Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 25, 2026

Soldiers' Memorial Hospital Orillia

Ontario Health

OVERVIEW

Orillia Soldiers' Memorial Hospital (OSMH) is committed to delivering high-quality, safe, and compassionate care to the communities we serve. Quality improvement at OSMH is grounded in collaboration, accountability, and a strong commitment to learning, with a focus on improving patient outcomes, experiences, and system performance across the continuum of care.

Over the past year, OSMH has advanced several foundational initiatives that will guide our quality journey moving forward. The launch of our new Strategic Plan provides a clear and shared direction for the organization, emphasizing patient-centered care, people experience, health equity, system integration, and continuous improvement. The Strategic Plan reinforces quality as a shared responsibility and embeds improvement into organizational planning, decision-making, and daily practice.

OSMH has also expanded its role as a teaching and learning organization through the establishment of a new Family Medicine Teaching Unit (FMTU). The FMTU strengthens access to primary care within the community, supports improved transitions between hospital and community-based services, and contributes to the training and retention of future health care professionals.

OSMH's commitment to quality is further demonstrated through external recognition and sustained improvement efforts. For the second year in a row, OSMH has been recognized through participation in the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP), reflecting ongoing excellence in surgical quality, outcomes monitoring, and data-informed improvement. In addition, OSMH successfully completed numerous quality improvement initiatives in support of accreditation, strengthening clinical processes, safety practices, leadership oversight, and organizational readiness.

ACCESS AND FLOW

OSMH continues to prioritize access and flow to ensure that patients receive the right care, in the right place, at the right time. Significant progress has been made through strong partnerships and targeted initiatives that support admission avoidance, timely discharge, and improved transitions across the health system. To continue monitoring and improving overall hospital flow, OSMH is maintaining the QIP indicator "90th percentile ED time to inpatient bed".

Building on strong community partnerships, OSMH supported integrated care and the operationalization of the Home First philosophy with the Couchiching Family Health Team System Navigation program, Helping Hands, Ontario Health at Home (OHaH), Couchiching Ontario Health Team (COHT) and the Nurse-Led Outreach Team (NLOT) at long-term care homes.

OSMH supported admissions to the Couchiching Health at Home (CHaH) program with the support and integration of the Nurse Practitioner role to support transitional care and assist patients in connecting with a primary care provider.

ALC avoidance and length-of-stay reduction remain key areas of focus. Weekly ALC rounds bring together hospital and community partners to proactively review patients who are at risk for ALC designation. Joint Discharge Operations Committee meetings review requests for ALC to long-term care, supported through senior leadership at both OHaH and OSMH. A Delirium ALC working group has focused on early identification of at-risk patients in the Emergency Department, implementation of standardized order sets, and mandatory e-learning, contributing to a decrease in ALC days for admitted patients with delirium.

Admission avoidance is further supported through the presence of a Geriatric Emergency Management (GEM) nurse, Ontario Health at Home Care Coordinators, patient flow navigation, social work assessments, ProResp at Home services, daily bed meetings, a Bed Management and Surge Policy, interdisciplinary scrums, and the use of offsite Alternate Health Facility beds to transition patients from acute care.

EQUITY AND INDIGENOUS HEALTH

OSMH remains committed to advancing health equity and improving access, experiences, and outcomes for Indigenous Peoples and other equity-deserving populations. Leadership teams participated in equity, diversity, inclusion, and antiracism education as part of Quality Improvement Plan commitments, alongside Indigenous-specific training including BANAC Knowledge to Action sessions.

OSMH implemented an updated smudging policy and process, along with Indigenous Self-ID education and training. Indigenous Self-ID was rolled out mid-2025 using the Knowledge to Action Framework. Equity and inclusion considerations are embedded into quality improvement, patient experience, and policy development, supported by the Inclusion and Belonging Framework and education plans. Through work such as the Indigenous Health Circle and the newly formed Indigenous Health Employee Resource Group, OSMH continues to drive meaningful change to support safe and inclusive culturally safe care. Looking ahead, the Indigenous Self-ID journey at OSMH will continue to strengthen through sustained education, meaningful engagement with Indigenous partners, and responsible use of data to identify gaps and improve outcomes. These efforts reflect our broader commitment to reconciliation, health equity, and delivering care that is responsive to the diverse communities we serve.

