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	22.20	21.10	Incremental improvements in Time to Inpatient Bed have occurred year over year. While fiscal year 25/26 fell slightly short of target by 0.2 hours, this performance reflects steady progress. For 2026/27, the target has been set at 21.1 hours, representing a 5% reduction from the current performance of 22.2 hours and signaling our commitment to continued improvement. This target will be supported by ongoing change initiatives focused on patient flow, discharge efficiency, and optimal bed utilization. As we adopt the Epic electronic medical record in 2027/28, enhanced data visibility will enable a comprehensive review of performance trends and inform future targets and improvement initiatives. 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	Implement ISAR flagging in the Emergency Department to support screening of older adults, with positive screens referred to Geriatric Emergency Management and compliance monitored through regular audits.		
Methods	Process measures	Target for process measure	Comments
The Emergency Department will run a Meditech compliance report to monitor ISAR screening and referral activity.	Number of ISAR assessments completed in the Emergency Department per month.	By March 31, 2027, at least 85% of eligible Emergency Department patients will have a completed ISAR assessment.	

Change Idea #2	Replace the Patient Flow stamp with an Emergency Department nursing risk□stratification entry in Teletracking (via Bedboard) to streamline time from admission to inpatient bed.		
Methods	Process measures	Target for process measure	Comments
Decision Support will extract, analyze, and report data on patient flow stamping to track impact on time from admission decision to inpatient bed assignment.	Percentage of Emergency Department risk-stratification interventions implemented (measured monthly).	By March 31, 2027, 100% of Emergency Department risk-stratification interventions will be implemented as planned.	

Change Idea #3	Create guiding principles to standardize interprofessional rounds on acute inpatient units, aligned with Home First, to support discharge planning and consistent practice.		
Methods	Process measures	Target for process measure	Comments
Self-measured based on creation of guiding principles.	Creation of guiding principles.	By June 30, 2026, guiding principles to standardize interprofessional rounds on acute inpatient units will be developed, endorsed, and documented for use in practice.	

Change Idea #4 Implement standardized interprofessional rounds on acute inpatient units, using the guiding principles and Home First philosophy to structure who attends, when and how rounds occur, and how discharge plans and next steps are documented and communicated.

Methods	Process measures	Target for process measure	Comments
Unit Care Facilitators will track interprofessional rounds using a standardized Microsoft Form, with an opportunity to transition to Epic-based reporting (e.g., SlicerDicer) after system go-live to automate and enhance data collection.	Percentage of acute inpatient units that complete discharge rounds in accordance with the established guiding principles.	By March 31, 2027, achieve 90% of acute medical inpatient units completing discharge rounds in accordance with the established guiding principles.	

Measure - Dimension: Timely

Indicator #6	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 / December 1, 2024, to November 30, 2025, in alignment with the Pay for Results program	8.20	3.40	QCH has employed structured problem-solving and a LEAN management approach to enhance PIA. With these planned initiatives, QCH aims to align time to PIA closer to provincial standard. 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	No
Pay-for-Results Action Plan	Yes

Change Ideas

Change Idea #1 Trial a physician schedule optimization initiative.

Methods	Process measures	Target for process measure	Comments
Data modelling will be completed by Decision Support in collaboration with the University of Ottawa to inform a trial for optimizing the physician schedule to forecasted patient demand.	Percentage of shifts where physician resources match forecasted demand (measured monthly).	By September 30, 2026, 80% of shifts will have scheduled resources that match forecasted patient demand.	

Change Idea #2 Implement a structured queue management process for ED patients.

Methods	Process measures	Target for process measure	Comments
Data modelling will be completed by Decision Support in collaboration with the University of Ottawa to inform guiding principles related to Queue management and the impact of medical directives in the patient journey.	Percentage of patients seen by a provider before a medical directive is initiated (measured monthly).	By September 30, 2026, 80% of patients will be seen by a provider before a medical directive is initiated.	

Change Idea #3 Develop and implement a structured escalation response process within the department.

