FY 2026-27 Quality Improvement Plan (QIP)

Workplan - Improvement Targets & Initiatives

AIM: OH Quality Issue	AIM: Quality dimension	Measure: Measure/ Indicator	Unit / Population	Source / Period	Current performance	Target	Target justification	External Collaborators	Change: Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Hospital Sector													
Access and Flow	Timely	**Monthly average open ALC cases**	Number / ALC patients	WTIS, EPIC / April 2025 - March 2026	**SMH: 48 SJHC: 75 PHC: 23**	**SMH: 43 SJHC: 68 PHC: 21**	10% improvement	Ontario Health (OH), GTA Rehab Network, WTOHT ALC Working Group, OH atHome	1. Develop and implement a standardized inter-professional rounding process to provide transparency in patient discharge information and barriers to discharge.	1. Complete current state analysis of inter professional rounding on inpatient internal medicine units; 2. Review of data including ALC LOS, duration of rounds and Estimated Date of Discharge (EDD) accuracy; 3. Collaborate with Digital team to leverage EPIC functionality and dashboard development. Identify pilot units to trial process improvement change initiatives; 4. track Transition Planner (TP) and Care and Transitions Facilitator (CTF).	1. Percentage of patients whose EDD is equal to actual discharge date, measured quarterly. 2. Percent of patients with transition planning initiated within 24 hours of admission. 3. Percent of complex discharges identified within 72 hours of ALC designation.	1. 10% improvement in EDD accuracy by March 31, 2027; 2. Transition planning will be initiated within 24 hours of admission 85% of the time for patients admitted to hospital inpatient wards by March 31, 2027; 3. 90% of patients with complex discharge dispositions will be identified within 72 hours of ALC designation.	
									2. Improve patient flow across the care continuum by strengthening partnerships with internal and external providers, reducing avoidable delays in access to care and transition processes.	1. Implement a partnership-driven model to align stakeholders, clarify roles, and improve shared accountability across care transitions; 2. Complete environmental scan of existing and potential partnerships supporting access to care and transitions; 3. Establish cross continuum patient-flow partnership KPI review process for high-volume facilities.	1. Number of new external partnerships with defined service level agreements; 2. % of identified internal stakeholder department representation attending monthly flow committee meetings; 3. Number of newly developed EPIC workbench reports related to KPI's identified to support access to care and flow to high-volume facilities.	1. UHT will build 3 new external partnerships by March 31, 2027; 2. Corporate flow committee meetings will have internal stakeholder representation 90% of the time over 12 months. 3. 2 new EPIC workbench reports will be developed to support monitoring of access to care and flow at identified high volume facilities by March 31, 2027.	By shifting from transactional referrals to structured partnerships with shared accountability, the organization will: a. Reduce discharge delays b. Improve throughput capacity c. Strengthen trust across the continuum d. Improve patient and family experience e. Support financial performance
		Average ED wait time from DTA to inpatient area	Hours / All patients admitted via ED transferring to inpatient unit.	CIHI NACRS / December 1, 2024 - November 30, 2025	**SMH: 9 SJHC: 17.7**	**SMH: 8.1 SJHC: 15.9**	Aligns with organizational target for ready bed transfer time and year over-year improvement.	Ontario Health (OH), OH atHome	1. Development of monthly and quarterly reports indicating daily average number of admitted patients who, at 8:00 am, had been waiting at least 2 hours since their disposition decision was made and who left the ED after 8:00 am. Report will be reviewed quarterly at the Access, Flow and Transitions Taskforce.	1. Review data analytics opportunities to monitor daily average of admitted patients who remained in the ED at 0800 with no identified bed on an inpatient unit; 2. Determine KPI's impacting the ability to transition patients who have been waiting at least 2 hours since disposition decision was made out of ED to inpatient beds; 3. Review current state process for use of unconventional spaces to support early transitions out of ED.	1. Development 0800 NBA dashboard and education rolled out 2. Standard process in place to review 0800 NBA report and KPI's at Access & Flow Taskforce.	1. 0800 NBA Dashboard developed in EPIC by July 31, 2026; 2. Quarterly review of 0800 NBA report and KPI's impacting transitions before 0800 at AFT Taskforce implemented by August 31, 2026.	1. Partnership with data analytics team will be required; 2. Access, Flow and Transitions (AFT) Taskforce will provide platform for data review and performance monitoring.
									2. Develop standard operating procedures for use of unconventional spaces to support early transitions out of ED.	Review current state process for use of unconventional spaces to support early transitions out of ED.	Number of hallway beds used on inpatient units monthly.	25% increased use of hallway beds on inpatient units by July 31, 2026.	Flow Manager and Patient Flow Specialists will be primary resource to support this work.
									3. Bed Management and assignment optimization through predictive flow planning.	1. Review of current process for bed assignment and associated data. 2. Review of data available and required to support predictive flow.	1. Time from bed request to assigned; 2. Percentage of admissions assigned appropriately on the first assignment.	1. Time from bed request to bed assigned will be 60 minutes or less 75% of the time by March 31, 2027; 2. 50% of admissions will be assigned to appropriate level-of-care bed on first assignment by Dec. 31, 2026.	Data analytics; Access and Flow; Critical Care leads; ED leads; Inpatient unit leaders.
									4. Develop standard operating procedure for admitted ED patients requiring transition to critical care units.	Review of current state pathways for transitions of ED admitted patients with a critical care status.	ED LOS for admitted patients with critical care designation.	25% improvement in time from decision to admit to critical care bed by March 31, 2027.	
