Baycrest

Hospital Quality Improvement Plan 2026/27 Workplan

Indicator: **Percent positive responses to the question - Are you kept well-informed about your progress in areas that are important to you?**
Source**: Client experience surveys (OHA and internally developed)**
Current performance**: 87.5%**
Reporting Period: **Q1- Q4 2026/2027**

2026-27 Target	Target Justification
90% in fiscal year 2026-27	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 2026-27 while increasing the target from the previous year, with a focus on sustainability of initiatives such as communication of discharge dates where applicable and strengthening our patient experience measurement system by implementing OHA's Standardized Surveying on Rehabilitation and Mental Health units.

Change idea	Process measure	Methods	Target
Implement OHA Mental Health and Rehabilitation surveys in collaboration with SOM	Implement post- discharge email distribution and QR-code-based access as first improvement cycle First improvement cycle recommendations incorporated 50% of eligible mental health and rehabilitation clients responding to the OHA Client Experience Survey	▪ Confirm Client Experience Survey distribution workflows with SOM, digital health, and privacy partners co-design a centralized post-discharge email survey process, including timing and exclusion criteria ▪ Co-design QR code-based survey access for inpatient units ▪ Apply structured improvement cycles to test distribution methods and compare response rates and accessibility across modalities ▪ Conduct monthly response rate review meetings and retrospective meetings following each improvement cycle	July 1, 2026 December 31, 2026 March 31, 2027

Share and use patient experience feedback to support learning and improvement	Percentage of inpatient units with a completed monthly Client Experience Survey summary report that is reviewed with interprofessional staff Plan developed to share key improvements made to patients and families	▪ Produce monthly unit- level summary reports from Client Experience Survey responses highlighting key themes ▪ Establish monthly, standardized communication points to review unit- level findings with interprofessional staff ▪ Implement consistent approaches to share key improvements resulting from the Client Experience Survey feedback with patients and families	100% by September 30, 2026 December 31, 2026
Standardize early communication in care and discharge planning	Percentage of newly admitted patients on one rehabilitation unit (7W) who have their estimated discharge date communicated within 4 days of admission Plan developed to spread to other units where applicable	▪ Standardize early admission communication with patient and families regarding care progression and discharge planning ▪ Use Interdisciplinary rounds to flag patients with complex discharge barriers impacting a timely Estimated Discharge Date (EDD) identification ▪ Identify and communicate an EDD within 4 days of admission ▪ Review the percentage of patients with an EDD within 4 days monthly	60% by December 31, 2026 March 31, 2027

Indicator: **Average Quarterly Number of New Hospital-Acquired Stage III/IV Pressure Injuries**
Source**: Patient electronic health record (EHR)**
Current performance**: 5.5 per quarter (Average)**
Reporting Period: **Based on collected data from Q3 & Q4 2025/26**

2026-27 Target	Target Justification
5.0 per quarter	In 2025–26, Baycrest Hospital focused on establishing baseline pressure injury prevalence and enhancing access to real-time data. In 2026–27, efforts will shift toward embedding sustainable processes to enable prevention and early detection, as well as reducing the risk of pressure injury progression. Baycrest Hospital will aim for a 10% reduction from the 2025-26 baseline average quarterly performance of 5.5 down to 5.0, with a focus on mobilization and repositioning, as well as updated policy and application changes to align with best practice use of the Braden Scale.

Change idea	Process measure	Methods	Target
Operationalize and sustain standard work for repositioning and mobility	Audit plan completed and rolled out across all three Complex Continuing Care (CCC) units Standardized communication tool developed and implemented across all three CCC units Standard Operating Procedures (SOP) completed for use of positioning posters on CCC units	• Develop and implement a sustainable audit plan for compliance of repositioning and mobility efforts • Implement a standardized communication tool that prompts timely repositioning and mobility of patients within an interprofessional team setting • Streamline an improved process for positioning posters at the bedside • Progress check-in to be conducted monthly at Interprofessional Pressure Injury Working Group	June 30, 2026 (Sample of 15 patients in total audited per quarter across all CCC units) September 30, 2026 September 30, 2026

Improve pressure injury prevention in CCC units by consistently implementing and documenting Braden subscale–aligned interventions for patients at moderate-high risk	Updated EMR screen with embedded mandatory fields including Braden subscale-aligned preventative interventions Implement education, resources, tools and policy rollout across all CCC units Established audit and follow-up process across all CCC units	• Embed mandatory fields and clinical decision-support prompts within the updated EMR to require selection of Braden subscale–aligned preventative interventions for patients identified as moderate-high risk • Establish routine audit and feedback cycles, supporting unit-level review, coaching and follow-up on gaps • Complete a quarterly summary report of contributing factors identified during interprofessional rounds • Project plan to established in Q1 2026-27, including project updates at monthly sponsor meeting	September 30, 2026 March 31, 2027 March 31, 2027

Indicator: **Rate of Falls with Mild or Greater Harm per 1000 Patient Days**
Source: **Patient electronic health record and the Safety Event Reporting System (SERS)**
Current performance: **Collecting Baseline**
Reporting Period: n/a

2026-27 Target	**Target Justification**
Collecting Baseline	Baycrest is establishing baseline data for this new indicator adapted towards a therapeutic falls approach that supports a balance between patient safety and recovery of mobility. Understanding falls' incident rates is important clinically and from a continuous improvement perspective while understanding patient falls' risk aligns with the hospital's strategic focus on reducing preventable harm.

