2025/26 Quality Improvement Plan Improvement Targets and Initiatives

William Osler Health System 2100 Bovaird Drive East, Brampton , ON, L6R3J7

Aim		Measure									Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) A= Additional (do not select if you are not working on this indicator) C = Custom (add any other indicators you are working on)															
Alternate Level of Care (ALC) Rate (%)															
Access and Flow	Efficiency	Alternate Level of Care (ALC) Rate (%)	C	Newly designated or discharged ALC patients within a specific time frame	Wait Times Information System (WTIS)	951*	14.80	14.20	4% improvement over baseline and aligns with FY24/25 strategy scorecard target.		1. Enhancing Senior Friendly Care processes in the Emergency Department (ED) by strengthening discharge transitions and enhancing Rapid Geriatric Assessment to improve care	1. Supporting discharge transitions with the goal of ED diversion 2. Enhancing Rapid Geriatric Assessment (RGA)	1. % of older adults >65 supported by GEM/Behavioural Interventionists 2. Implementing revised GEM referral document which incorporates standardized tool, ISAR (Identification of Seniors At Risk)	1. 70% of older adults supported through interprofessional rounds 2. 90% ED staff education and 90% use by GEM by Q4 FY 2025/26	
											2. Increasing compliance of completion of Blaylock Risk Assessment in ED for early identification of at-risk patients, implementation on risk-assessment score available on Bullet Round Boards in the units	1. Completion of Blaylock Risk assessment for all in-patient admissions to Medicine units 2. Blaylock risk assessment score to be displayed on the bullet round board, so that the inter-professional team can understand the risks and decide the appropriate care plan.	1. Rate of completion of Blaylock Risk assessment (in-patient admissions to Medicine units)	1. 90% by Q4 FY 2025/26	
											3. Develop and implement ALC Pathways for proactive transitions of patients	1. Development, Implementation & Evaluation of ALC Pathways	1. % of ALC Patients on a defined ALC Pathway	1. 80% by Q4 FY 2025/26	
											4. Development of Code RAPID (Resolving ALC and prolonged In Patient Days)	1. Development & Evaluation of Code RAPID	1. The development and evaluation of Code RAPID is completed	1. By Q2 FY 2025/26	
90th Percentile Ambulance Offload Time (BCH & EGH)															
Access and Flow	Efficiency	90th Percentile Ambulance Offload Time (BCH and EGH)	P	Patients arriving to the Emergency using EMS	National Ambulatory Care Reporting System (NACRS)	951*	38 min	36 min	5% improvement over baseline		1. Assessing current processes to enhance ambulance offload efficiency through quality improvement methodology	1a. Map the current Ambulance Offload process 1b. Use Lean and / or other Quality Improvement tools to redesign the Ambulance Offload process	1. Completed current state assessment 2. Recommendations developed for future state improvement	1. By Q1 FY 2025/26 2. By Q1 FY 2025/26	
											2. Increase the number of offload beds at BCH (8) and EGH (4) to improve patient flow and reduce wait times	1a. Develop an algorithm that identifies zones / areas within the department that can be sequentially accesssed to absorb net new Ambulance Offload beds. 1b. Identify new zones / areas within and external to the department to create net new Ambulance Offload beds.	1. Number of additional Ambulance Offload Beds at BCH and EGH 2. Reduce RN staff vacancy rate at BCH and EGH 3. AOT for BCH and EGH	1. Access to 8 additional Offload Beds at BCH and 4 additional beds at EGH by Q2 FY 2025/26 2. Reduce RN staff vacancy rate by 10% by Q4 FY 2025/26 3. Reduce BCH and EGH combined AOT by 5%	
											3. Expand the discharge feasibility pilot to other Medicine units beyond General Medicine 3	1. Engage with teams and scale/ spread the existing pilot program	1. Expansion of the pilot to other units at BCH 2. Discharges by 11 am 3. Discharges on weekends	1. By Q1 FY 2025/26 2. Statistically significant improvement by Q3 FY 2025/26 3. Statistically significant improvement by Q3 2025/26 4. Statistically significant improvement by Q3	
											4. Redesign hallway patient management process	1. Map current process 2. Engage inpatient and Access and Flow teams in identification process and strategies. 3. Clarify roles and responsibilities for overcensus patient identification in all areas.	1. Complete mapping of current process 2. Number of overcensus patient on inpatient units at 11am during extreme gridlock. 3. Number of overcensus patients on inpatient units at 11am during gridlock	1. By Q1 FY 2025/26 2. Achieve 80% of overcensus threshold in Extreme Gridlock 3. Achieve 80% of overcensus threshold in Gridlock	
% of respondents who responded 'always' to the following question " Were you involved as much as you wanted to be in decisions about your care and treatment?"															