Methods	Process measures	Target for process measure	Comments
Internal data, analyzed and reported by Decision Support, will be used to monitor and assess the effectiveness of the escalation response process.	Percentage of time the Emergency Department has 14 or fewer admitted patients in the department at 8 am (measured monthly).	By September 30, 2026, achieve a 20% improvement from baseline (to be established) in the percentage of time the Emergency Department has 14 or fewer admitted patients in the department.	

Change Idea #4 Optimize departmental space utilization.

Methods	Process measures	Target for process measure	Comments
Internal Emergency Department data, analyzed and reported in collaboration with Decision Support, will be used to monitor and assess the impact of space utilization changes.	Percentage of time an appropriate space is available for patient assessment (measured monthly).	By September 30, 2026, an appropriate space for patient assessment will be available at least 80% of the time.	

Measure - Dimension: Timely

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department length of stay for nonadmitted patients (all acuity).	C	Hours / ED patients	CIHI NACRS / December 1, 2024, to November 30, 2025	11.00	9.60	With the initial focus being on PIA improvements, QCH aims for an initial improvement of 1.4 hours for ED LOS, with a stretch goal of achieving 6 hours. 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	No
Pay-for-Results Action Plan	Yes

Change Ideas

Change Idea #1 Optimize turnaround times for Laboratory and Diagnostic Imaging investigations to support timely patient care.			
Methods	Process measures	Target for process measure	Comments
Meditech, the electronic medical record (EMR) data will be used to measure and monitor turnaround times for Laboratory and Diagnostic Imaging investigations.	Percentage of investigations where turnaround time from order to result meets the defined target. Performance will be measured and reviewed monthly.	Achieve a 20% improvement from baseline in the percentage of investigations where turnaround time (order to result) meets target, by December 31, 2026, following completion of PIA work.	

Change Idea #2 Enhance the timeliness and effectiveness of consultant involvement to support clear, safe, and efficient patient disposition decisions.			
Methods	Process measures	Target for process measure	Comments
Data related to consultant care in the Emergency Department will be reviewed to identify opportunities for improvement.	1) Percentage of consultations where consultants meet the targeted consult response time. Performance will be measured and reviewed monthly. 2) Percentage of consultations where consultants meet the targeted disposition decision time. Performance will be measured and reviewed monthly.	By December 31, 2026 (following completion of PIA work), achieve consultants meeting: Targeted consult response time in 80% of consultations. Targeted disposition decision time in 80% of consultations.	

Change Idea #3 Optimize the use of an Occupational Therapist (OT) in the ED to provide rapid functional assessment, develop safe discharge pathways, and facilitate safe discharge to the community.			
Methods	Process measures	Target for process measure	Comments
Utilize Meditech data to track ED Occupational Therapy consults, assessments, and discharge dispositions.	Time from OT consult order to completion of OT assessment in the ED. Performance will be measured and reviewed monthly.	Achieve a 20% improvement from baseline in the time from OT consult order to completion of OT assessment in the ED by June 30, 2026.	

Equity

Measure - Dimension: Equitable

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of management who have completed relevant equity, diversity, inclusion, and anti-racism education	C	% / Staff	Local data collection / Most recent consecutive 12-month period	45.00	50.00	A 50% target by March 31, 2027, for completion of the Equity and Indigenous Cultural Safety Leadership Learning Pathway by QCH management, including Indigenous Cultural Safety and anti-racism/microaggression training, reflects cohort size, training requirements, and operational coverage needs while supporting a phased and sustainable approach to implementation. It also supports the expansion of education to the management cohort while maintaining a 100% completion rate among Directors, Executives, and the Board. This indicator is aligned with the QCH True North goal of "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	Integrate equity, anti-racism, and Indigenous cultural safety principles into leadership recruitment, onboarding, annual performance reviews, and succession planning processes to embed accountability for these expectations across all leadership roles and ensure sustained application beyond initial training.		
Methods	Process measures	Target for process measure	Comments
Quarterly documentation review and manual audit of leadership onboarding, performance management, and succession planning templates and policies by People & Culture.	Percentage of leadership performance management, onboarding, and succession planning templates and guidelines that are updated to formally embed Equity, Anti-Racism, and Indigenous Cultural Safety expectations, reviewed and approved by executive leadership, by the end of fiscal year 2026.	By March 31, 2027, 100% of leadership onboarding materials, performance review templates, and succession planning guidelines will be updated, approved, and implemented to formally embed Equity, Anti-Racism, and Indigenous Cultural Safety expectations.	Last fiscal year, our focus was on delivering education to the Board, Executive, and Director levels. In the coming fiscal year, this work will expand to the management cohort, while maintaining a 100% completion rate among Directors, Executives, and the Board.