Change idea	Process measure	Methods	Target
Trial and optimize falls safety huddles on the palliative unit and spread use across inpatient units	Percent of select hospital inpatient units that implemented falls safety huddles (% target & sequence to be determined with Operations Management).	• Monitoring and guiding progress with regular working group reviews and quarterly reporting updates to a quality committee that are supported with leadership coordination of resources to ensure objectives are met. • Inclusion of appropriate precautionary measures in proportion to identified falls risk or incidents & communicated with shared documentation in the health information system. • Sharing of huddle discussion with the interprofessional team.	March 31, 2027
Trial and optimize validated falls risk assessment tool (FRAT) and approach on the palliative unit and spread use across inpatient units.	Percent of select hospital inpatient units that implemented falls risk assessment tool and approach (% target & sequence to be determined with Operations Management).	• Monitoring and guiding progress with regular working group review of modifications, screening activity, and the spread of FRAT screening to other hospital inpatient units. • Tracking and support includes quarterly reporting updates to a quality committee that are supported with leadership coordination of resources to ensure objectives are met.	March 31, 2027

Indicator: **Number of new patient enrollments to team-based primary care for residents of a Naturally Occurring Retirement Community condo building in North York.**
Source**: Wellness Clinics**
Current performance**: 54 of 60 residents seen at the Wellness Clinic in December 2025 were enrolled with a family doctor.**
Reporting Period: Annually in Q3

2026-27 Target	Target Justification
Increase new enrollments to team-based primary care by 10% by March 31, 2027 (↑10%)	**Introduction** The Neighbourhood Care Team (NCT) is a Primary Care Geriatric Integrated Team that unites health care organizations, providers and their clients (patients, families, and caregivers), to improve the integration and coordination of care and operate as 'one team' in the eyes of the patient. The NCT care model addresses the needs of a population of older adults congregated in a residential building who want to age in place in the community. This QIP will evaluate the feasibility of expanding the NCT model to a non-Toronto Seniors Housing Corporation building at 100 Upper Madison Avenue. This building is identified as a Naturally Occurring Retirement Community (NORC). Change ideas are about analyzing data we have about people living in the building for two purposes: (1) to apply appropriate interventions that meet the health needs of people living in the building; and (2) to observe and understand the logic model for how the NCT affects priority indicators for Ontario Health Teams and Ontario Health - primary care attachment and Ambulatory Care Sensitive Conditions - as well as strategic indicators for Baycrest - long-term care bed days avoided. **QIP Target Justification** New patient enrollments to team-based primary care are a priority indicator for Ontario Health as the Primary Care Action Team strives to attach 100% of Ontarians to a family doctor. Attachment for older adults is more challenging than attaching young families. For example, older adults can become intermittently homebound and thus loose attachment to their office-based family doctor. NCT has been successful in attaching older adults with complex health needs to primary care in their building. Only 10% increase in enrollments is proposed as it takes a while to find the older adults in a building who are unattached and orient the team to their needs. As the homebound situation illustrated many residents in NCT buildings already have a family doctor, but office-based care models may no longer meet their needs. Sorting out the optimal attachment requires time and effort.

Change idea	Process measure	Methods	Target
Apply the standard Neighbourhood Care Team approach to organizing care with new buildings.	Completion of needs survey.	• Interpret the results of the needs survey being distributed in February 2026.	March 2026

	Schedule primary care provider and team to attend the building.	• Assign family physician plus appropriate team to attend the building and start up collaborative care.	June 2026
Deliver appropriate chronic disease management.	Number of individuals connected to a pathway they need. (Note: in December 2025 no residents at this address with a diagnosis of diabetes were connected to a diabetes program.)	• Analysis of building data to identify which pathways (Diabetes, COPD, CHF, Dementia) are needed and engage individuals with those pathways. • Use tenant co-design to deliver appropriate chronic disease management pathways. • Evaluate feasibility.	100% of residents at this address with a diagnosis of Diabetes, COPD, CHF or Dementia are offered an appropriate chronic disease management pathway. 60+% engage with the pathway.
Avoiding use of long-term care bed days.	Number of long-term care bed days saved	• Analysis of building data to identify tenants with MAPLE 3, 4 or 5. Work with Ontario Health @Home to gain access to MAPLE scores. Determine how to meet the needs identified.	200 days per nursing home eligible tenant.
Manage needs upstream of hospital.	Ambulatory Care Sensitive Condition (ACSC) Admissions per 10,000 Population	• Analysis of building data to identify reasons for being admitted for Ambulatory Care Sensitive Conditions[1] and plan to meet needs.	The population of this building maintains the provincial average of 7.6 admissions (Baseline from Q1 2025/26).

