Access and Flow

Measure - Dimension: Timely

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile ambulance offload time	P	Minutes / Patients	CIHI NACRS / For ERNI hospitals: Dec 1, 2023, to Nov 30, 2024 (Q1 and Q2)	126.00	30.00	Provincial Target. This target reflects our commitment to enhancing access to timely and effective emergency care. It has been informed by program-level review and benchmarking against peer organizations, as well as provincial performance. This indicator is associated with the QCH Strategic Goal identified as "Seamless System of Care".	

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

Change Ideas

Change Idea #1 Evaluate efficacy of standardized ambulance triage and offload nursing roles.			
Methods	Process measures	Target for process measure	Comments
Project team to conduct focus group to determine efficacy of standard roles	Percent of nurses who are satisfied with standard work related to ambulance triage and offload nursing roles	By June 2025, 90% of nurses will be satisfied with standard work related to ambulance triage and offload nursing roles	

Change Idea #2 Escalation tool for offload time target breach developed and implemented			
Methods	Process measures	Target for process measure	Comments
Staff to document escalation on a Defect Check Tool.	Percent of escalations actioned within 5 minutes	By June 2025, 90% of escalations will be resolved within the 15 minutes	

Change Idea #3 Rotation change required to permanently fill these 2 nursing roles			
Methods	Process measures	Target for process measure	Comments
Manager to track vacancies and recruitment leveraging position occupancy	Percent of positions filed with a new rotation	By December 31, 2025 rotation changes will be implemented 2 positions will be filled.	

Measure - Dimension: Timely

Indicator #7	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 / For ERNI hospitals: Dec 1, 2023, to Nov 30, 2024 (Q1 and Q2)	23.17	22.00	Notably, throughout 2024-2025 QCH was successful in reducing this wait time by greater than 5 hours, surpassing our previous target. QCH aims to further reduce this wait by an additional 5%, seeking a wait less than 20 hours. Although our current performance surpasses that of our peers, our target is grounded in recent quarterly data and accounts for existing system pressures, ensuring it remains both feasible and reflective of ongoing improvement efforts. This indicator is associated with the QCH Strategic Goal identified as "Seamless System of Care".	

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

Change Ideas

Change Idea #1 Spread of standardized multidisciplinary rounds across inpatient units.

Methods	Process measures	Target for process measure	Comments
Tracked by steering committee via project plan updates	Percent of units with multidisciplinary rounds implemented	By December 31, 2025, standardized format for multidisciplinary rounds will spread to 100% of inpatient units.	

Change Idea #2 Early identification and intervention of patients who are at risk of becoming ALC through screening tool such as the ISAR.

Methods	Process measures	Target for process measure	Comments
Tracked by steering committee via project plan updates	Percent of units using the screening tool to identify patients who are at risk of becoming ALC	By December 31, 2025, screening tool will be fully implemented to identify patients who are risk of becoming ALC.	

Change Idea #3 Further develop the corporate Surge Plan to address seasonal surge pressures.

Methods	Process measures	Target for process measure	Comments
Care facilitator to complete surge tool during q2hour rounding	Number of patients admitted in the ED daily and at 0800.	By March 31, 2026 the target number of patients admitted at 0800 will be 12 or less as per the provincial P4R measure.	

Measure - Dimension: Timely

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department wait time to physician initial assessment	P	Hours / ED patients	CIHI NACRS / ERNI hospitals: Dec 1, 2023, to Nov 30, 2024/Non-ERNI hospitals: Apr 1, 2024, to Sept 30, 2024 (Q1 and Q2)	8.38	4.00	Provincial Target. This target reflects our commitment to enhancing access to timely and effective emergency care. It has been informed by program-level review and benchmarking against peer organizations, as well as provincial performance. This indicator is associated with the QCH Strategic Goal identified as "Seamless System of Care".	

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

Change Ideas

Change Idea #1 Room standardization to be completed to improve efficiency for patient throughput

Methods	Process measures	Target for process measure	Comments
ED Xcellence team tracking via project plan	Percent of rooms standardize patient rooms in Emergency Department.	100% of rooms will be standardized by March 31, 2025	

Change Idea #2 Rapid Assessment Physician (RAP) pilot to improve Physician Initial Assessment (PIA) time during peak periods

Methods	Process measures	Target for process measure	Comments
ED Xcellence team tracking via project plan	PIA Time ED Length of Stay Number of patients seen / hour	90th percentile PIA time to decrease by 20% (7.2 hours) by mid-pilot, end of Q1 2025-2026 FY.	

Equity

Measure - Dimension: Equitable

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	O	% / Staff	Local data collection / Most recent consecutive 12-month period	84.23	100.00	The target is focused on all leadership completing the relevant Equity, Diversity, Inclusion, and Belonging (EDIB) training that is part of onboarding with corporate orientation. Setting a target of 100% for all leadership and in the future building to all staff to complete EDIB training aligns with our organization's commitment to comprehensively rolling out the EDIB strategy. This target underscores our dedication to fostering a culture of inclusivity from the top down, ensuring that all executives have the necessary knowledge and skills to champion EDIB initiatives effectively. This indicator is associated with the QCH Strategic Goal identified as "Positive Work Life".	