		Average ED wait time from triage to decision to admit (DTA)	Hours / ED patients	CIHI NACRS / January 2025 - November 2025	**SMH: 8.9 SJHC: 9.5**	**SMH: 8 SJHC: 8.5**	10% improvement target which we feel is meaningful and feasible.		1. Identify and address workflow bottlenecks that delay admission decision making.	1. Conduct weekly frontline flow huddles (5–10 minutes) across shifts to capture real-time barriers. 2. Complete rapid flow mapping to identify delays in: a. Imaging & diagnostics b. Consult response times c. Decision communication & order completion	1. % of shifts completing flow huddles 2. % of actions implemented within agreed timelines	1. By July 2026 a. >= 75% of shifts complete flow huddles within 16 weeks. 2. By October 2026 b. Implement 2 identified action items.	1. Visible leadership support and responsiveness to frontline input 2. Rapid feedback loop (heard -> action -> update) 3. Protect huddle time to ensure consistency 4. Ensure psychological safety for staff to identify barriers.
									2. Solicit patient feedback to identify improvement opportunities to address process delays that target improving patient satisfaction.	Implement patient wait experience feedback tools: a. short discharge surveys b. QR code feedback posters c. patient relations themes	1. Number of patient feedback responses collected per week 2. Percentage of patients who selected Top two box for the question "How would you rate this overall visit (0-10)?"	1. By July 2026: a.>= 25 patient feedback responses/week. 2. By March 2027 a. Achieve 60% on "Percentage of patients who selected Top two box for the question "How would you rate this overall visit (0 10)?"	
									3. Implement quality improvement initiatives aimed to reduce ED to CT turnaround time.	1. ED/CT Improvement Project working group to monitor project progress and support implementation of improvement ideas. 2. Understand process flow and develop pathway to support ED/CT flow.	1. Completion of current state analysis. 2. Completion of ED/CT escalation pathway.	1. Current state analysis completed by June 30, 2026. 2. Implementation and communication of ED/CT escalation pathway to key stakeholders by Dec 31, 2026.	
Equity	hbh	**Percentage of clinical areas that are making substantial progress on at least one patient-focused equity oriented improvement initiative.**	% / All inpatients and select outpatient units	Clinical Program self reporting with ARESA support and evaluation / n/a	**Collecting Baseline**	**100**	Last year we aimed to improve the quality and number of equity oriented improvements by moving beyond staff education to focusing on increasing initiatives with direct patient care impact. With many new initiatives implemented, we want to focus on evaluating impact, improving effectiveness, and developing new initiatives		1. Improve ease of reporting and document tracking: We want to leverage Microsoft 365 to improve the clinical program user experience when providing progress updates. Each program will have a dedicated SharePoint to support tracking and monitoring their progress.	Monitor completion of initiative status reports to determine impact of using Sharepoint on report completion and submission.	We will also explore any utilisation data of the portal that may be available to us via Sharepoint (# of link visits etc.)	Create a SharePoint for each program that includes easy to access information for: a. Current performance by Quarter b. A list of all 26/27 reporting dates c. Templates for 26/27 reporting d. Previous submission documents We aim to have this implemented and distributed in May 2026.	Success is dependent on user adjustment to this new platform.
									2. ARESA and OpEx to do cross training to better support continued embedding of equity in the QMS.	Quality and ARESA will do some cross training on new equity in the QMS and equity oriented initiative guidance and explore opportunities for additional resources like short videos/ pre recorded presentations that could support councils and clinical areas.	% of quality huddle boards with equity goals or initiatives featured.	50% of quality huddle boards include equity goals or initiatives by March 2027.	Success is dependent on the roll out and implementation of QMS structures across clinical areas.
									3. The Anti-racism, Equity and Social Accountability (ARESA) office to continue to provide ongoing and direct support to three units or departments per annum as well as opportunities for short term/single session consultation with programs and committees.	The ARESA office to continue direct consultations with program/units to improve the quality and impact of their equity-oriented initiatives. Focus will be on those areas who may have had challenges with their equity initiative progress.	We will evaluate outcomes from previous partnerships and consultations. ie # of consultations, # of new ideas that have moved forward (net new or strengthen existing initiatives).	ARESA office provides direct support to 3 units or departments with a focus on new initiatives, evaluation of initiatives or new tactics to improve impact by March 31st.	
									4. The Office of Indigenous Wellness, Reconciliation and Partnership (IWRP) in partnership across the organization will begin to roll out improvements prioritized from the community engagement report.	IWRP office will continue to track workplan developments and engage accountable VP and Director.	Percent of the assigned recommendations on the Indigenous Voices Annual Work-Plan for the current year that have been implemented.	1. 100% of the assigned recommendations from the Indigenous Voices Report (IVR) work-plan for the 2026-27 fiscal year will be implemented by March 31, 2026 2. 33% of the recommendations that are assigned an "on-going status" will be started in the 26-27 fiscal year.	
Experience	Patient-Centered	**Percentage of patients with a MyChart Account.**	% / All patients	EPIC / January 2025 - January 2026	**41.4**	**47**	Target of 47% was chosen based on Unity performance within the baseline period (January 2025-2026) with an average increase every month of 0.5%. This is higher than the Ontario wide monthly improvement of 0.41% which will look to move us forward as leaders in this space.	EPIC	1. Enhance staff knowledge and skills in supporting patients with activating and navigating the MyChart patient portal.	Progress measured by: a. Development of a MyChart 101 education session curriculum b. Implementation of sessions across all three hospital sites c. Measuring the number of staff who participate in education sessions	Continuously track the number of staff who complete a MyChart 101 education sessions.	By March 31, 2027 two-hundred Unity staff will have completed a MyChart 101 education session.	Close collaboration with the Digital Change Management, Adoption and Education team to deliver the education series.
									2. Implement initiatives to increase the MyChart activation rate in the pediatrics (JFK, Pediatric Clinics, NICUs)	Progress measured by: a. Identification of targeted initiatives within pediatrics (JFK, Pediatric Clinics, NICUs) to increase MyChart activation rates b. Monitoring of MyChart activation rates within pediatric population (JFK, Pediatric Clinics, NICUs)	MyChart activation rate for pediatric population (Just for Kids clinic, Pediatric Clinics, NICU)	By March 31. 2027 the MyChart activation rate for pediatrics (Just for Kids clinic, Pediatric Clinics, NICU) will increase by 10%	Close partnership with the Women's and Children's program will be necessary to drive this work forward. Continued updates to proxy settings and workflow in Epic is a risk as the continued changes to the process may impact success.