Experience	Patient-centred	Were you involved as much as you wanted to be in decisions about your care and treatment? - Always	C	Number of inpatients surveyed in the timeframe that responded 'Always' to the survey question.	Patient Experience Call Centre Data	951*	CB (Collecting Baseline)	CB (Collecting Baseline)	Transitioning from the Patient Experience Call Centre to Qualtrics Inpatient Short-Form Survey		1. Strengthen patient-provider partnership through implementation of refreshed whiteboards, evaluating inpatient nursing assessment documentation and increasing MyChart registration among patients	1. Implement the refreshed whiteboard 2. Evaluate inpatient nursing assessment documentation of "whats is most important to you" question 3. Increase MyChart registered new users, including implementing age 12 consent process	1. # of inpatient units with refreshed whiteboards (excluding speciality units) 2. Inpatient nursing assessment audits 3. Percentage of MyChart new user registrations per month	1. 100% by Q4 FY 2025/26 2. Collect current baseline 3. 56% or greater per month by Q4 FY 2025/26 (based on 2024 CY baseline + 2% improvement)	There are 860+ whiteboards, so the total number is anywhere between 800-900 (excluding NICU, ICU and MH)
											2. Implement the Health Justice Plan to foster culturally safe care and humility in patient-provider interactions	1. Development, approval and execution of the Health Justice Plan	1. Implementation of Health Justice Plan Year 1 initiatives 2. New Health Justice question in the patient experience survey responses	1. 100% of Year 1 Initiatives completed by Q4 FY 2025/26 2. Collecting baseline	
											3. Elevate health literacy by increasing utilization of health literacy applications on the Integrated Bedside Terminals (IBTs)	1. Increase utilization rate of health literacy applications and patient-facing digital resources on the Integrated Bedside Terminals (IBTs)	1. Percentage of current patient-facing digital resources updated on IBTs 2. Number of new patient-facing digital resources added on IBTs 3. Increase in average session (in minutes) of health literacy applications and patient-facing digital resources that are accessed on IBTs	1. 100% by Q4 FY 2025/26 2. Collecting baseline 3. Collecting baseline	
											4. Advance People-Centred Care at Osler through achievement of PCC Certification by Accreditation Canada	1. Achievement of PCC Certification (Accreditation Canada)	1. Implementation of PCC Action Report (from Accreditation Canada)	1. By Q1 FY 2025/26	
Number of Falls with harm per 1,000 Patient Days on the Best Practice Spotlight Organization (BPSO) and Dedicated Education Units (DEU)															
Safety	Safe	Number of falls with harm per 1,000 patient days on the Best Practice Spotlight Organization (BPSO) and Dedicated Education Units (DEU)	C	Number of harmful falls (Mild, Moderate, Serious and Death) on EGH Respirology, EGH 6W Gen Med, EGH 7E Cardiology, BC H Respirology, BCH Stroke and BCH Gen Med 3 in the timeframe.	DATIX (numerator- number of harmful falls) and Meditech (denominator- patient days)	951*	1.17	1.12	5% improvement over baseline		1. Develop a standardized process for engaging falls champions and strengthen dissemination of falls audit results with teams to drive targeted improvements	1. Selection, training and tracking of falls champions 2.Develop a tool for program leadership to track active Falls Champions 3. Unit leadership engagement process - debrief, audit and data sharing - set targets for compliance	1. Number of active trained Falls Champions (2 per BPSO and DEU units) 2. Formal process for selection, training and tracking falls Champions 3. Development of a tool for leadership tracking	1. Aleast 2 Falls champions per BPSO and DEU unit 2. By Q2 FY 2025/26 3. By Q2 FY 2025/26	Covered in corporate nursing orientation
											2. Provide targeted falls prevention education for patients and families and and roll out a Falls Prevention LMS staff training	1. Develop patient/family education (inlcuding brochure) on side rails and falls prevention (with feedback from PFAC) 2. Campaign during fall prevention month (Nov 2025) 3. Implement LMS Module with staff on the 6 BPSO/DEU units 4. Increase compliance to the Falls Management System LMS on the 6 units	1. Development of an education brochure 2. Completion of side rail education campaign during Nov 2025 fall prevention month 3. Complete the implementation of Falls LMS Module on the 6 BPSO/DEU units 4. Staff Compliance on LMS completion	1. By Q2 FY 2025/26 2. By Q3 FY 2025/26 3. By Q2 FY 2025/26 4. 80% of patient facing staff by Q4 2025/2026	
