Baycrest Hospital
2025-26 Quality Improvement Plan Workplan

Baycrest Hospital

Patient Experience

Indicator: Percent positive responses ("always" and "most of the time") to the question - Are you kept well-informed about your progress in areas that are important to you?
Source: Client experience surveys
Current performance: 76%
Reporting Period: Fiscal Year Q1 to Q3 (i.e., April 1, 2024 to December 31, 2024)
Scope: Inpatient hospital

2025-26 Target	Target Justification
80% in Fiscal Year 2025-26	Information exchange continues to be a priority to ensure patients and families can be true partners in their care. The inpatient units will expand efforts from last fiscal year into 2025-26 while maintaining the target from the previous year, with a focus on sustainability of initiatives such as patient-centred whiteboards and communication of discharge dates for units where applicable.

Change idea	Methods	Process measure	Target
Finalize implementation and develop sustainability plan for patient-centred whiteboards in each patient room	▪ Interprofessional staff on the unit to trial revised whiteboard headers as part of first improvement cycle ▪ Interprofessional staff on the unit to track progress on changes tested via idea board ticket at improvement huddles ▪ Staff to co-design standard work for completion of whiteboards; standard work to be communicated by unit leadership ▪ Hospital interprofessional working group to support with overall strategy for evaluating effectiveness of whiteboards (e.g., weekly audits, strategy to incorporate feedback from staff, patients and families)	First improvement cycle completed on one rehabilitation unit (7E) Recommendations from first improvement cycle implemented on the unit Plan developed to spread to other units	By June 30, 2025 By September 30, 2025 By October 31, 2025

	▪ Unit leadership to partner with Facilities/Redevelopment where applicable (e.g., on project request to install whiteboards)		
Sustain and spread process to communicate the estimated discharge date to patients and families, as well as revisions to the discharge date	▪ Standard work for interprofessional rounds to include component of confirming whether discharge dates have been communicated (including revisions) ▪ Unit leadership to communicate designated role(s) so all members of the interprofessional team are aware ▪ Unit orientation to incorporate discharge date communication process for new staff	Percentage of newly admitted patients on one rehabilitation unit (7W) who have their estimated discharge date communicated within 4 days of admission Action plan developed for spread to other units	50% by June 30, 2025 By September 30, 2025
Explore transition to standardized surveying via Ontario Hospital Association's patient experience measurement program in the coming year	▪ Custom questions for inclusion presented at various forums (e.g., interprofessional working group, Client & Family Partner Panel) and presented for approval at Hospital Quality & Risk Committee ▪ Appropriate internal partners engaged to help inform potential implementation (e.g., Privacy, IT, Digital Health, Legal, Procurement) ▪ Proposed timelines presented at Senior Executive Team (SET)	Proposed timelines presented to SET	By June 30, 2025

Safe & Effective Care

Indicator: Percentage of reduction in new hospital-acquired Stage III & IV Pressure injuries
Source: Patient electronic health record and the Safety Event Reporting System (SERS)
Current performance: Collecting Baseline
Scope: Inpatient hospital

2025-26 Target	Target Justification
Collecting Baseline	Baycrest will continue its focus on pressure injury prevention. To align with Never Event Reporting, the indicator will now focus on Stage III & IV pressure injuries acquired in real-time at Baycrest. Historically, the indicator measured pressure injuries acquired through point-in-time quarterly prevalence and incidence studies on the following units: Complex Continuing Care units, Transitional Care Unit and Slow Stream Rehabilitation Unit. The 2025-26 indicator aims to capture real-time pressure injury data across all inpatient units. In parallel, data from the incidence studies will also be used to validate this new indicator (understanding that the incidence studies only reflect pressure injuries from a snapshot in time).

Change idea	Methods	Process measure	Target
Develop a sustainability plan and process to monitor mobilization and repositioning strategies	▪ Interprofessional working group established for all change ideas; meeting agenda to include current state assessment of strategies and gap analysis when applicable ▪ Unit-based forums leveraged to engage point-of-care staff (for example, weekly interprofessional improvement huddles, ETL meetings) ▪ Gap analysis presented at Nursing Practice Affairs Committee for feedback	Gap analysis completed on all 3 Complex Continuing Care units Areas of focus prioritized and action plan developed with timelines and leads	By June 30, 2025 By September 30, 2025
Implement reporting of pressure injuries as safety events in the Safety Event Reporting System (SERS)	▪ Collaboration with SERS administrator on current reporting form requirements ▪ Communication plan presented and approved at interprofessional working group ▪ Existing visual management system leveraged at improvement huddles to review data on incidents reported	Event reporting form finalized Communication plan developed and integrated into practice Monthly SERS incidents posted on each unit	By April 30, 2025 By June 30, 2025 By July 30, 2025

	▪ Monthly review of events reported incorporated into the interprofessional working group agenda ▪ Unit leadership discuss learnings at huddles from events reported	First monthly review of incidents by interprofessional working group	By August 30, 2025
Implement standardized approaches for interprofessional review of new pressure injuries	▪ Clinical rounds to include standard work on how to flag and action on active pressure injuries on the unit ▪ Leverage clinical report that outlines real-time wounds active on each unit	Pilot discussion of new pressure injuries on one Complex Continuing Care (CCC) unit Spread standardized approach to all CCC units	By April 30, 2025 By September 30, 2025

Safe & Effective Care

Indicator: Delirium Onset during Baycrest Hospitalization
Source: Finalizing order set changes to enable tracking of delirium onset during admission to Baycrest