									3. Understand and improve the experience of patients with the labelling and message functions within MyChart through user experience design session.	Progress will be measured by: a. Completion of one user experience design session b. Identification of change ideas to improve user experience with labelling and message functions c. Implementation of prioritized change ideas	Track number of change ideas implemented to improve user experience.	By November 30, 2026 complete one user experience design session to assess labelling and message functions within MyChart.	Partnership with Digital team to implement changes.
									4. Investigate additional metrics available through Epic to drive activation (e.g. process metrics)	Progress to be measured by: a. Identification of process metrics to drive MyChart activation through monitoring and improvements b. Addition of new process metrics to MyChart Activation dashboard	Track number of process metrics added to the MyChart Activation dashboard and overall MyChart activation rate.	Implement additional process metrics to the MyChart Activation dashboard by March 31, 2027.	Work will be in partnership with the Epic analytics team
									5. Formalize MyChart support resources for patients in the Patient and Family Learning Centres (SMH & PHC).	Progress to be measured by: a. Development and implementation of patient facing resources (tipsheets, education sessions, navigation support) on using MyChart b. Track number of patients who access resources and support on using MyChart at the Patient and Family Learning Centres (SMH & PHC)	Number of patients accessing MyChart support through the Patient and Family Learning Centres	Implement patient facing resources by August 31, 2026 (tipsheets, education sessions, navigation support) on using MyChart in the Patient and Family Learning Centres (SMH&PHC).	In partnership between Digital Care Experience and Patient Education teams.
Safety	Safe	**Number of reported workplace violence incidents that resulted in First Aid, Health Care and Lost Time claims.**	Number / Number of workplace violence incident reports	Parklane database / Q4 2024/25 – Q3 2025/26	**35.3**	**31.7**	The target applies a 10% reduction to our current baseline of 35.3 reports, making it realistic and attainable. Derived from the previous four-quarter data, it focuses on First Aid, Health Care, and Lost Time claims to prioritize incidents with the greatest impact/harm to health care workers.		1. Design and establish an organization-wide TIDES program. This fiscal year will focus on creating a standardized corporate curriculum and infrastructure to ensure the program is evidence-based and aligned with organizational policies and procedures.	1. Complete a comprehensive organizational needs assessment and finalize a report of findings and recommendations. 2. Provide quarterly progress updates to senior leadership to confirm the project remains on schedule for the targeted Q4/Q1 launch.	The percentage of project plan components completed and developed according to the project timeline will be tracked monthly.	1. Complete 100% of the needs assessment activities which may include surveys, interviews, and focus groups from March to August 2026. 2. Complete the first course curriculum content by March 31, 2027. 3. Provide quarterly updates to the Prevention of Workplace Violence and Harassment Steering Committee by March 31, 2027.	1. Success factors include strong collaboration among partners, timely feedback, and engagement from clinical staff. 2. Partnerships with educational and clinical teams are essential for relevance and buy-in. 3. Linkages to other quality improvement initiatives will enhance overall impact.
									2. Develop comprehensive educational materials to promote awareness and support increased compliance with safety plans.	1. Work with the clinical teams to develop educational materials related to completion of safety plan in EPIC. 2. The number of materials created and distributed will be recorded monthly. 3. Progress will be reviewed quarterly, and summaries will be shared with relevant partners to ensure materials effectively promote awareness and improve safety plan compliance.	1. % compliance with the safety plan as per policy requirements in the ED and inpatient areas. 2. # of units that have conducted education on safety plan compliance	Achieve at least 50% compliance with safety plan policy requirements in both the Emergency Departments and inpatient units by March 31, 2027.	1. Success depends on collaboration with clinical teams and effective messaging. 2. Materials should be accessible, engaging, and aligned with best practices to maximize impact. 3. Regular feedback from staff will inform ongoing refinement.
									3. Develop a comprehensive corporate communication strategy that provides information and updates on corporate workplace violence prevention efforts.	1. Collaborate with Corporate Communications lead to develop and implement the corporate communication strategy. 2. The strategy will include tracking, creation and distribution of ongoing updates about current education initiatives, new policies, emerging trends, education documents and committee workstream progress. 3. Development of a biannual newsletter in collaboration with corporate communication.	1. % of planned communication updates (including education initiatives, policies, trends, and committee progress) that are completed and distributed according to the schedule outlined in the communication calendar. 2. The number of biannual newsletters successfully created and shared within the organization will be tracked.	1.Achieve at least 80% of scheduled communication updates (including education initiatives, policies, trends, and committee workstream progress) being completed and distributed on time by March 31, 2027. 2. Create and share 2 biannual newsletters within the 26/27 fiscal year.	1. Factors for success include consistent messaging, timely updates, and active engagement with relevant partners. 2. Strong partnership with communication is essential for ensuring sustainability. 3. The strategy will enhance transparency, awareness, and organizational commitment to workplace violence prevention.
		Percentage of inpatients with a completed Braden scale risk assessment within 8 hours of admission.	% / Inpatients (exclude. NICU, Pediatrics, ED non-admitted and outpatient)	EPIC / January 1, 2025 - December 31, 2025	**67**	**85**	The current pressure injury prevention policy requires completion of a risk assessment within 4 hours of admission, whereas the 2020 NPIAP guidelines recommends completion within 8 hours. This assessment time frame also aligns with the Falls assessment indicator.		1. Ensure appropriate program level representation at the Skin Integrity & Pressure Injury Steering Committee.	The Skin Integrity and Pressure Injury Steering Committee to review membership representatives and identify appropriate representatives by clinical program as member of the Skin Integrity and Pressure Injury Steering Committee.	Percentage of inpatients with a Braden Scale risk assessment below target with a representative on Skin Integrity and Pressure Injury Steering Committee.	100% of inpatients that are below target with a representative on the Skin Integrity and PI Steering Committee by June 2026.	