											3. Optimize the consistent activation and application of Bedside Mobility Assessment Tool	1. Bedside mobility tool data qshift 2. Audit Score 3.Osler BMAT Poster and whiteboard BMAT addition	1. Compliance rate from Meditech % 10 increase 2. Audit score	1. By Q3 FY 2025/26 2. Collecting Baseline	
											4. Optimize effective and timely activation of the high-risk falls protocol	1.Protocol documentation in falls intervention screen and Post fall baseline data	1. Compliance rate from Meditech % 10 increase 2. Audit score	1. By Q3 FY 2025/26 2. Collecting Baseline	
Percentage (%) of Identified Leaders who have Completed Equity, Diversity and Inclusion and Anti-Racism Education															
Equity	Equitable	Percentage (%) of Staff Leaders, Physician Leaders, Board and Community Members who have Completed Equity, Diversity and Inclusion and Anti-Racism Education	O	Staff Leaders, Physician Leaders, Board Members, and Community Members	LMS/workshop data	951*	59.2%	90%	Target set at 90%, considering factors like staff turnover and staff leaves		1. Establish Equity, Diversity and Inclusion and Anti-Racism learning as an essential training for Staff Leaders, Physician Leaders, Board Members and Board appointed Community Members, Clinical Educators & Professional Practice Leaders	1.Staff Leaders: Foundational education will be coordinated through the LMS. 2.Physician Leaders: Foundational education will be delivered through the LMS. 3 Board members and Board-appointed Community Member/Patient Representatives: Foundational education will be part of Board Orientation. New education every 2 years will be delivered in workshop format. The cadence of the education is every two years, with leaders completing EDI Foundations learning with other opportunities to receive further education on EDI and health justice content within the two years. 4. Clinical Educators & Professional Practice Leaders will complete their EDI education in person; education/summit in June 2025 during Q1. Contigency plan for new PPLs or absentees is to complete EDI education via LMS. 100 compliance Q1.	1. Staff Leaders: Completion captured by tracking through LMS. For Clinical educators and PPLs, EDI education will be tracked in their new leader orientation checklist. 2. Physician Leaders: Completion will be tracked via LMS. 3. Board members and Board-appointed Community Member/Patient Representatives: Completion of education tracked through Osler's Board Office.	90% completion: 1. Staff Leaders: Recommended EDI learning has been completed before the end of the fiscal year. 2. Physician Leaders: Recommended EDI learning has been completed before the end of the fiscal year. 3. Board members and Board appointed Community Members: Recommended EDI learning has been completed before the end of the fiscal year. For board members, one workshop training with 90% completion.	90% recognizes that at any given point in time when you are pulling reports from the system you will be transitioning - new hires, sick or pregnancy leaves, etc. We will use as a base the Employee and Physician Engagement Survey (inclusion questions) and Patient Engagement Survey (discrimination complaint and health equity questions) to trend impact on learnings within the culture of the organization. Trending will be monitor throughout our EDI and Health Equity framework and programs - foundational training (QIP year 1) is a portion of this broader work. EDI learning will be identified and recommended (by Senior Lead, Strategic Advisor, EDI) for completion by Osler leaders
											2. Incorporate EDI training goals and actions into performance reviews and new leader orientation checklists for Staff Leaders, Physician Leaders, Clinical Educators, and Professional Practice Leaders. (This change does not apply to Board Members or Board-appointed Community Members/Patient Representatives.)	1. Staff Leaders & Physician Leaders: EDI learning will form part of each leaders development plans	1a. Staff Leaders: Through regular performance/development plan check-ins 1b. Physician Leaders: Through regular department and division meetings.	1. 90% completion of performance review with EDI reference actions.	This will ensure that is it a prioritized learning and managers can work to aligning the learnings of this foundational education to specific work in the department/program the manager leads. For physicans, EDI learning will be tracked by the MSO as there cannot be any updates to CMaRS in 2024. Going forward (2025-2026) once there is coordination between the LMS and CMaRS and alignment, EDI goals can be added to performance reviews. On going monitoring will occur with the board office.