PATIENT/CLIENT/RESIDENT EXPERIENCE

OSMH is committed to integrating patient, family, caregiver, and visitor experience feedback into every stage of quality improvement (QI) work. We collect experience data through surveys (including the Qualtrics platform) and real time feedback channels, including in-person leader rounding and point of care observations. This information is reviewed quarterly by the Patient Experience Team, QI leads, and leadership to identify trends, emerging themes, and opportunities for improvement.

Each program receives a tailored experience feedback report, which is used to guide unit-level discussions and to co-design improvement actions with staff, patients, and families. Priority areas, such as communication, emotional support, care coordination, and responsiveness are linked directly to organizational QI initiatives. Experience data is triangulated with safety and clinical indicators to ensure a comprehensive understanding of care quality.

To strengthen accountability and transparency, results and improvement actions are shared with frontline teams, leadership, and patient/family partners through dashboards, huddles, and board committees. Patient partners are embedded in QI projects to ensure that lived experience meaningfully informs the design, testing, and evaluation of changes.

Feedback from surveys also guides team member education, service design, and the refinement of evidence informed practice standards. By grounding QI activities in experience data, we aim to deliver care that is compassionate, consistent, and aligned with what matters most to those we serve. Our goal is to continuously improve the care experience through listening, learning, and partnering with patients, clients, residents, and families.

PROVIDER EXPERIENCE

A key area of success in strengthening provider experience at OSMH has been the intentional evolution of our people-focused approach through the development of the myBrand framework. This work has helped create a stronger sense of ownership, connection, and belonging for our team members by clearly anchoring initiatives to a shared identity and purpose.

The myBrand was intentionally co-created with our people, using engagement data, feedback from surveys, onboarding insights, exit feedback, and ongoing dialogue through huddles and team conversations. Programs developed under this framework are designed to be practical, people-centered, and responsive to emerging needs, reinforcing a consistent and supportive employee experience across the organization.

This approach has supported recruitment and retention by strengthening workplace culture, improving clarity around career growth and learning opportunities, and reinforcing our commitment to wellbeing. As we move forward, the myBrand continues to evolve with an increasing focus on wellness, leadership development, and learning, ensuring that initiatives remain relevant and sustainable.

By maintaining continuity in engagement and intentionally listening to our people, OSMH is building a strong foundation for provider experience that supports both individual growth and organizational resilience.

SAFETY

Preventing Never Events is a critical component of OSMH's patient safety strategy and reflects our commitment to providing safe, reliable, and high-quality care. OSMH focuses on proactive risk identification, standardization of evidence-informed practices, and continuous learning to reduce the likelihood of serious, preventable harm. At OSMH, Never Events are treated with similar rigor and reporting as a critical incident prompting a quality-of-care review with system level recommendations.

A key area of focus this past year has been on skin integrity, recognizing that hospital-acquired pressure injuries represent a significant patient safety risk. OSMH has undertaken extensive work to strengthen its skin integrity program, including standardized risk assessments, early prevention strategies, interdisciplinary collaboration, staff education, and regular monitoring of practices and outcomes. This work is supported by routine audits, frontline engagement, and leadership oversight to ensure consistency and accountability across care settings.

PALLIATIVE CARE

To support a collaborative and integrated approach to palliative care, a new palliative care integrated pathway task force has been developed through the COHT. This group is chaired by OSMH and has been launched to support the development of integrated pathways between hospital, home and other community providers. The group has members from the Patient and Family Advisory Committee (PFAC), paramedics, hospice, Indigenous Navigator, bereavement care, long term care and Ontario Health at Home. The intent of the group is to develop referral pathways and to create linkages to resources to support knowledge translation and ease of access for both our providers, our patients and their families. Internally this aligns with ongoing work to review and refine palliative and end-of-life ordersets, ensuring consistency, clarity and seamless transitions in care. The task force will also support addressing a wider access to grief and bereavement support for families in our community.

This past year, OSMH received a donation to support the renovation of an inpatient room to support palliative care. While palliative care can and is provided in any room at OSMH, this room was thoughtfully designed to create a peaceful, supportive environment that promotes comfort, privacy and a sense of calm for patients and their families. This aligns with Quality Standard 11, supporting patients to receive palliative care in their preferred setting. Recognizing the complexity of end-of-life care, the task force will work to enhance coordination and integration across settings, supporting patients' wishes regarding where they receive care wherever possible.