									2. Monitor, identify & communicate Braden Assessment completion rates that are below target, while also identifying and sharing success factors of clinical programs that meet or exceed target compliance, to facilitate program level action-planning.	1. Work with Epic analytics team to revise Braden Scale assessment rate indicator to within 8 hrs. 2. Review and identify inpatients areas; that are below target. 3. Create a structured data collection assessment tool to be completed by unit leaders of the inpatient areas to assess challenges and barriers. 4. Through program quality councils, when completion percentage is below target in partnership with the inpatient area to develop at least 1 key action/interventions.	Number of inpatients areas with Braden Scale assessment completion rate on their quality boards.	75% of inpatient areas as Braden Scale compliance below target have Braden Scale assessment completion rate on their quality boards by Sept 30, 2026.	Partnership with Operational Excellence, Quality & Safety.
									3. Implement a corporate education strategy on the Braden Scale features in Epic.	1. Develop a standardized UHT education and resources on Braden Scale 2. Develop Braden Scale module in partnership with digital education	100% of new hires that completed Braden Scale module.	By June 2026, Braden Scale and Pressure Injury Prevention Care Plan is embedded in Corporate Nursing and IPP Orientation and/or education resources is available to clinical programs/units.	
									4. Standardize the use of Skin Metrics on Unity's Quality & Practice dashboard by clinical leaders, to enhance data access and monitoring.	1. Develop education and resources for clinical leaders on Skin Metrics located on the Unity Quality & Practice dashboard	By September 2026, an education session for clinical leaders at UHT on Skin Metrics is completed.	100% of identified clinical leaders attended Skin Metrics education session by September 2026.	
									5. Continue support in cascading organizational Pressure Injuries indicator on the QIP to program and local level monitoring and actioning through QMS implementation.	Operational Excellence team to continue providing support to programs in QMS implementation, facilitating the cascade of QIP pressure injuries indicator.	Number of units with Braden Scale assessment completion rate on their quality boards.	75% of units with Braden Scale assessment completion rate on their quality boards by Sept 30, 2026.	
		Percentage of High Skin Risk Patients with Pressure Injury Prevention Care Plan initiated and documented.	% / Inpatients (exclude. NICU, Pediatrics, ED non admitted, outpatient)	EPIC Unity Quality & Practice Dashboard / Q3 2025/2026	**35**	**85**	Target of Braden Scale Risk assessment and Pressure Injury Prevention Care Plan to be the same as risk assessment and interventions must occur together.		1. Ensure appropriate program level representation at the Pressure Injury Steering Committee.	The Skin Integrity and Pressure Injury Steering Committee to review membership representatives and identify appropriate representatives by clinical program as member of the Skin Integrity and Pressure Injury Steering Committee.	Percentage of inpatients with a pressure injury prevention care plan below target with a representative on Skin Integrity and Pressure Injury Steering Committee.	100% of inpatients that are below target with a representative on the Skin Integrity and PI Steering Committee by June 2026.	
									2. Monitor, identify & communicate Pressure Injury Care Plan completion rates that are below target, while also identifying and sharing success factors of clinical programs that meet or exceed target compliance, to facilitate program action-planning.	1. Work with Epic analytics team to review pressure injury prevention care plan indicator 2. Review and identify inpatients areas; that are below target. 3. Create a structured data collection assessment tool to be completed by unit leaders of the inpatient areas to assess challenges and barriers 4. Through program quality councils, when completion percentage is below target in partnership with the inpatient area to develop at least 1 key action/interventions.	Number of inpatients with pressure injury prevention care plan completion rate on their quality boards.	75% of inpatient areas as pressure injury prevention care plan below target have care plan completion rate on their quality boards by Sept 30, 2026	Partnership with Operational Excellence, Quality & Safety.
									3. Implement a corporate education strategy on the Pressure Injury Prevention Care Plan features in Epic.	1. Develop a standardized UHT education and resources on pressure injury prevention care plan. 2. Develop pressure injury prevention care plan module in partnership with digital education.	100% of new hires that completed pressure injury prevention module.	By June 2026, Braden Scale and Pressure Injury Prevention Care Plan is embedded in Corporate Nursing and IPP Orientation and/or education resources is available to clinical programs/units.	
									4. Standardize the use of Skin Metrics on Unity's Quality & Practice dashboard by clinical leaders, to enhance data access and monitoring.	Develop education and resources for clinical leaders on Skin Metrics located on the Unity Quality & Practice dashboard.	By September 2026, an education session for clinical leaders at UHT on Skin Metrics is completed.	100% of identified clinical leaders attended Skin Metrics education session by September 2026.	
									5. Continue support in cascading organizational Pressure Injuries indicators on the QIP to program and local level monitoring and actioning through QMS implementation.	Operational Excellence team to continue providing support to programs in QMS implementation, facilitating the cascade of QIP pressure injuries indicator.	Number of inpatient units with pressure injury prevention care plan completion rate on their quality boards.	75% of units with pressure injury prevention care plan completion rate on their quality boards by Sept 30, 2026.	
