of written information at discharge.

Change Idea #3 ☑ Implemented ☐ Not Implemented

The Expected date of discharge will be displayed on the newly standardized patient whiteboards, ensuring that all patients and their families are informed. This will facilitate proactive discussions regarding discharge planning with the care team.

Process measure

- Managers will round with patients and review to ensure whiteboards are updated. patient rounding surveys will include a questions of: Is the whiteboard fully up-to-date.

Target for process measure

- 75% of all new patient whiteboards will be fully up-to-date by Q4 2024.

Lessons Learned

Whiteboard project completed as of Jan 2025. New whiteboards installed on all inpatient units that were co-designed with patient and families. Expected date of discharge audit planned for February 2025. Challenges included logistics and resourcing to install new whiteboards. Successes included co-design with patient and families; staff have adopted into practice, great uptake.

Change Idea #4 ☑ Implemented ☐ Not Implemented

Utilize volunteers to complete phone surveys to better understand feedback related to barriers to discharge information.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Completed in Fall 2024. Helped to build relationships between patients/families and patient experience department. Feedback was used to help inform both current and future initiatives on this indicator.

Change Idea #5 ☑ Implemented ☐ Not Implemented

Develop discharge brochure to support guided conversations between the patient/family and the team.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Patient discharge brochure developed and will be piloted on high turnover units. Developed by patient and family advisor.

Comment

Working group for this indicator will be continuing to support the patient discharge brochure, this indicator will also remain on the next year QIP.

Safety | Safe | Custom Indicator

	Last Year		This Year		
Indicator #5 The number of lost time incidents due to workplace violence (WPV) injury. (Orillia Soldiers' Memorial Hospital)	**4.00** Performance (2024/25)	**5** Target (2024/25)	**2.00** Performance (2025/26)	**--** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Review and customization of in person crisis prevention intervention training/SMG.

Process measure

- Consultation, contract negotiation and implementation all in scope.

Target for process measure

- Completion targeted for Q1.

Lessons Learned

Complete, program rolled out, consulted SMG provider along with internal departmental leads and updated contract as well as program offering to meet organizational needs. Shifted to a centralized scheduling model to ensure 80% attendance per session. Further customized the program to meet organizational needs.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Implement a mock code white opportunities for staff.

Process measure

- Monitoring will be completed at EPC and reported to workplace violence committee.

Target for process measure

- 1 mock code white per quarter.

Lessons Learned

Complete, mock codes continue through EPC committee. Reporting through to workplace violence committee is occurring.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Rebuilt the individualized safety plan process for staff experiencing any violence.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Previous process was difficult to follow and rebuilt process includes a simple one page form and a pathway for staff to follow. Education to follow shortly.

Change Idea #4 ☑ Implemented ☐ Not Implemented

Revise the education provided to onboarding team members to be up to date with current process.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Improved initial education for new staff on both what workplace violence is and processes used at hospital to mitigate and manage episodes.

Change Idea #5 ☑ Implemented ☐ Not Implemented

Assess and implement program clinical supports to support patients with high-risk behavioural challenges.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Restructured Gentle persuasive approach programming; Enhanced patient observation policy update and roll out complete

Comment

This indicator will remain on the QIP for the upcoming year.