2025/26 Quality Improvement Plan
"Improvement Targets and Initiatives for TORONTO Region"

Last Updated - October 15, 2025

Aim	Measure													Change					
Priority Issue	Measure/Indicator	Type	Unit/Population	Source/Period	Organization Id	Quarter (October, November, December 2024)	Annual Rate FY 2024/2025	Q4 (January, February & march)	Q1 (April, May, & June)	Q2 (July, August & September)	Target (2025/2026)	Target Justification	External Collaborators	Planned Improvement Initiatives (Change Ideas)	Methods	Process Measures	Performance	Target for Process Measure	Comments
Access and Flow	Reduction in the Alternate Level of Care (ALC) Rate		All Patients	Access & Flow		2.4%	2.4%	1.9%	0.35%	1.5%	3%	Sustain target based on current baseline performance.		1. To continue evaluating and improving an existing system for early ALC identification and escalation.	1. Develop an ALC to Long-Term Care (LTC) escalation form and incorporate it into the existing organizational ALC escalation process 2. Continue educating clinical interdisciplinary teams about ALC avoidance and Ontario Health's (OH) Operational Directive: Home First 3. Engage Ontario Health Team (OHT) partners to identify and refer to community partners offering appropriate services in the community.	Escalation Form developed and incorporated Home First operational directives to be communicated to the Access and Flow team and interdisciplinary	ALC to LTC escalation practice is alligned with MOH's Home First operational directions and is conducted in collaboration with OHaH	Escalation Form developed ; 100% of Access and Flow team to be educated on HomeFirst Operational directives	Sustained
														2. Training staff on delirium prevention and management; and seniors' sensitivity.	1. Continue orienting new hires on Delirium prevention and management. 2. Manager to monitor staff's compliance with completing annual eLearning module on delirium prevention and management. 3. Develop SQL report for Delirium incidence by January 2025 4. Implement a practice of monitoring delirium incidence across all Patient Care Units (PCU) – by February 2025.	% of staff who completed LMS Module for Delirium (annually)	Delirium prevention and management educational module has been included in mandatory online education for all clinical staff; 71.81% of staff completing	80% of the clinical staff will complete this module by March 2026	sustained
														3. To provide an Estimated Date of Discharge (EDD) to the patient within 4 calendar days of admission.	1. Perform monthly audits on Discharge Coordinators' compliance with providing EDD to their patients within 4 calendar days of admission. 2. Implement practice change project for Patient Oriented Discharge Summary (PODS), that involves Discharge Coordinators delivering a discharge package to a patient at 48hrs prior patient's confirmed discharge day – by January 2025 3. Continue to address barriers to providing EDD within 4 calendar days of admission.	% of patients who received EDD within 4 days of admission	In Q1 of FY 2025/26, average of 87% of patients have received their EDD within 4 days of admission	80% of patients receive EDD within 4 days of admission	sustained
	Increase and Maintain Occupancy Rate > 95%			Access & Flow		(Q3) 98.6%	98%	98.1%	98.4%	98.7%	95%	Health Quality Ontario recommends 5-10% increase or decrease when deciding a quality improvement project target		1. Strengthening partnerships with acute care partners to improve access and flow (Humber River Health (HRH), St. Joseph's Health Centre (SJHC)).	1. Attend Join Discharge Rounds twice a week with the HRH team. 2. Send daily occupancy information to acute care partners. 3. Generate and send daily census reports to Senior Leadership informing them of census and mitigation strategies employed to address low census.	% of discharge rounds attended; Daily occupancy information to Humber and St.Joe's	In Q1 of FY 2025/26, Manager of Access and flow had attended 60% of JDR meetings	60% of the discharge rounds to be attended	Sustained
														2. Flex beds to accommodate acute care admissions during outbreaks at Runnymede (i.e. Low Tolerance Long Duration (LTLD) admission on Medically Complex (MC) floor).	1. Admit LTLD patients to MC floor to maintain occupancy rate above 95% based on the feasibility of human resources and patient safety. 2. Flex High Tolerance Short Duration (HTSD)/LTLD beds as necessary to accommodate acute care admissions.	Maintain 95% occupancy	In Q1of FY 2025/26, the occupancy rate was 98.4%	maintain occupancy trate above 95% at all times	Sustained
														3. Collaborate with acute care partners and OH organizations to develop various pathways for patients admissions to RHC's rehab programs.	1. Participate in Post-Fall Rehab Pathway admissions project led by GTA Rehab Network group to facilitate rehab admissions from community by Paramedics referrals 2. Collaborate with GTA Rehab Network's working group on developing the project "Direct Access from Acute Care to Inpatient Rehab", which will optimize the bed occupancy and release the bed surge in emergency departments across GTA. 3. Maintain daily communication with transitions managers at HRH and SJHC to prioritize admissions from acute care.	Monitoring number of patients admitted via each pathway (Post Fall, Acute to Rehab) ; Daily communication with HRH for bed availability	Manager of Access and Flow is attending all meetings related to initiatives led by GTA Rehab Network group and communicates bed availability to acute care partners daily	participating in GTA Rehab Network group meetings, sending daily bed availability reports to acute care partners	sustained