		Percentage of patients with a Fall Risk Screen completed within 8 hours of admission or transfer to inpatient units.	% / Adult inpatients and admitted ED patients	EPIC Quality and Practice Dashboard / January 1, 2025 - December 31, 2025	**43**	**75**	It is best practice to complete a Fall Risk Screen upon admission (Accreditation Canada 2026 Falls Prevention ROP). A 75% target aligns with our goal to meet best practices, while taking into consideration patient acuity and the reasonable amount of time required to complete the assessment and documentation.		1. The Falls Steering Committee will review the falls screening data to identify and flag clinical areas with completion rates less than 65% and collaborate with associated clinical program leaders to monitor progress and improvement strategies at local Quality Performance Councils.	1. The Falls Steering Committee will undergo a membership review to ensure clinical program representation that aligns with program Quality Performance Councils. 2. Prior to Q1, the Steering Committee will be made aware of the new QIP falls indicators and education will be given on new targets and strategies for fiscal year 2026/27. The Falls Steering Committee will regularly review program areas with fall screening data rates <65%. 3. Steering Committee representatives will report regularly at program-based Quality Performance Councils on performance relative to targets set, and discuss opportunities for improvements. 4. Good news stories regarding QI improvement will be spotlighted at Falls Steering Committee meetings during Q2 and Q4. 5. Effective improvement QI strategies will aim to be shared for scale and spread	1. Falls Screening Completion rates to be reviewed at least quarterly at Falls Steering Committee. 2. The number of presentations that are completed at Quality Performance Councils by Steering Committee members.	1. By Q1, 100% of clinical programs with completion rates of less than 65% will be contacted. 2. In Q2 100% of local Quality Performance Council presentations will commence. 3. Updates shared at the Steering Committee. 4. By Q3 100% of clinical programs with completion rates less than 65% will be engaged to identify supports needed and ideas for improvement.	Clinical Program Directors and Co-chairs of local Quality Performance Councils.
									2. A Falls Huddle Guidance Document will be created for use by local leaders at Huddles to guide discussion on falls, to raise awareness, actively engage front line staff and identify barriers to completion of falls screens and care plans.	1. Develop Falls prevention Guidance Document. 2. Provide education to unit leadership on use of the Guidance Document. 3. Generate endorsement and awareness of the Guidance Document at planned opportunities, e.g. the Leadership Exchange Series.	Completion of Falls Huddle Guidance Document and dissemination to all inpatient units.	1. The Falls Huddle Guidance Document will be completed by Q2. 2. All inpatient units will be offered the Fall Huddle Guidance Document to track Fall Screen and Care Plan utilization.	Clinical Leaders
		Percentage of patients identified as Fall Risk with a Fall care plan initiated and documented	% / Adult inpatients and admitted ED patients who are identified as a fall risk	EPIC Inpatient Leader Dashboard / January 1, 2025 - December 31, 2025	**5.2**	**40**	As of Feb 2026, UHT YTD Care Plan completion for patients who are identified as a risk for falls is 5.2%. However, with our planned improvement initiatives, it is hoped that we will reach a target of 40%, with aim to increase to a higher target year over year.		1. Clinical documentation of Falls prevention, including screening assessment results and care plans will be streamlined in EPIC to support more efficient workflows. This will be done through the creation of the Falls Navigator to support timely completion of falls risk assessment and care plan completion rates in one tool.	1. A subcommittee of the Falls Steering Committee will be launched to partner with the Digital team to optimize falls clinical documentation through the creation of a Falls Navigator. 2. Falls Care Plan completion and documentation data will be monitored corporately by local program leaders at Quality Performance Councils. 3. Performance Councils will identify barriers to target attainment and come up with local QI initiatives to address barriers to Care Plan completion and documentation.	Falls Clinical documentation Working Group launched by the beginning of Q2 2026.	By July 2026, The Falls Navigator will be completed in EPIC.	EPIC Analysts Clinical Program Leaders
									2. Implement a corporate education strategy to raise awareness on when and how to complete Fall Care Plans.	Develop UHT standard education and resources on Fall Risk Screening and Fall Prevention Care Plan to include education in new orientation material.	Number of new hires who complete falls risk assessment and fall prevention care plan modules.	1. 80% of staff on inpatient units will receive education by their Educator on the importance of Fall Care Plans and how they can be accessed. 2. By the end of Q2 100% of new hires will receive education on the Falls Navigator.	
		Rate of Vancomycin Resistant Enterococcus (VRE) – Nosocomial Colonization or Infection	Number of new cases per 1000 inpatient days / All inpatients	IPAC VRE surveillance data (internal) and patient days (Decision Support and EPIC) / January 1, 2025 - December 31, 2025	**SMH:0.75 SJHC: 0.97 PHC: 0.07**	**SMH:0.66 SJHC: 0.87 PHC: 0.07**	A target of 10% improvement across both acute sites is reasonable based on past performance. For PHC Our target is to maintain current performance given the very low rate of VRE at PHC.		1. Implement Shared Equipment Management policy and education (and align with accreditation activities).	1. Track Shared Equipment policy approvals 2. Assess employee awareness and understanding of policy 3. Track completion of equipment audits 4. Track educational efforts and accreditation efforts	1. Approval of policy 2. Equipment audit completion by clinical areas 3. Employee compliance rate with education and accreditation activities	1. Policy will be approved by April 1, 2026. 2. By March 31, 2027 75% of staff will have received education on the Shared Equipment policy 3. Equipment audits will be completed by clinical areas at all three sites by October 1, 2026 4. Successfully comply with Accreditation required organizational practice tests for compliance by October 1, 2026.	Exact accreditation activities to be determined.
									2. Body fluid management—this is the safe management of body fluids in clinical areas, including availability of required systems (e.g. macerators) and staff understanding of correct procedures.	1. Macerator downtime algorithm created, revised and posted (complete) 2. Process for Macerator function audits in place 3. Education on macerator use for staff on high risk units (complete)	1. Number of macerators assessed 2. Compliance of staff with education	1. 100% of macerators to be assessed on high risk units by June 30, 2026 2. 10% reduction in macerator down time by June 30, 2026. 3. 80% of staff in high risk areas complete education	
									3. Outbreak prevention plans — development and implementation of plans focused on preventing VRE outbreaks on high risk units, with strong collaboration between IPAC, clinical units and EVS, patient flow.	1. Implement and evaluate plans 2. Tracking and communication of VRE bioburden across high risk units, utilizing EPIC data functionalities 3. Regular check ins with high risk units to assess effectiveness of plans	1. CHG bathing for VRE positive patients on high risk units compliance reviewed quarterly 2. Weekly distribution of VRE bioburden data to IPAC team; to consider dissemination to clinical and flow teams, when relevant	1. 100% of high risk units have quarterly check-ins with IPAC, EVS, Patient Flow. 2. Chlorhexidine Gluconate bathing compliance is 80% or higher 3. VRE bioburden is shared weekly with IPAC team, clinical team, patient flow	
									4. Optimize environmental cleaning to mitigate transmission of VRE by ongoing education and exploring quality improvement opportunities.	1. IPAC training and certification for EVS staff on hire 2. Retraining of bed team 3. Develop collaborative QI approach between EVS and IPAC to improve room cleaning, as assessed by Glogerm audits 4. Expansion of learnings from Barret Centre for QI project	1. Continue Glogerm (environmental cleaning) audits and reporting in conjunction with EVS team 2. Monitor impact of BCQI work on Glogerm scores and attempt to expand key learnings 3. IPAC to attend EVS meetings regularly and find other links	1. Achieve Glo Germ audit compliance of 80% by March 2027 2. Create a QI approach in collaboration with EVS by April 30, 2026 3. Implement and evaluate QI strategies as determined above by September 2026	This improvement initiative requires extensive collaboration with our EVS colleagues and will be updated further after further discussion about methods, targets and measures have been held.