Apotex and Hospital
2026-27 Quality Improvement Plan (QIP)
Equity, Diversity and Inclusion (EDI) and Workplace Violence (WPV)

Indicator: **% of Hospital and Long-Term Care Home Leaders complete at least one foundational and one applied equity, diversity and inclusion designated educational session by March, 2027.**
Source: **Internal data collection**
Current Performance: To be confirmed
Reporting period: **Q1 – Q4 2025-26**

2026-27 Target	Target Justification
65%	Achieving an equitable and inclusive workplace requires sustained investment in education, culture-building, leadership and employee engagement. Baycrest will prioritize building leadership capacity through a structured Equity, Diversity and Inclusive (EDI) learning framework that includes foundational and applied education delivered via e-learning, facilitated sessions, expert-led sessions and external partnerships. Leaders will receive targeted support to embed inclusive practices into hiring, decision-making, accessibility, conflict resolution and team operations. In parallel, Baycrest will strengthen organizational culture and belonging through coordinated EDI initiatives and inclusive communications aligned with organizational priorities and sector-wide equity goals. Continuous employee voice will be supported through EDI governance structures, committees, communities of practice and safe feedback channels. Insights gathered through surveys, listening sessions and forums will inform policy, practice and program improvements, with clear communication to staff on actions taken. This integrated approach supports measurable progress, accountability and sustainable culture change.

Change idea	Process measure	Methods	Target
Education, Training & Capacity Building Equip leaders with the knowledge and skills to foster an inclusive workplace. Launch EDI eLearning,	LMS tracking for eLearning (completion reports)	• Number of modules launched	6 modules launched throughout the calendar in alignment with various cultural heritage days, dates of significance and any relevant foundational EDI training.

development of TAHSN antisemitism eLearning and integration of the EDI learnings into the learning management system			
Inclusive Culture, Events & Initiatives Build a culture where employees feel valued, respected, and engaged, and where diverse identities are recognized.	Activation attendance tracking (Tracking activations over calendar year: number of activations offered)	• Number of and diversity of cultural recognition and awareness initiatives delivered (Holocaust Remembrance, Black History Month, Women's History, Asian Heritage, Pride, National Day for Truth and Reconciliation, etc.)	6 activations throughout the calendar year in recognition of various cultural heritage days, dates of significance
Employee Voice, Leadership Engagement & Feedback Maintain meaningful feedback loops to identify barriers and inform evidence-based improvements. Regular feedback collection and reporting through leadership and staff listening tours	Establish an EDI governance structure in order to expand employee feedback loops	• Number of engagements and feedback channels	At least 1 engagement monthly beginning in June

Indicator: **Work Place Violence (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: **0.9**
Reporting period: **Q1 -Q3 2025-26**

2026-27 Target	Target Justification
0.4	Align to OHA LTIF for all incidents and benchmarks set by peer organizations within TAHSN

Change idea	Process measure	Methods	Target
Prevention of High-Severity WPV Events 1. Violence risk screening for patients/residents	Violence risk screening data derived from SERS and statistical reports from Acclaim Ability Management	• % of high-risk units reporting via SERS WPV incidents	≥90% of high-risk units assessed annually Occupational Health & Safety team to collaborate with clinical and operational leaders to review issues identified and recommendations emerging from the high-risk unit assessments annually By December 31, 2026
Staff Training & Competency **Staff Training:** Review staff education and training related to responsive behaviours on high-risk units	In collaboration with the Occupational Health & Safety team, Apotex and Hospital operations/ practice teams, to review leading/emerging sector-	• Review and recommendations completed • % staff in high-risk areas (TBSU and 4 West) who complete required training completed	80% of staff in identified high-risk areas (TBSU and 4 West) complete required training By December 31, 2026

	specific training and update training requirements for high-risk units as needed.		
Rapid Post-Incident Response 1. Immediate medical and psychological assessment. 2. Early modified work and return to work (RTW) planning	% of WPV incidents assessed within 24 hours % of WPV Lost Time incidents offered modified duties and Full RTW within 72 hours	• Incident reporting timestamps via SERS and/ or Occupational Health records via ParkLane • RTW case management files	Reduction of approved lost time (Total approved lost time reduced)
Strengthened RTW Coordination Collaboration between OHS, Third party WSIB/claims management - Acclaim and leadership Proactive monitoring and adjustment of RTW plans by Acclaim	% of New WPV claims each quarter % of staff that RTW full duties	• All WSIB RTW claims are managed by Acclaim • Quarterly reports on RTW / Modified cases • Standardized RTW from STD/ Sick Leave Absence correspondence from Baycrest OH&S Team	≥75% of staff that RTW full duties