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		
23.35 Performance (2025/26)	**22** Target (2025/26)	**23.40** Performance (2026/27)	**-0.21%** Percentage Improvement (2026/27)	**22** Target (2026/27)

Change Idea #1 ☐ Implemented ☐ Not Implemented ☑ In Progress

Continued focus on ICU and Mental Health Time to inpatient bed

Process measure

- Time to inpatient bed measured in minutes

Target for process measure

- 90% patient are admitted to ICU within 30 minutes of being assessed by intensivist and 90% of patients are admitted to the Inpatient Mental Health Unit within 30 minutes when a bed is available

Lessons Learned

Successes included increased awareness of process measure and some progress was achieved. For mental health admissions, there was success in the regional lens for timely access. Staffing model for mental health was adjusted to support internal transfers to unit, this has created some success. Challenges for mental health include central intake process and model which doesn't necessarily prioritize OSMH patients. Challenges for intensive care unit admission time include lack of admission criteria.

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

Improve attendance at and consistency of weekend/STAT holiday bed meetings

Process measure

- Number of units attending after hours bed meetings

Target for process measure

- 100% of all units to attend weekend bed meetings, and pre-populate information into the daily bed meeting form

Lessons Learned

Overhead announcements implemented to notify team members of timing of bed meetings. Participation rate has improved from limited attendance to about 60% on a regular basis. Challenges remain to be workload on weekends and competing demands.

Change Idea #3 ☐ Implemented ☐ Not Implemented ☑ In Progress

Develop admission and discharge criteria for the intensive care unit.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Admission and discharge criteria policy has been developed but not yet implemented. Planned implementation is Q1 of 2026/2027.

Comment

Benchmarking completed with top performer on this indicator in the province. Workplan developed for fiscal year 2026/2027.

Access and Flow | Timely | Custom Indicator

Indicator #2

Number of potential admissions avoided with utilization of the CHaH Program (Orillia Soldiers' Memorial Hospital)

Last Year		This Year		
248.00	**260**	**168.00**	**--**	**NA**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Promotion and education on the use and importance of the Couchiching Health at Home program through visual cues in the emergency department.

Process measure

- Number of patients who are referred to CHaH from the emergency department and are not admitted.

Target for process measure

- Increase by 3 patients referred per quarter.

Lessons Learned

Brochures were developed and are in the ER department. GEM has been instrumental in supporting education and promotion of the program. Q2 referrals were 16 referrals from ED - an increase from the previous quarter.

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

Leverage coordinators to support education of admission avoidance strategies through referral to CHaH

Process measure

- 6 education sessions will be provided to emergency department staff.

Target for process measure

- This will be completed by the end of Q2

Lessons Learned

Education sessions completed by GEM nurses on behalf of CHaH, 10 sessions completed by the end of Q3

Comment

Will be continuing to work on increasing admissions through this program through operational work.

Equity | Equitable | Optional Indicator

	Last Year		This Year		
Indicator #4 Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education (Orillia Soldiers' Memorial Hospital)	**CB** Performance (2025/26)	**75** Target (2025/26)	**88.31** Performance (2026/27)	**--** Percentage Improvement (2026/27)	**NA** Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Offer equity, diversity, inclusion and accessibility training directed to the need of the recipient (audience). We will engage partners with expertise (indigenous health circle for example) to develop an education plan geared towards indigenous cultural safety using the KTA framework wherein training opportunities are offered in different ways for different levels of learning In order to ensure meeting the widest group of people, and to accommodate timing and resourcing, we will plan in advance.

Process measure

- Number of leaders who have received training.

Target for process measure

- 50% of the desired target audience will be trained by the end of the second quarter.

Lessons Learned

90% of leaders completed training offered through Rama/BANAC utilizing the KTA framework. Directors attended this training, either one or two days. Various training modalities were offered. Board of directors and Senior team attended an off site facilitated session.

Change Idea #2 ☐ Implemented ☑ Not Implemented ☐ In Progress

Offer IDI training to leadership (senior team and directors) for self-reflective learning. DEIRB committee will guide the use of a platform called the IDC to support individual learning journeys in cultural competence.

Process measure

- Number of directors receiving training.

Target for process measure

- 25% of directors will have an IDI facilitator by the end of Q4

Lessons Learned

Dependent on resources, unable to facilitate this fiscal will look to include in next year's plan.

Comment

Completed and moving to a similar indicator considering all team members.

Experience | Patient-centred | Custom Indicator

Indicator #3

Percentage of respondents who responded "completely" or "quite a bit" to the following question: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital? (Orillia Soldiers' Memorial Hospital)

Last Year		This Year		
84.00	**80**	**81.08**	**--**	**NA**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Improve consistency in discharge documentation to ensure standardization in alignment with our policy and accreditation standards. 20 patients per quarter will be surveyed post roll out of discharge brochure and policy via phone.