									5. Implementation of a multi-module IPAC training program and optimize delivery and tracking of IPAC training and certification on hire.	1. Implementation of a 7 module IPAC training program for all staff on high risk units 2. Track compliance with IPAC training 3. Key clinical staff receive training during orientation	Staff compliance with education, including casual/night staff	1. At least 80% of staff in high risk units receive training (all 7 modules) by July 1, 2026 (within 3 months). 2. At least 90% of staff in high risk units receive training (all 7 modules) by October 2026 (6 months)	
		Staff Hand Hygiene – Moment One	% / Healthcare workers and other clinical staff that enter patient rooms or provide patient care on any inpatient unit across all three hospital sites, or in the ED or dialysis units	Data is collected by IPAC's hand hygiene auditor across all three sites / January 1, 2025 - December 31, 2025	**SMH: 51 SJHC: 55 PHC: 78**	**SMH: 70 SJHC: 70 PHC: 80**	The target demonstrates a moderate but meaningful improvement from baseline. Recent data shows decreasing performance, so it will be necessary to initially reverse the downward trend.		1. Corporate Hand Hygiene Campaign – Hand hygiene will be promoted across UHT via a bi-annual corporate promotions campaign modelled on the annual flu vaccine campaign.	1. IPAC will monitor when each campaign is launched. 2. Staff feedback on the campaign will be assessed via an internal survey.	Proportion of healthcare workers that are aware of the campaign.	New corporate hand hygiene campaign launched by September 30, 2026.	1. Each initiative is intended to work synergistically with the others. The corporate campaign, by including messaging from senior leadership and by mirroring the tactics used during the flu campaign, will demonstrate to all staff that UHT leadership takes patient safety and hand hygiene improvement seriously. 2. The initiative will include posters in clinical areas, screen savers, announcements at town hall and other forums by senior leaders, and communications via social media and internal news sources.
									2. Unit-Based Quality Improvement - All inpatient units plus ED/dialysis will participate in a Unity-wide community of practice (COP), identify barriers to hand hygiene, develop a sustainable QI program, and set hand hygiene improvement targets.	Progress will be tracked based on the number of units participating in the COP, and the number of units moving through each stage of the unit-based improvement plan (i.e. identify barriers, develop a QI plan using PDSA methodology, implement the first PDSA cycle, revise plan based on assessment of results.	Proportion of units that complete each of the following steps: a. Develop a QI plan to improve hand hygiene c. Set a hand hygiene target d. Implement a PDSA cycle e. Adjust their plan based on data regarding its impact	1. All inpatient units, emergency departments and dialysis units have their monthly/quarterly hand hygiene performance reports posted on their unit quality boards by July 1 1, 2026. 2. All inpatient units, emergency departments and dialysis units set a unit based target to improve Moment 1 hand hygiene compliance by 10% by October 1, 2026.	1. Unit-based QI allows identification of local barriers to hand hygiene improvement and empowers and encourages front-line staff to be involved in QI. 2. Units will come online at the COP in a staggered fashion starting with highest risk units, and then fanning out to all units. 3. The COP will provide opportunities for common barriers to be identified and successful QI strategies shared.
									3. Pathway for Dispenser Assessment – IPAC will work with stakeholders to develop and implement process for maintaining access to functional hand sanitizer dispensers.	Progress will be measured based inclusion of process in relevant policy and implementation of process via managers and educators.	1. Proportion of clinical areas that have the procedure available. 2. Proportion of dispensers that are functional in hallways of inpatient units assessed quarterly by IPAC.	1. All managers and educators notified of new process by April 2026. 2. >90% of hand sanitizer dispensers in hallways of clinical areas are functional in by October 2026.	1. Empty and non-functional dispensers have already been identified as a barrier to effective hand hygiene across multiple units. 2. Ensuring dispensers are full and functional is a responsibility that is shared by clinical staff, EVS, ward clerks, unit leadership and engineering. 2. The development and rollout of an infographic demonstrating each groups' rolls in ensuring dispenser functionality is critical to achieving excellent and sustained performance with near 100% dispenser functionality.
									4. Audit and Feedback – IPAC will work with all units, unit leadership, senior leadership and communications to ensure that all levels of the organization are aware of current hand hygiene performance and key infection indicators.	Progress will be measured based on confirmation that hand hygiene performance reports are reaching unit and senior leadership, and that hand hygiene results are posted in timely manner on all units.	Proportion of units with the most recent hand hygiene results posted.	1. >90% of units with hand hygiene results posted by July 1, 2026. 2. >75% of units with the most up to date hand hygiene results posted by October 1, 2026.	1. To drive improvement, it is critical that all stakeholders are aware of the data. 2. Supportive messaging from senior leadership to unit leadership, and from unit leadership to staff, can drive improvement – particularly when the feedback recognizes top performance, units that are improving and units that have implemented novel and innovative QI programs.