Change Idea #2	Operationalize and formalize the Health Equity Action Forum as a recurring, cross-departmental Quality and Health Equity case review and shared-learning model that supports applied learning, collaborative problem-solving, and shared accountability through the development, implementation, and follow-up of health equity–focused action plans with departments and clinical/service collaboratives.		
Methods	Process measures	Target for process measure	Comments
Health Equity Action Forum agendas, minutes, attendance logs, and documented case reviews will be used to track sessions held, with action-item tracking records reviewed quarterly by the Quality and Health Equity leads and reported to senior leadership.	Number of Health Equity Action Forum sessions held per quarter with documented case reviews and action items distributed to participating departments and collaboratives.	By March 31, 2027, the Health Equity Action Forum will be formally established with a defined structure and cadence and will convene at least three times, with each session producing documented case reviews and follow-up action plans shared with participating departments or collaboratives.	

Change Idea #3	Develop and finalize QCH's Indigenous Health Equity, Healing, and Self-Determination Roadmap and Action Plan in collaboration with Indigenous partners and communities, outlining organizational priorities, actions, timelines, and accountability approaches aligned with Ontario Health priorities, the TRC Calls to Action (18–24), Joyce's Principle, and culturally safe care expectations.

Methods	Process measures	Target for process measure	Comments
Engagement records and meeting documentation with Indigenous partners and communities, tracked alongside draft and final roadmap versions, feedback, and revisions, will be reviewed by the project lead. Formal approval records from leadership or governance will be used to confirm completion and will be reported through existing Quality and Equity oversight structures.	Completion and formal approval of an Indigenous Health Equity, Healing, and Self-Determination Roadmap and Action Plan, developed with documented Indigenous partner engagement and including defined priorities, actions, timelines, and accountability mechanisms.	By March 31, 2027, the Indigenous Health Equity, Healing, and Self-Determination Roadmap and Action Plan will be finalized, reviewed with Indigenous partners and communities, and formally approved for organizational implementation.	

Experience

Measure - Dimension: Patient-centred

Indicator #3	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	67.46	70.00	Performance on this indicator has improved to 67.46%, reflecting ongoing efforts to strengthen discharge communication and patient education. A target of 70% has been established to support continued improvement as we refine our digital survey processes and expand patient experience measurement across additional tools. Although this target represents a realistic next step, we will continue to challenge ourselves to go beyond it and identify opportunities to further enhance the care experience. As our benchmarking and comparative data mature, this work will help inform future targets and align expectations with emerging peer and provincial benchmarks. This indicator aligns with QCH’s strategic goal of delivering an Exceptional Care Experience.	

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	Leverage the opening of the onsite outpatient pharmacy to offer patients the option to fill discharge prescriptions before leaving the hospital, creating an additional opportunity to review medications, clarify instructions, and support understanding of what to do if concerns arise after discharge.		
Methods	Process measures	Target for process measure	Comments
Manual tracking of QCH discharge prescriptions as a proportion of inpatient discharges (excluding Special Care Nursery discharges), using a simple tally or audit process to support timely, small-scale quality improvement measurement.	Percentage of discharged inpatients who fill their discharge prescriptions at the QCH outpatient pharmacy.	By December 31, 2026, achieve 25% of eligible inpatient discharges having their discharge prescriptions filled at the QCH outpatient pharmacy (measured from July 1 to December 31, 2026).	Total Surveys Initiated: 962

Change Idea #2	Implement a standardized MyChart onboarding process to strengthen discharge communication by ensuring patients are consistently enrolled and supported to access their discharge information and post-discharge instructions.		
Methods	Process measures	Target for process measure	Comments
Local EMR/MyChart reports will be used to calculate the monthly percentage of discharged patients with an active MyChart account within 7 days of discharge, with data compiled by Decision Support/Quality.	Percentage of patients discharged from QCH who have an active MyChart account (new or existing) within 7 days of discharge.	By March 31, 2027, at least 70% of patients discharged from QCH will have an active MyChart account (new or existing) within 7 days of discharge, measured monthly from October 2026 to March 2027.	