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 Targeted training for QCH Leaders on RESPECT training.			
Methods	Process measures	Target for process measure	Comments
Completion rate of the RESPECT training module tracked through VIP application.	Percent of QCH Leaders (management formal leaders) who have completed the training.	By March 31, 2026, 100% of QCH Leaders (formal and informal) will have completed the RESPECT training.	

Change Idea #2 Develop EDIB learning curriculum / training material for all staff to complete.			
Methods	Process measures	Target for process measure	Comments
EDIB Steering Committee to track via EDIB Strategic Plan	Percent completion of the learning curriculum.	By September 2025, the EDIB learning curriculum and training material is 100% developed.	

Change Idea #3 Establish and launch a centralized learning hub and community of practice			
Methods	Process measures	Target for process measure	Comments
EDIB Steering Committee to track via EDIB Strategic Plan	Hub and Community of Practice are established and active.	By December 2025, the learning hub will be launched and community of practice with be established.	

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” 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?	O	% / Survey respondents	Local data collection / Most recent consecutive 12-month period	66.60	67.40	We observed continued improvements in performance since 22/23. The 24/25 fiscal year saw an almost 9% increase. Looking ahead, we will aim to sustain these improvements throughout the year and engage in benchmarking initiatives facilitated by the Ontario Hospitals Association. This presents an opportunity to align our practices with industry standards and further enhance our patient experience initiatives. This indicator is associated with the QCH Strategic Goal identified as "Exceptional Care Experience".	

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	Implement the updated LACE post-discharge follow-up tool across all inpatient medicine units to standardize follow-up calls, enhance care transitions, and support early identification of patients at risk of readmission.		
Methods	Process measures	Target for process measure	Comments
Manual tracking based on the implementation and use of the updated LACE post-discharge follow-up tool across inpatient medicine units.	Percent of inpatient medicine units implementing the LACE post-discharge follow-up tool.	By September 2025, the updated LACE post-discharge follow-up tool will be implemented across 100% inpatient medicine units	Total Surveys Initiated: 1048

Change Idea #2	Understand and work to increase the number of surveys distributed to patients discharged from an inpatient medicine or surgery visit.		
Methods	Process measures	Target for process measure	Comments
Patient relations / Decision Support can provide a report from the Qualtrics patient experience survey platform.	Number of surveys distributed to patients post-discharge compared to the survey response rate.	By December 31, 2025, we will have evaluated the response rate and distribution patterns with the electronic patient experience survey to optimize and inform the next steps.	

Change Idea #3	Implement a standardized discharge education strategy for postpartum patient by leveraging digital solutions for educational content, updating the parent booklet, and developing a dedicated discharge video to improve accessibility and patient understanding of postnatal care.		
Methods	Process measures	Target for process measure	Comments
Childbirth Program Leader review based on project plan.	Percent completion of standardized postpartum discharge education strategy	By March 31, 2026, the standardized postpartum discharge education strategy will be 100%implemented.	

Change Idea #4	Provide targeted staff education for frontline teams to ensure consistent postpartum discharge teaching, reinforcing key messaging on newborn care, maternal recovery, and follow-up needs to ensure patients feel informed and supported during discharge and their transition home.		
Methods	Process measures	Target for process measure	Comments
Educator to track completion rate of education sessions offered related to standardized discharge practices.	Percent of frontline staff who received education on new standard postpartum discharge strategy.	By March 31, 2026, 90% of frontline staff will complete the education on standardized postpartum discharge teaching.	

Change Idea #5	Develop targeted training for frontline staff on high-alert medication education at discharge, ensuring staff deliver clear, consistent information to help patients safely manage their medications at home.		
Methods	Process measures	Target for process measure	Comments
Educator to track completion rate of the education sessions offered.	Percent of frontline staff in medicine program who receive high-alert medication education training.	By March 31, 2026, 80% of frontline staff in the medicine program will have completed the training session.	

Safety

Measure - Dimension: Safe

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged.	O	% / Discharged patients	Local data collection / Most recent consecutive 12-month period	84.95	90.00	QCH demonstrates consistent performance in discharge medication reconciliation practices, with numerous departments achieving compliance rates exceeding 90%. However, targeted efforts in specific services to enhance overall compliance rates and achieve targeted improvements will drive continued improvement work in this area. With an overarching target of 90% (and a stretch goal of 95%), this initiative aligns with our commitment to ensuring patient safety and quality care throughout the discharge process. This indicator aligns with the QCH Strategic Goal identified as "Exceptional Care Experience".	

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 Creation of surgeon specific Discharge Medication Reconciliation educational tip sheets to provide individualized feedback and education.			
Methods	Process measures	Target for process measure	Comments
Tracked via MedSafe Committee based on project plan	Percent of surgeons the tip sheet is distributed to.	The tip sheet is created and distributed to 100% of Surgeons by August 31, 2025.	