Long-Term Care Sector													
Access and Flow	Timely	**Number of ED visits for long-term care residents.**	Number / LTC home residents	In house data collection / January 1, 2025 - December 31, 2025	**150**	**143**	The Houses of Providence current rate of ED transfers sits below the provincial average. The Houses set a goal for 2025-26 to reduce the overall number of ED transfers by 10% and based on performance from Q1-Q3 may achieve this goal. The Houses has committed to continue work on this priority indicator in order to sustain quality improvement initiatives from 2025-2026 and further improve our home's performance.	Unity Health Toronto - Nursing Led Outreach Team (NLOT), Palliative Care Nurse Specialists (CNS), Palliative Integrated Long Term Care (iLTC	1.Update decision tree for residents experiencing an acute change in condition.	1. Revise decision tree and policy on Acute Change in Condition to incorporate external providers. 2. Share with Physicians and provide education to registered staff. 3. Clinical Operation Leads (COL's) to re-implement audit tool – "Staff response to acute change in condition" for ED transfers and re admissions.	Track attendance on # of registered staff who attended educa	1. 60% of Registered staff attend education on new policy and decision tree by June 2026. 2. COL's to complete audit tool on one resident/week that has been transferred out to ED utilizing audit tool.	
									2. Digitize advance care planning form and provide staff education around facilitating goals of care (GOC) conversations.	1. Create digitized version of advance care planning form in PointClickCare. 2. Provide education to registered staff on form and process to facilitate GOC conversations at admission, with changes in condition and annually. 3. Engage Palliative Clinical Nurse Specialist in offering education to enhance registered staff's skill with facilitating GOC discussions with residents and families.	1. Digitize Advance care Planning form by May 2026. 2. Education sessions booked on policy and new process (at registered staff meeting) and with Palliative CNS.	Provide education to registered staff on: 1. Updated process/policy by July 2026 2. Facilitating GOC conversations with Palliative CNS by July 2026	Education provided by Palliative CNS on facilitating GOC conversations.
									3. Implement post-fall huddles.	1. Develop post-fall huddle interdisciplinary assessment in PCC 2. Develop prioritization matrix for occasions with multiple falls/shift 3. Create schedule for post-fall huddles 4. Trial on one floor 5. Provide staff education 6. Implement on all floors	1. Number of floors that have implemented post-fall huddles by July 2026. 2. % of falls that have an interdisciplinary post-fall huddle assessment completed.	1. Post fall huddles to be implemented on all floors by July 2026. 2. 70% of falls have an interdisciplinary post-fall huddle completed by December 2026.	
									4. Create protocol for management of tubes and IV's.	1. Conduct environmental scan of needed equipment including securement devices 2. Develop process to ensure all equipment is available on all shifts 3. Create nursing protocols for tubes/IV's including g-tube, foley catheters 4. Provide staff education on nursing protocols for securing and monitoring all tubes/lines each shift 5. Develop escalation protocols/procedures for when tubes are dislodged (G-tubes, Foleys and any other lines we care for)	1. Process developed by August 2026. 2. Education provided to registered staff on new protocol	Education on new protocol provided to registered staff by August 2026.	
Experience	Patient-Centered	**Percentage of residents who responded 'Always' to the survey question "Staff listen to me"**	% / LTC home residents	residents Quarterly / Annual resident experience surveys / Q4 (24-25) - Q3 (25-26)	**60**	**65**	The Houses is aiming for a 8% increase in the number of residents who respond "Always" to the question, "Staff listen to me".	Registered Nurses Association of Ontario (RNAO)	1. Enhance interdisciplinary collaboration and resident and family involvement during care conferences.	1. Engage resident and families in focus groups about care conference processes. 2. Engage with interdisciplinary team and Physicians about care conference processes. 3. Review and update Care Conference policy to reflect feedback. 4. Establish regular meeting times for each floor. 5. Develop agenda and email communication to send to resident/family. 6. Communicate updated process to staff at general staff meeting.	RN to track attendance for meetings as well as completion of discipline specific sections on the Care Conference assessment.	Interdisciplinary care conferences to be initiated by June 2026.	Also a recommendation of RNAO's Palliative Care Best Practice Guideline implementation.
									2. Partner with RNAO to implement People Centered Care Best Practice Guidelines (BPG)	1. Create expression of interest for People Centred Care project team. 2. Schedule date for gap analysis. 3. Complete implementation planning. 4. Prioritize one change idea to initiate from the gap analysis by December 2026.	1. Assemble project team by April 2026 2. Complete gap analysis by May 2026 3. Complete implementation planning by July 2026.	1. Have a complete implementation plan by July 2026. 2. Implement one recommendation from the gap analysis by December 2026.	Partner with RNAO.
									3. Implement noise and sensory reduction strategies (People Centered Care BPG).	1. Conduct focus groups with residents, families and staff about noise concerns and suggested implementations eg. quiet hours (e.g. after lunch and dinner) 2. Explore sensory minimizing strategies including availability of ear plugs, noise cancelling headphones, eye masks. 3. Work with Medical media to develop communication tools for units. 4. Provide staff education on noise reduction strategies as part of People Centred Care BPG.	# of education sessions offered per shift (minimum 2 per shift).	1. At least 2 focus groups with residents completed by June 2026. 2. 4 Education sessions on day and evening shift and 2 on night shift are completed by August 2026 on People Centred Care BPG and Houses' sensory reduction strategies.	Partner with RNAO.
