2026/27 Quality Improvement Plan
"Improvement Targets and Initiatives"

Runnymede Healthcare Centre 625 Runnymede Road, Toronto , ON, M6S3A3

AIM		Measure						Change				
Issue	Quality dimension	Measure/Indicator	Unit / Population	Organization Id	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Access and Flow	Timely	Rate of potentially avoidable emergency department (ED) visits for all programs	Number / All patients	850*	CB	Health Quality Ontario recommends 5-10% increase or decrease when deciding a quality improvement project target	n/a	1)Education for all physicians on limiting avoidable ED transfers	o Educational sessions with locums (i.e. situations in which acute care transfer is needed versus managing clinical issues in-house) o Review resources within Runnymede o Chief of Medical Staff to curate sessions (presentations) and/or emails to medical staff	% of medical staff/physicians informed	100% of medical staff/locum physicians informed	
								2)Quarterly ED transfer analysis (sent out and returned within 24 hours)	Data collection: o Quarterly review of ED transfer of patients sent out and returning within 24 hours	physician trends; time of day; total avoidable ED transfers	Review of perceived "avoidable" ED transfers	
								3)Staff recognition of early warning signs of clinical deterioration	Creating modules to promote awareness of early clinical warning signs: o create slides and case studies Safety huddle led by Advanced Practice Nurse (APN)/Site Operations and Practice Lead (SOPL) Most Responsible Physician (MRP) education: o crafting	o % of staff (nursing and allied health) completed modules o # of safety huddles o crafting # care pathway, if identified as a gap in the avoidable	o 80% of front-line staff (nursing and allied health) review of modules/attendance of safety huddles o Clinical Educators/delegate will	
Equity	Equitable	Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	% / Staff	850*	90.00	Leaders should set as an example of equity competency training for the staff	Ontario Health Team (OHT)	1)Co-development of Standardized Health Equity Education Content- 4 Topics: Each topic is one hour each; 2 sessions in all	Designate leaders who have completed health equity training will meet to collaboratively develop standardized content aligned with organizational priorities and Accreditation Canada standards	Completion of standardized training materials	Number of leaders attending each sessions	
								2)Delivery of Foundations of Health Equity Training to Managers and Directors	2 sessions delivered by trained internal leaders using standardized materials	Attendance rate will be taken as a data gathering method	It is an expectation to gather 100% of attendance	Delivery starts in quarter 2 of the fiscal year
		Evaluate and recommend practices to align equity principles in all People and Culture processes: Embed Equity, Diversity & Inclusion (EDI) in HR practices and processes	Number / Leaders (Managers and Directors)	850*	2.00	Not applicable	n/a	1)Refresh job postings to promote EDI o Include EDI in the hiring and selection process	Review standardized job posting language, hiring and selection process Implement	Number of job postings reviewed % of implemented	target is 80% of the job postings will promote EDI or include EDI	
Experience	Patient-centred	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?	% / Survey respondents	850*	CB	Health Quality Ontario recommends a 5-10% increase or decrease when deciding a quality improvement project target	n/a	1)Mark discharge envelopes as "important' discharge information	a. Team will reconvene on the terms, budget and label designs b. All discharge envelopes will be clearly labelled with an indicator denoting their importance c. Clerical Associates (CAs) will be educated on support for marking discharge packages d. Discharge coordinators will provide feedback to CAs	a. The team decides on label design b. % of labelled discharge packages handed to patients c. % of clerical associates educated d. Number of meetings with CAs	a. One label design b. 100% c. 80% d. Discharge coordinators will meet with CAs to 1 x weekly	
								2)Patient Oriented Discharge Summary (PODS) form will be updated to reflect current discharge process	a. Meet the experience working group to look at the current PODS form and make a draft b. Review of the form by the discharge team before giving it to the patient c. Review PODS Form by Patient and Family Advisory Council (PFAC) for feedback d. Ask for feedback on the new form to sample section of 3 High Tolerance Short Duration (HTSD) and 3 Low Tolerance Long Duration (LTLD) patients e. Start using new form	a. n/a b. % of form reviewed c. Present PODS form to PFAC d. Number of rehab patients presented PODS form to e. % of new forms attached to discharge packages	a. n/a b. 100% form reviewed c. Attend one PFAC meeting to discuss PODS d. Get feedback from 3 HTSD and 3 LTLD patients e. 100% of new forms attached to discharge packages	
								3)Provide education sheets to specific patients (patients with ostomy/colostomy, insulin, and Foley)	a. Research and validate the information sheet by the Clinical Education Team b. The sample patient population will provide feedback on education sheets c. All patient-specific print-outs (ostomy/colostomy, insulin, foley) will be added in the discharge package by APNs and added to Integrated Bedside Terminals (IBT) d. Audit of 5 files (discharge forms and labelled envelopes) per month	a. Number of information sheet with Clinical Education Team validation b. Number of patients provided feedback c. % of specific patients given education sheets d. Number of files audited	a. 3 targeted (ostomy, insulin, urinary catheter) information sheet validated by Clinical Education Team b. Get feedback from 2 patients with ostomy, 2 patients who use insulin, 2 patients with urinary catheter c. 100% of specific patients d. 5 files audited	
Safety	Safe	Percentage of patients whose stage 2 to 4 pressure injuries have worsened	% / All patients	850*	CB	Health Quality Ontario suggest 5-10% improvement from baseline (Baseline to be collected in Q4 of FY 2025/2026	n/a	1)Training and education on wound care prevention	Conduct monthly themed planned roadshow on topics such as offloading, staging of wound, understanding Braden scale, worsening wound and submission of incident report	10 chart audits/ month	75% of all staff trained (PSW/Nursing) for roadshow	
								2)Bridging the Braden Scale response Gap	Creation of LMS for sustainability	a. Weekly random audits of five charts; traces b. The attendance sheet will give a snapshot of engagement	a. 5 chart audits b. 60% of frontline staff attend engagement	