- Existing rehab admission order set will be updated to allow the admitting physician to note that a patient is being admitted with delirium
- New delirium order set has been approved to guide delirium management and support tracking of patients with delirium

Current performance: Collecting Baseline
Scope: Inpatient hospital – Rehabilitation program

2025-26 Target	Target Justification
Collecting Baseline	1. Baycrest does not have accurate baseline data for this indicator 2. Important clinically and from a continuous improvement perspective to understand Baycrest-acquired delirium rates 3. Data for this indicator are required for external reporting 4. Understanding delirium onset during admission aligns with the hospital's strategic focus on reducing preventable harm

Change idea	Methods	Process measure	Target
Implement necessary order set documentation changes to allow for the identification of patients who develop delirium during their Baycrest admission & to respond with care	▪ Monitoring and guiding progress with regular working group reviews ▪ Establishing documentation of identified delirium within the health information system ▪ Disseminating of data to the interprofessional team and organizational monitoring via the Hospital Quality & Risk Committee	Date by which monitoring of metric begins	September 30, 2025
Trial modifications to 4AT screening practices in the rehab program, while maintaining improvements to the percentage of patients screened within 24 hours of admission	▪ Monitoring and guiding progress with regular working group review of modifications, screening activity and the spread of 4AT screening to the Transitional Care Unit (TCU)	Percentage of patients screened within 24 hours of admission using the 4AT	90% by end of Dec. 2025 for Rehabilitation units & end of Mar. 2026 for TCU

Education for People with Delirium, Family, and Caregivers	▪ Random audit of patients, families/caregivers for having received education regarding delirium	Percentage of patients, families/caregivers admitted to the Rehabilitation program who report receiving education regarding delirium	50% by end of Dec. 2025

Corporate

Safe and Effective

Indicator: WPV incidents that result in lost time reported per 100 FTE hospital and LTC workers within a 12 month period
Source: internal data collection
Current performance: collecting baseline
Reporting period: April 1 2023 – March 31 2024
Scope: # of Hospital and Long Term Care workers (FTE)

2025-26 Target	Target Justification
Collecting baseline	Collecting baseline data on workplace violence incidents resulting in lost time is essential to help the organization understand current state, measure progress, identify risk factors and develop targeted prevention strategies. This initial data collection is crucial for setting informed targets and measuring progress over time. Over the next year, Occupational Health & Safety will be working with Acclaim (3rd party WSIB company) to generate reports, baseline data and to understand the root cause for the lost time due to workplace violence.

Change idea	Methods	Process measure	Target
Process Improvement: Improve WSIB return to work process: foster ongoing collaboration between Acclaim, OHS & Management to enhance efficiency and effectiveness in supporting employees' return to work	OHS monitor RTW and types of Workplace Injuries tracking from Acclaim	% of Workplace Violence WSIB Claims	Setting base line for the 25/26 FY
Policy: Update the workplace violence and harassment policy and provide staff education	HR will track policy training completed	60% of staff provided with training on the updated policy within the first year of implementation	Policy approved by Q3
Education: Support managers and point of care staff through safety culture training including leadership forums, safety huddles and reinforcement of code of conduct	OHS to track # of huddles and attendance, survey attendees to track effectiveness of huddles.	24 safety huddles/training sessions conducted within FY25/26	2 safety huddles/training sessions per month

Equity

Indicator: % of all Baycrest hospital and long term care staff who have completed relevant EDI and antiracism education
Source: internal data collection
Current performance: 46.4%
Reporting Period: January 1 – December 31, 2024
Scope: all Baycrest Hospital and Apotex staff and physicians

2025-26 Target	Target Justification
60%	The improvement target reflects the important work to deliver meaningful and accessible training to our staff as well as building leadership capacity in this area (with a goal that 80% of leaders attend in person training). Recognizing the tremendous education and training that our staff already complete throughout the year, the 10% improvement target acknowledges the importance of offering a diverse approach to EDI and antiracism education. There is also significant work required to align the organization's learning management systems to better capture and integrate EDI offerings and data tracking.

Change idea	Methods	Process measure	Target
Expand in person EDI educational offerings to Baycrest hospital and LTC leadership (i.e. managers, advanced practice leads, supervisors, directors, executive, physician leaders)	EDI/OE to collect attendance and competency evaluation	% of management attending in person training; # of in person offerings	At least 80% of leaders; at least 3 in person sessions held by end of Q2
Relaunch anti-Black racism eLearning, development of antisemitism modules and integration of the EDI micro-learnings into the learning management system	OE/EDI track quarterly data collection	Module completion rates	Launch anti-Black racism education all staff by the end of the calendar year; Antisemitism training modules launched for all staff by end of calendar year
Develop an Inclusive, Diverse, Equitable, Accessible, Anti-racist, Anti-oppressive Systems (IDEA³s) Integration Plan in alignment with our Accreditation Canada standards and corporate values that aims to establish a Leadership Community of Practice for supporting IDEA³s Integration policy development, education,	Community of Practice will inform the development and monitor completion and approval of IDEA³s Integration policy	Extent of collaboration and engagement across Baycrest contributing on development of coordinated and integrated policy standards with measurable KPI and equity impacts	Development of integration framework, key performance indicators and policy draft by August 2025

leadership capacity-building, and systemic maturity through cross-entity collaboration and equity impact assessments. Develop robust organization-wide practice and Identity-Based Data Governance policy that emphasizes the collection and utilization of socio-demographic data to drive equity in healthcare and employment/ recruitment and that aligns with existing privacy and cybersecurity polices, legislation, reporting, and use of equity data (covering patient/ resident and employees data).			