Safety	Safe	**Number of newly acquired stage 2,3,4 unstageable and deep tissue pressure injuries (PI's).**	Number / LTC home residents	home residents In house data collection / January 1, 2025 - December 31, 2025	**37**	**33**	The Houses has been focusing on Pressure injuries for the last several years on the QIP. We will continue work on this indicator by focusing on the enhancement and sustainment of initiatives implemented in 2025-26. Our improvement target of an 11% decrease in total pressure injuries reflects baseline performance from the last two years (39 total in 2024 25 and 28 total from Q1-Q3, 2025 26) as well as the changing complexity of residents being admitted to long-term care (for example, 32% of residents admitted to the home in 2025 had a length of stay of less than one year).	Wound Clinical Nurse Specialist (CNS) Team (Unity Health Toronto)	1. Establish auditing process for completion of high risk prevention rounds.	1. Develop standard process for conducting weekly high risk prevention rounds (HRR), including checklist. 2. Establish process to conduct regular audits of HRR completion. 3. Establish process for auditing follow-up of recommendations from Interdisciplinary wound rounds. 4. Auditors to share feedback with Clinical Operations Leads for staff/units experiencing compliance issues	# of audits completed each month.	1. 9/9 units have audits completed at least once/month from April 2026 – March 2027. 2. 100% of recommendations made for residents reviewed in Interdisciplinary Wound Rounds are audited and actioned each month from April 2026 – March 2027	
									2. Promote continuous nursing education on the management and prevention of pressure injuries.	1. Provide education for all newly hired registered staff on Skin and Wound management. 2. Increase # of registered staff receiving refresher education who have not recently received specialized skin and wound education. 3. Develop HOP Community of Practice; add Skin and Wound management as regular agenda item on monthly registered staff meetings to enhance collaboration.	% of newly hired staff who have completed education with Wound CNS team.	1. 80% newly hired FT/PT RN's have attended education by March 31, 2027. 2. Register a minimum of 4 registered staff (not recently registered for training) for skin and wound education from April 2026 – March 2027. 3. Skin and Wound management added as regular agenda item for registered staff meetings by April 2026.	Education provided by Wound CNS team
									3. Ensure timely access to pressure injury prevention and management supplies.	1. COL's to conduct inventory of supplies needed for pressure injury management and prevention. 2. Collaborate with Wound CNS on prevention supplies for residents with contractures. 3. Skin and Wound Lead to conduct a scan of supply rooms on each unit. 4. Work with Clinical Co-lead to set up access to supplies for staff on the unit. 5. Clinical Co-Lead to conduct regular audits of supplies and work with Skin and Wound Lead on reordering bi-monthly.	1. Inventory created by May 2026. 2. Supply rooms cleaned out and set up by July 2026. 3. Process communicated to staff by July 2026.	Process developed and education/communication sent out to nursing department by July 2026.	Collaborate with Wound CNS on prevention supplies for residents with contractures
		Number of Residents without a Diagnosis of Psychosis who were given Antipsychotics.	Number / LTC home residents	In house data collection / January 1, 2025 - December 31, 2025	**56**	**45**	The Houses is aiming for a 20% reduction of 11 residents which is a realistic and meaningful improvement for 2026-27. This is also bringing our performance closer in alignment with best practice guidelines of 15% or less of the total resident population. Over the past few years, the Houses was consistently below the provincial average for this indicator, however recent increases in the number of residents on antipsychotics from 2024-25 warrants a focus on improvement efforts.	Psychogeriatric Resource Consultant (PRC) - Regional Geriatric Program (RGP), Behaviour Supports Ontario (BSO)	1. Facilitate a timely and interdisciplinary process for medication reviews utilizing the deprescribing algorithm.	1. MDS team to provide monthly list of residents receiving antipsychotics to Behaviour Support (BSO) Lead 2. BSO Lead to review list to track # of residents who receive antipsychotics without a diagnosis of psychosis 3. BSO Lead to review residents' behavior management including non-pharmalogical approaches 4. Develop schedule for interdisciplinary antipsychotic review with Physician, RN and BSO Lead 5. BSO Lead to facilitate monthly meetings of residents who may benefit from deprescribing. 6. Physician to connect with resident's Substitute Decision Maker (SDM) to discuss deprescribing initiative and BSO Lead to provide educational material.	1. # of residents per quarter that may benefit from deprescribing. 2. Monthly KPI's # of residents on antipsychotics without a diagnosis of psychosis.	1. Monthly medication reviews initiated by May 2026. 2. BSO lead identifies 4-5 residents per quarter for deprescribing initiative. 3. By March 31st, 2027, the Houses will have 40 or less residents on antipsychotics without a diagnosis of psychosis.	
									2. Increase registered staff's knowledge of deprescribing initiative and risks associated with antipsychotics.	Psychogeriatric Resource Consultants (PRC) to provide education to staff on deprescribing initiative, risks of antipsychotics and non-pharmalogical approaches to managing BPSD.	Track staff attendance at education sessions.	60% of registered staff attend education on deprescribing algorithm by July 2026 in-person or virtually.	Education provided by Psychogeriatric Resource Consultants / RGP.
									3. Increase number of staff who have completed Gentle Persuasive Approach (GPA) training.	1. BSO Lead to regularly schedule GPA training sessions 2. Register all newly hired staff, all staff working in secure dementia units, and increase percentage of staff not previously trained with GPA.	1. Track attendance at sessions. 2. Book 4 sessions by December 2026 on varied shifts; register minimum of 10 staff per session.	1. By December 2026, 100% of 4 East and newly hired staff have attended GPA training. 2. By December 2026, 4 sessions of GPA training have been scheduled with a minimum of 10 staff registered per session.	
									4. Enhance non-pharmacological behaviour support for residents undergoing deprescribing.	1. Upon referral from BSO Lead, Activation Assistant/Social Worker to assist resident/family to complete "My Personhood" summary page. 2. BSO Lead arranges team huddle including RA, registered staff, activation, SW, Spiritual Care, PRC, and/or BSOT. 3. RA/Activation trial out non-pharmacological strategies 4. RA to complete Dementia Observation System (DOS) for monitoring 5. Add to Behavior Rounds for review if needed.	Monitor resident's behaviours and outcomes using Dementia Observation System.	1. Interdisciplinary huddles initiated by April 2026. 2. By March 31st, 2027, the Houses will have 40 or less residents on antipsychotics without a diagnosis of psychosis per month.	