Process measure

- Number of patients that received adequate discharge documentation

Target for process measure

- 80% of surveyed patients will have received discharge documentation in alignment with hospital policy.

Lessons Learned

Successes included engagement from team perspective which has helped profile the discharge process. Working group has expanded so that it is now more interdisciplinary. Engagement with environmental services. Engagement to review materials was successful including physician partners. Content is public facing. Challenges included manual workload and retrospective nature of survey (calling). Extracting patient data difficult and patients often don't remember all aspects of their care journey.

Change Idea #2 ☑ **Implemented** ☐ **Not Implemented** ☐ **In Progress**

Improve the depart tool by completing a fishbone, 5W 2H analysis and a prioritization matrix with the multidisciplinary working group and physician leads to further understand root cause related to the depart tool.

Process measure

- Number of root cause analysis activities completed

Target for process measure

- 3 root cause analysis activities will be completed by the end of Q1, 1 scheduled per month.

Lessons Learned

Root cause analysis tools were completed with great engagement including physician group. Use of depart tool along with education has been socialized; roll out included link with patient story to support understanding with team members.
Challenge is that there is a limitation in the technology to make any changes to the actual tool.

Comment

This indicator will be carried over to the next QIP.

Safety | Safe | Optional Indicator

Indicator #5

Rate of delirium onset during hospitalization (Orillia Soldiers' Memorial Hospital)

Last Year		This Year		
1.08	**1.50**	**1.36**	**--**	**1.35**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Improve accurate completion of the CAM tool, delirium standard of care and prevention protocol through education on use. Collaborate with Specialized geriatric services in the development of education related to delirium identification and prevention.

Process measure

- Number of staff trained

Target for process measure

- 60% of frontline staff will receive education by end of Q3

Lessons Learned

Moved education target to Q4, e-learning developed that includes screening and education on Delirium. SGS completed training sessions with team members and designed and shared the e-learning for OSMH. Anticipate to meet the target by Q4. E-learning is annual and mandatory. OSMH supported World Delirium Day also supporting education through the organization.

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

Assess current structures where similar delirium initiatives are currently being worked on and reformat delirium working group to include all delirium initiatives

Process measure

- Number of similar initiatives

Target for process measure

- Based on assessment, reduce similar initiatives by 20% by the end of Q2

Lessons Learned

Completed, duplication identified and streamlined into the ALC working group with focus on value added changes. Regional sharing of resources with respect to delirium to support standardization across the region. Delirium huddle developed this year through SGS, OSMH participating. Surgical Manager leading DASH is a member of the delirium working group.

Change Idea #3 ☑ Implemented ☐ Not Implemented ☐ In Progress

Update ordersets and protocols

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Protocols and ordersets updated to reflect best practice in delirium assessment and management

Change Idea #4 ☑ Implemented ☐ Not Implemented ☐ In Progress

Support development of regional structure for standardization of delirium practices, education and knowledge sharing

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Supported development of regional huddle in partnership with SGS; prompted development of e-learning through SGS for regional use

Comment

In process of developing change ideas for upcoming year, indicator to remain on QIP.

Indicator #6

Rate of workplace violence incidents resulting in lost time injury (Orillia Soldiers' Memorial Hospital)

Last Year		This Year		
2.00	**5**	**2.00**	**0.00%**	**NA**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☐ Implemented ☐ Not Implemented ☑ In Progress

Delineation and customization of SMG, GPA and civility training to the right audience at the right time.

Process measure

- Number of courses assessed

Target for process measure

- SMG, GPA and civility training alignment with organization and staff needs will be completed by end of Q2

Lessons Learned

Proposal in development but not yet approved. Assessment and root cause activities completed.

Change Idea #2 ☐ Implemented ☐ Not Implemented ☑ In Progress

Provide education and awareness for workplace violence and joint health and safety committees for utilization of SBAR framework (ethical decision making) related to specific and/or generalized workplace violence cases. Develop and deliver an SBAR education session focused on case specific workplace violence incidents to the workplace violence committee and joint health and safety committee

Process measure

- Number of staff trained

Target for process measure

- 80% of workplace violence and joint health and safety committees by the end of Q3

Lessons Learned

Added as a part of the workplan but not yet fully executed. SBAR framework utilized with a specific case example and was shared at a HIROC meeting to share at provincial level. Work to continue on sharing internally.

Change Idea #3 ☑ Implemented ☐ Not Implemented ☐ In Progress

Review and evaluate the current reporting process and tools to ensure adequate response measures in alignment with the workplace violence policy. A root cause analysis on current data from both the incident management system and HR investigation will be completed

Process measure

- Number of root cause analysis activities

Target for process measure

- Two root cause analysis activities will be completed by the end of Q2

Lessons Learned

Define the problem activities including 5 why and analyse the situation including fishbone analysis were completed as a part of the RL project. Data such as # of incivility reports and incidents were also reviewed.