Access and Flow

Measure - Dimension: Timely

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department wait time to inpatient bed	O	Hours / ED patients	CIHI NACRS / December 1, 2024, to November 30, 2025, in alignment with the Pay for Results program	23.40	22.00	Working this year to continue to maintain gains over past few fiscal years.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	Yes
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1 Enhance the escalation of care pathways for bed management by developing accountability for time to inpatient bed targets.

Methods	Process measures	Target for process measure	Comments
Review and analyze the current bed management policy to enhance accountability and escalation as needed to meet targeted times.	Complete review of policy, stakeholder engagement and determine targets and escalation process.	By end of Q4, there will be an established escalation of care pathway for bed management with identification of how many times escalation was necessary.	

Change Idea #2 Develop admission and discharge criteria for ICU.

Methods	Process measures	Target for process measure	Comments
Engage stakeholders, benchmarking, and regional admission and discharge criteria to be the foundation to the policy development.	Increased bed utilization and access to bed within 90 minutes.	By the end of Q4, the policy will be established with a 30% improvement in time to ICU bed.	

Change Idea #3 Use root cause analysis to examine ENVS bed turnover process and data collection.

Methods	Process measures	Target for process measure	Comments
Analysis of current state, examine technological advancements to support timely notification to staff.	Complete root cause analysis and identify strategies to address gaps.	By end of Q4 decrease bed turnover time by 10%.	

Change Idea #4 Develop a strategy to promote timely discharge for patients awaiting diagnostic imaging procedures.

Methods	Process measures	Target for process measure	Comments
Utilize the discharge option on the order entry within EMR technology.	Complete stakeholder engagement and awareness to align practice throughout inpatient settings to utilize this function.	By end of Q4 there will be a 50% increase in utilization of this function within inpatient units.	

Equity

Measure - Dimension: Equitable

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of team members who have completed learning on Inclusion & Belonging @OSMH	C	Number / Staff	Local data collection / 2026/2027	0.00	1050.00	Aiming at 60% of all team members for education on inclusion and belonging on our new framework. Education will include e-learning and inclusive discussions in person.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	Yes
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1 Create an inclusion and belonging e-learning module accessible to all team members.

Methods	Process measures	Target for process measure	Comments
An inclusion and belonging e-learning module will be developed and made available to all team members, aligned with the Inclusion and Belonging @OSMH framework and organizational expectations.	Inclusion and Belonging e-learning module developed and launched; Module embedded into standard onboarding and education pathways.	By the end of Q1, the e-learning module will be developed and available to all team members.	

Change Idea #2 Create opportunities for open-space dialogue to support inclusion and belonging.			
Methods	Process measures	Target for process measure	Comments
Facilitated open-space dialogue sessions will be offered to provide team members with opportunities for reflection, discussion and shared learning related to inclusion and belonging.	Number of dialogue sessions delivered.	By the end of Q4, 6 sessions will be delivered and attendance will be tracked.	

Change Idea #3 Establish Inclusion & Belonging Ambassadors to support integration into daily work.			
Methods	Process measures	Target for process measure	Comments
Inclusion & Belonging ambassadors will be identified and supported through people services and Quality Experience Leaders (QELS) to reinforce inclusive practices and conversations within teams.	Number of ambassadors participating.	By Q4, 6 Inclusion and Belonging Ambassadors are established and active across clinical and non-clinical areas.	

Change Idea #4 Leverage the Diversity, Equity, Inclusion, Reconciliation & Belonging (DEIRB) Committee to support external learning and knowledge transfer.			
Methods	Process measures	Target for process measure	Comments
The DEIRB Committee will support access to externally facilitated inclusion and equity learning (e.g., articles, webinars, conferences), using a train-the-trainer approach to share learning internally and support integration into practice.	External inclusion and equity learning opportunity is formally reviewed and shared internally using a train-the-trainer approach.	By end of Q4, at least one external inclusion and equity learning opportunity used to support integrated into practice.	

Experience

Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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?	C	% / Survey respondents	Local data collection / Fiscal quarters	81.10	80.00	This performance indicator has been set at 80 percent, it was increased this past fiscal year. We are hoping to meet this target in all four quarters.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	Yes
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1 Conduct root cause analysis activities to further understand current state discharge process. This is to understand typical process, identify any gaps or opportunities and to understand the process from the patient perspective.

Methods	Process measures	Target for process measure	Comments
Either an in-person walkthrough or table-top exercise with the support and partnership of patient advisor, team leads, clinical scholars and/or team members in the ED.	Number of patient types mapped.	Create a current state discharge process map for 3-5 common patient types.	

Change Idea #2 Ensure ED patients, families & caregivers receive clear, consistent and accessible discharge information.

Methods	Process measures	Target for process measure	Comments
Complete chart audits on the top 3-5 diagnoses to understand policy to practice using the process maps and current standard of care.	Number of charts audited.	Enhanced understanding of the current state; 20 charts audited by the end of Q2.	

Change Idea #3 Create and embed standardized discharge education expectations for nursing and credentialed staff.

Methods	Process measures	Target for process measure	Comments
Develop orientation and ongoing learning opportunities for both nursing and credentialed team members.	Number of organizational education and orientation touchpoints where standard discharge education has been embedded.	By the end of Q4, 5 touchpoints will be embedded.	

Change Idea #4 Update and reinforce the Clinical Documentation Policy to clearly articulate discharge documentation and patient education expectations.