Safety

Measure - Dimension: Effective

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of reported patient safety events and near misses where Epic or Epic related workflow is identified as a contributing factor, per 1,000 inpatient days, in the early implementation period after Epic go live.	C	Rate per 1,000 patient days / All patients	Local data collection / October 2026 - March 15, 2027	CB	4.50	The target of 4.5 Epic related patient safety events per 1,000 inpatient days reflects a cautious increase from the current rate of 3.5, acknowledging that implementation of Epic is a significant change and is expected to enhance detection and reporting of events and near misses in the early phase. This target supports a strong reporting and learning culture during the initial months post implementation, with the intent to use this baseline year to understand patterns and inform future targets focused on reducing Epic related events over time. 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 a formal signoff process for high risk Epic enabled clinical workflows prior to go live and major upgrades to reduce Epic related patient safety events.		
Methods	Process measures	Target for process measure	Comments
Manual tracking of high risk Epic workflows using a simple log to confirm signoff completion prior to go live.	Percentage of identified high risk Epic workflows with completed and documented signoff prior to go live or major upgrade.	100 percent of identified high risk Epic workflows have completed and documented signoff prior to Epic go live (October 2026).	

Change Idea #2	Implement a Patient Surveillance Safety Checklist with follow up at 30, 60 and 90 days post Epic go live to ensure completion of relevant safety interventions.		
Methods	Process measures	Target for process measure	Comments
Manual tracking of checklist completion at 30, 60 and 90 days post Epic go live using a simple log or report.	Percentage of checklist interventions completed at 30, 60 and 90 days post Epic go live.	At least 90 percent of checklist interventions completed at each of 30, 60 and 90 days post Epic go live.	Epic go-live is scheduled for October 24, 2026.

Measure - Dimension: Safe

Indicator #4	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	0.46	0.35	The target has been reset using data from the past three years with more typical hospital activity, rather than the atypical early pandemic period. This results in a higher target than last year, which better reflects current performance and expected volumes while still supporting a focus on reducing incidents over time. 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	No
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1 Create a corporate workplace violence risk review checklist/tool for leaders to complete annually to identify, prioritize, and address violence risk and prevention actions across programs and departments.

Methods	Process measures	Target for process measure	Comments
Manual data collection and tracking of checklist approval status by the responsible department.	Approval of a corporate workplace violence risk review checklist/tool for annual use by organizational leaders.	By March 31, 2027, the corporate workplace violence risk review checklist/tool is formally approved for organizational use by leaders.	

Change Idea #2	Establish a standardized onboarding process to ensure all new Emergency Department and Mental Health staff complete Nonviolent Crisis Intervention (NVCI) training within their first month of employment.		
Methods	Process measures	Target for process measure	Comments
HRIS report from VIP on NVCI completion for new ED and MH hires.	Percentage of new Emergency Department and Mental Health staff who complete Nonviolent Crisis Intervention (NVCI) training within 30 days of their employment start date.	Achieve 75% of new Emergency Department and Mental Health hires completing NVCI within 30 days of their start date by March 31, 2027.	

Change Idea #3	Develop education and tools to support staff and leaders in conducting structured debriefs following incidents of workplace violence.		
Methods	Process measures	Target for process measure	Comments
Manual tracking of the development and approval status of workplace violence debrief tools and education resources.	Tools and education resources for staff and managers to support workplace violence debriefs are developed and formally approved.	Tools and education resources for staff and managers to support workplace violence debriefs will be developed, finalized, and approved by March 31, 2027.	

Change Idea #4	Implement a standardized process in RL to document, assign, and monitor follow-up on recommendations arising from workplace violence risk assessments.		
Methods	Process measures	Target for process measure	Comments
Manual tracking to confirm the new RL function has been created and adopted for use.	RL function for tracking and follow-up of workplace violence risk assessment recommendations is created and in use.	By March 31, 2027, create the new RL tracking function for workplace violence risk assessment recommendations and have it active for use.	