Equity	Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and antiracism education	P	All Staff	Human Resources		60% (Q2)			0.0%	64.0%	80.0%	Health Quality Ontario recommends 5-10% increase or decrease when deciding a quality improvement project target		1. Rollout of relevant equity, diversity, inclusion, and antiracism education and training plan for staff, Senior Leadership, and the Board.	1. Webinars and e-learning	Number of webinars and e-learning			
Experience	Percentage of respondents who responded "completely" and "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?		Rehab Patients	Qualtrics		73% (Q2)	67%	59%	86%	68%	60%	Health Quality Ontario recommends 5-10% increase or decrease when deciding a quality improvement project target		1. Enhancement of PODS	1. Discharge date will now be flagged on the status board on Meditech.	Working with MediTech developer to create a discharge date on status board	All rehab in-patients will be flagged on status board.	100%	sustained
														2. Engaging patients/SDM 2 days prior to discharge.	1. The interdisciplinary team will meet with the patient 72 hours prior to discharge to provide teaching and information. 2. The Advanced Practice Nurse/Clerical Associate will prepare the PODS 24 hours before the patient's discharge date. 3. The Discharge Coordinator will meet with the patient and family to orient them to the PODS and discharge package 2 days prior to discharge.	% of patients who were orientated to PODS 2 days prior to discharge	95.7% number of PODS delivered (July 93%, August 97%, September 97%)	80% of % of patients who were orientated to PODS 2 days prior to discharge??	sustained
														3. Analysis of Qualtrics survey	1. Quarterly review will be conducted with Directors and Managers to assess the results. If necessary, action points will be determined and implemented to address any identified issues or areas for improvement.	Number of reviews conducted	One review conducted for the quarter.	Four reviews for the fiscal year.	Completed
Safety	Decrease the number of workplace violence incidents		All Staff and Volunteers	Incident Management System		4.50	5.00	5.00	9.00	5.00	<5/month	Health Quality Ontario recommends 5-10% increase or decrease when deciding a quality improvement project target		1 Attend safety huddles/staff meeting (with Allied health) to promote workplace violence reporting	Managers and educators to attend safety huddles.	Quarterly huddles for workplace violence.	Completed for Q4& Q1	Attend 1 huddle/unit /quarter	Completed
														2. For staff and volunteers to have a standardized understanding of workplace violence	Code of the month, monthly orientation, annual LMS, tabletop, discussion during huddles and tracers	> Ongoing monthly orientation. > Ongoing orientation for code white, and orientation for new hires.	completed and ongoing	Attend scheduled monthly orientation for new hires.	Completed and ongoing
														3. Socialize Patient Rights and Responsibilities	> MEMO and updated posters pasted around the hospital. > Huddles on 3 units. > Include posters in admission packages.	Continued inclusion of posters in admission packages.	Completed and ongoing	Attend 1 huddle/meeting per month	Completed and ongoing
														4.Review Workplace Violence Policy and integrate and escalation process/flow chart for patients and family members (verbal warning, cautionary letter, serving of trespass notice, declaring persona non-grata)	> WPV Policy reviewed > Creation of Trespass SOP	> WPV Policy is approved and socialised > Trespass policy is approved and socialized	Trespass SOP socialization policy was done and also recorded and was sent to all relevant and required staff	n/a	> WPV policy is Completed > Trespass SOP is completed
														5. Establish a process for addressing patients who are repeat offenders	Establish a process for addressing patients who are repeat offenders (TBD with PCMs)	Working with MediTech developer to create a discharge date on status board	Report was shared with PCMs and other required managers	Quarterly	Ongoing
														6. Monitoring the rate of workplace violence resulting in lost hours due to injury	Extracting the data from leave data from Human Resources and/or Occupational Health	Ongoing tracking by OCH	Q4 (0); Q1 (0) ; Q2 (0)	Quarterly	Completed and ongoing
														7. Different approaches to managing violence from cognitively intact patients and cognitively impaired patients	AIDET Roadshow, GPA training in progress (TBD with educators)	Approaches have been developed	Staff are receiving AIDET and GPA training on a monthly basis	Monthly	Completed and ongoing