Methods	Process measures	Target for process measure	Comments
Review and update the Clinical Documentation Policy ensuring that expectations are clearly articulated including discharge conversations with patients and families.	Clinical Documentation Policy updated to include explicit discharge documentation and patient education expectations (Yes / No).	The policy will be updated by end of Q4.	

Safety

Measure - Dimension: Safe

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of delirium onset during hospitalization	O	% / Hospital admitted patients	CIHI DAD / April 1 to September 30, 2025 (Q1 and Q2), based on the discharge date (Discharge Date/Time)	1.36	1.35	Year two on QIP, working this year to reduce rate of delirium onset across the organization. Target was developed with all previous data considering that teams are still working on QI related to identifying delirium.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	Yes
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1 Reduce modifiable risk factors that contribute to delirium by creating a delirium-friendly environment for rooms.

Methods	Process measures	Target for process measure	Comments
Standardized delirium prevention practices will be reinforced on inpatient units including updated whiteboards with nurse's name, date, patient's mobility, feeding assistance and toileting assistance.	Complete quarterly audits on inpatient units to measure whiteboard completion.	In the Q4 audit, 60% of patients will have updated whiteboards with delirium friendly practices.	

Change Idea #2 Reduce medication-related delirium triggers through timely medication reconciliation.

Methods	Process measures	Target for process measure	Comments
Develop process for medication reconciliation in the emergency department with defined roles and expectations.	A standard process will be developed and implemented for medication reconciliation in the emergency department.	By the end of Q3, a process is developed for medication reconciliation for high-risk patients in the emergency department.	

Change Idea #3 Ensure consistency in approach in the recognition, prevention, and management of delirium through credentialed staff education.

Methods	Process measures	Target for process measure	Comments
Delirium-focused education will be developed and delivered to credentialed staff through learning modules, rounds, or appropriate forums to support consistent practice.	Development of credentialed staff module/learning session (rounds or another forum), % credentialed staff completed delirium focused education.	By end of Q4, 50% of active credentialed staff caring for high-risk patients will receive targeted education.	

Change Idea #4 Ensure delirium education, measurement and oversight structures are embedded for continuous quality improvement and sustainability.

Methods	Process measures	Target for process measure	Comments
Incorporate prevention and monitoring into workplans and embed continuous education and tracking into routine workflows.	Number of times delirium sustainability actions (education, tracking, etc.) are incorporated in routine work.	By the end of Q4, 5 sustainability actions have been completed to ensure continuous oversight and quality improvement for delirium.	

Measure - Dimension: Safe

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Promote psychological safety for all team members	C	Working to identify unit of measure / N/a	Local data collection / 2026 2027	CB	CB	The organization has identified through root cause analysis that there is opportunity to work on psychological safety as an organization. As an indicator, this is not currently something we have the ability to measure so will be taking the year to define this as we work on our change ideas.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1 Conduct targeted focus groups to better understand team member experiences related to psychological safety, speaking up and responses to concerns.

Methods	Process measures	Target for process measure	Comments
Facilitated focus groups will be conducted with representative team members across programs to explore themes related to trust, reporting, and psychological safety, informed by RL data and Just Culture principles.	Number of focus groups conducted.	By the end of Q1, 5 focus groups will be completed with representation across clinical and non-clinical areas with key themes summarized to inform improvement actions.	

Change Idea #2	Adjust RL incident reporting system and mechanisms based on feedback gathered through team member focus groups to better support psychological safety and appropriate reporting.		
Methods	Process measures	Target for process measure	Comments
Focus group findings and root cause analysis of RL data will be used to identify opportunities to improve clarity, usability and tracking of files for team members.	Communication of changes to team members and number of system or reporting pathway adjustments implemented.	By the end of Q4, at least two improvements made to RL reporting pathways, guidance or system configurations are implemented based on focus group feedback and communicated to team members.	

Change Idea #3	Develop measurement strategy to assess psychological safety using a combination of workforce survey data, RL reporting insights and qualitative feedback.		
Methods	Process measures	Target for process measure	Comments
Analyze focus group findings and root cause analysis of RL data to inform selection of appropriate psychological safety measures, including identifying relevant questions from the Global Workforce Survey to establish a baseline and support ongoing monitoring.	Measurement strategy approved for implementation.	By the end of Q2, a psychological safety measurement strategy is established.	

Change Idea #4	Develop and implement an organizational Psychological Safety Policy to support consistent expectations for speaking up, reporting and learning.		
Methods	Process measures	Target for process measure	Comments
A Psychological Safety Policy will be developed using findings from staff focus groups, root cause analysis of RL data, and alignment with Just Culture principles and existing OSMH policies. The policy will define expectations for team members and leaders related to speaking up, respectful communication and non-punitive responses to concerns.	Draft Psychological Safety Policy developed and consultation with key stakeholders, implementation plan developed.	By the end of Q4, an organizational Psychological Safety Policy is developed, approved, and communicated across the organization.	

Change Idea #5 Develop a standardized escalation pathway for escalated/disruptive/violent patient behaviour.

Methods	Process measures	Target for process measure	Comments
Define roles and responsibilities for team members, credentialed team members and leaders during escalation. Identify clear triggers and corresponding actions for each role. Embed escalation pathway into existing workflows.	Escalation pathway developed and approved, number of clinical areas where pathway implemented.	By the end of Q3, a standardized escalation pathway for disruptive patient behaviour is implemented across the organization improving clarity and consistency in escalation and supporting team member safety.	