Change Idea #2 Change documentation practices to standardize documentation location (e.g. what is documented in home med section of Meditech vs. PCS)			
Methods	Process measures	Target for process measure	Comments
Tracked via MedSafe Committee based on project plan	Number of implemented BPMH document standards.	Implement 100% of changes aligned with BPMH standardized documentation by June 30, 2025	

Change Idea #3 The Medication Reconciliation Policy is updated to support the Medication reconciliation practice.			
Methods	Process measures	Target for process measure	Comments
Tracked via MedSafe Committee based on project plan	Approval of the Medication Reconciliation Policy	By June 30, 2025, the Medication Reconciliation Policy is updated and published on the corporate policy manager.	

Measure - Dimension: Safe

Indicator #4	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, 2024 (Q1 and Q2), based on the discharge date	1.60	2.00	Setting a target of 2.0% for the rate of delirium onset during hospitalization aligns with our commitment to enhancing patient care and safety. This target reflects our dedication to proactive monitoring and intervention, ensuring early detection and appropriate management of delirium to improve patient outcomes and overall quality of care. This indicator is associated with the QCH Strategic Goal identified as "Exceptional Care Experience".	

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	Staff education on delirium prevention, recognition, and management.		
Methods	Process measures	Target for process measure	Comments
Manual tracking for this indicator is required. This is to be collected by the Geriatrics team.	Number of staff trained through education sessions.	150 staff trained by March 31, 2026.	

Change Idea #2	Quarterly chart audits on compliance with the Confusion Assessment Method (CAM) documentation.		
Methods	Process measures	Target for process measure	Comments
Manual tracking of this indicator is required. This is to be collected by those responsible for the chart audits.	Number of chart audits completed per quarter.	By March 31, 2026, 80 chart audits are completed (20 audits per quarter).	

Change Idea #3	Engage and Educate Family and Care Partners on Delirium Prevention. Offer education about delirium to people at risk for delirium or who have delirium, and their family and caregivers. The education should explain what delirium is and provide information such as what the risk factors are and how to identify early symptoms. Ensure that the information provided is tailored to their needs and meets people's cultural, cognitive, and language needs.		
Methods	Process measures	Target for process measure	Comments
Utilize the Patient experience survey	Percentage of people with delirium who are discharged from hospital to home and who report feeling that they were involved in care delivery and discharge planning as much as they wanted to be.	Target 75% by end of 2025-2026 FY.	

Measure - Dimension: Safe

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of workplace violence incidents resulting in lost time injury	O	% / Staff	Local data collection / Most recent consecutive 12-month period	0.47	0.24	This indicator target was developed through analysis of internal data and trends and aligns with the previous years target. Our rate fluctuates and we hope to maintain a measure below the target. The indicator is associated with the QCH Strategic Goal identified as "Positive Work Life".	

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 Expand Behaviour Support Ontario (BSO) education sessions beyond nursing to allied health, support services (e.g. security, environmental services and others) through Behaviour Support Champions program.

Methods	Process measures	Target for process measure	Comments
Advanced Practice Nurse in Geriatrics manually tracks all staff trained.	Number of staff trained through BSO education sessions.	15 staff trained as Behaviour Support Champions and of Q4 2025-2026.	

Change Idea #2	Increase capacity in each training session for Gentle Persuasive Approach (GPA) techniques.		
Methods	Process measures	Target for process measure	Comments
The Advanced Practice Nurse in Geriatrics manually tracks all sessions offered.	Number of staff trained through GPA education sessions.	125 staff will be trained by Q4 2025-2026.	

Change Idea #3	Increase Non-Violence Crisis Intervention (NVCI) Corporate Compliance Rate		
Methods	Process measures	Target for process measure	Comments
Self measured captured through our HRIS training system	Percent increase in NVCI rate.	Increase percent trained by 10% to 70% Corporate Compliance by end of Q4 2025-2026.	

Change Idea #4	Reinforce Gentle Persuasive Approach (GPA) training through mobile skills talks throughout the year.		
Methods	Process measures	Target for process measure	Comments
The Advanced Practice Nurse in Geriatrics manually tracks all sessions offered.	Number of GPA sessions completed.	12 sessions completed by end of Q4 2025-2026.	

Change Idea #5	Update the RL Tool to better understand circumstances resulting in violence Make adjustments to the dropdowns in RL that enable the organization to better understand root cause and focus on more targeted mitigation strategies		
Methods	Process measures	Target for process measure	Comments
Self measured changes captured through the RL system	Update RL platform to enable improved reporting.	Implement by end of Q1 2025-2026 measure action - Complete or not complete	

Change Idea #6 Complete risk assessment for high risk area D3 and monitor compliance of completion of controls.

Methods	Process measures	Target for process measure	Comments
Self measured and reported to Senior Leadership Team and JOHSC	Percent completion of risk assessment in D3.	100% completion of assessment by end of Q4 2025-2026 measure action as complete or not complete	

Change Idea #7 Develop Gentle Persuasive Approach (GPA) training risk matrix to determine appropriate denominator and resultant compliance rate target.

Methods	Process measures	Target for process measure	Comments
Self measured by team	Develop risk matrix and enable calculation of compliance rate.	Develop matrix and determine denominator by end of Q2 2025-2026 measure action as complete or not complete	