POPULATION HEALTH MANAGEMENT

Population health integration is the focus of our COHT and Primary

Care Network (PCN). OSMH is one of the 14 anchor partners of the COHT and as such, has a role to play through both direct clinical initiatives and oversight and partnership roles within the COHT. Such initiatives include the Substance Use Navigator (SUN) role, which supports improved access to substance use disorder care and system navigation; coordinated, team-based emergency response during community-wide events such as the ice storm; Couchiching Health at Home, which supports care closer to home; and strong linkages with the Chronic Disease Hub to improve continuity and coordination for patients with complex and ongoing needs.

The recently launched FMTU not only allows more patients access to care, but teaches the next generation of family physicians a holistic approach to healthcare and population health management, including an Indigenous healing rotation. OSMH recognizes and works to enact truth and reconciliation in all ways, inclusive education of family medicine residents. The Medical Trainee Education Committee is dedicated to high quality education of medical learners across all dimensions of population health. Of note, recruitment and retention efforts in which OSMH participates (Medical Affairs, Recruiter and the Orillia Lake Country Physician Recruitment Committee) also include fulsome support to internationally trained physicians providing return of service care in communities that are underserved, bringing care closer to home for our communities and ensuring immigrant physicians and their families are welcomed and supported.

In addition, through supporting the wider population health, OSMH has had strong involvement and leadership in joint birthing program work that is inclusive of our neighbouring rural geographies including community-based perinatal care access.

EMERGENCY DEPARTMENT RETURN VISIT QUALITY PROGRAM (EDRVQP)

Quality Improvement Priorities

Discharge Planning for Patient Success: Action Plan

1. Use standardized discharge planning tools to identify barriers, such as social supports, transportation, medications, equipment, and follow-up care.
2. Integrate allied health and care coordination earlier for patients at risk of delayed or unsafe discharge. This work is supported through the GEM nurse, SUN, and Ontario Health at Home that work within the ED.
3. Ensure discharge information is completed and reviewed with the patient/family before departure.
4. Ensure clear pathways for discharge questions and clinical signs of deterioration.
5. Providing culturally appropriate and accessible discharge materials when necessary.

Clinical Documentation Standards: Action Plan

1. Ensure standardized documentation tools are utilized to ensure documentation supports clinical decision-making, medical necessity, and patient outcomes.
2. Addressing and monitoring gaps in charting standards through chart reviews.
3. Ensure documentation captures patient education, informed consent, and shared decision-making.
4. Future state is to leverage documentation audit data to identify trends in delays, readmissions, and adverse events.

Quality Issues Identified

1. Inconsistent or incomplete clinical documentation can compromise continuity of care, increase clinical risk, and limit the ability to evaluate outcomes, particularly during care transitions.
2. Incomplete or delayed discharge planning increases the risk of

readmission, adverse events, and poor patient experience, particularly for patients with complex medical and psychological needs.

EXECUTIVE COMPENSATION

As required by the Excellent Care for All Act, executive compensation is linked to the hospital's Quality Improvement Plan (QIP). The OSMH Board of Directors holds hospital leadership accountable through the annual establishment of an evaluation framework and the quarterly reporting of results. Executive compensation has been linked to four of the five indicators. The indicator Promote Psychological Safety is a newly developed indicator with the establishment of a baseline identified as the target for the 2026/2027 fiscal year. As this indicator is developmental in nature and focused on building organizational understanding and measurement capability, it is not weighted for executive compensation at this time.

Both the patient experience and access and flow indicators have been weighted at 30%, reflecting their longer-standing inclusion on the QIP and OSMH's sustained commitment to improvement in these priority areas. These indicators represent core system outcomes that are well established and measurable and are supported through ongoing organizational focus.

The indicators Rate of Delirium Onset During Hospitalization and Number of Team Members who have Completed Learning on Inclusion & Belonging @OSMH have each been weighted at 20%. This weighting reflects the relative maturity of the underlying improvement work to date, while recognizing that further development and refinement will continue over time.

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 **March 25, 2026**

Lawrence Pietras, Board Chair

Sheila Clark, Board Quality Committee Chair

Carmine Stumpo, Chief Executive Officer

Rebecca Liebau, EDRVQP lead, if applicable