MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

F2025/26 Quality Improvement Plan (QIP)

Narrative

March 2025

Create Health. Build Community.

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2025/26 QIP Narrative

Overview

At Michael Garron Hospital (MGH), we care for people during the most significant and challenging moments in their lives: from welcoming a newborn to ensuring dignity at the end of life, and everything in between. We serve over 400,000 people in East Toronto, one of Canada's most diverse communities, as well across the city and throughout Ontario. We treat each person who comes through our doors like a neighbour; this is a commitment we've upheld for nearly 100 years.

We are proud to introduce our 2025-2035 Strategic Plan - a bold, impactful and forward-thinking vision that will shape the next decade of transformation at MGH. Our plan has been shaped by actively engaging diverse voices—patients, families and caregivers, healthcare providers, community organizations, health care leaders, our dedicated staff and credentialed clinicians.

In doing so, our strategic plan pillars and priorities reflect real-world experiences, challenges and insights from those that play a vital role in our future. Through their collective input with over 1,400 touchpoints, we have an exciting roadmap that will shape our commitment to those we serve. Striving to provide the highest quality care and our journey to eliminating preventable harm are centrally featured in this plan.

2025/26 QIP Narrative

Alongside the development of our new strategic plan, we collaborated with staff and patient partners over the past year to create a new seven-year Quality and Safety Strategy. Our ambitious goal: to become one of the safest hospitals in the country, ensuring that we always deliver excellent, high-quality and safe care to everyone we serve. Over the next seven years, our vision for quality and safety is to eliminate preventable harm and deliver the highest quality care, which will enable the best outcomes and experiences for our patients, families and teams.

This developing strategy serves as a key foundation for shaping MGH's Quality Improvement Plan (QIP) priorities and initiatives for 2025/26, focusing on the following objectives:

- Committing to a zero-harm high reliability organization journey
- Striving to deliver healthcare that recognizes and aims to eliminate health disparities
- Building a board to bedside culture of psychological safety
- Advancing quality and patient safety in partnership with patients and families
- Increasing our quality improvement science capacity and spread
- Having a data driven approach to quality & patient safety

The selected QIP indicators are aligned with the Ontario Health direction as well as internal quality and strategic priorities. Our priority dimensions for this year include

- Access & Flow
- Safety (both staff and patient safety)
- Experience
- Equity

Each year, MGH renews its Quality Improvement Plan (QIP) to reflect our shared quality commitments to patients and staff. The Plan highlights key areas of focus for targeted quality improvement activities, focusing on enhancing patient and staff experience, reducing harm and improving access to care when and where patients need it most. The following page shows a summary of the eight indicators selected for inclusion in the 2025/26 QIP.

QIP Indicators and Targets for 2025/26

Priority Areas	QIP Indicators	Baseline 24/25	Target	Target Justification
Access and Flow	1. 90th percentile emergency department (ED) non-admitted length of stay (high acuity)	8.1	7.9	3% moderate decrease
	2. 90th percentile ED wait time to inpatient bed	19.3	18.7	3% moderate decrease
Equity	3. Rate of staff and leaders completing mandatory foundations of sexual and gender diversity training	NA	80%	Same as target for cultural competency training
	4. Percentage of Adult Day Surgery and Adult Elective Surgical patients who have completed the Health Equity Questionnaire	17.4%	19.1%	10% increase with focused improvement efforts
Experience	5. Percentage of inpatient medicine and surgery patients reporting complete satisfaction with “Did patients feel they received adequate information about their health and their care at discharge?”	60.8%	63.8%	5% increase as previous year
Safety	6. WVP incidents resulting in lost time	12	11	8% decrease; equivalent to 1 incident
	7. Percentage of physical restraint events longer than 4 hours in the ED	TBD	TBD	Collecting Baseline
	8. Number of incidents reported per month	292	321	10% increase

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Access and Flow

MGH continues to prioritize access and flow optimization to improve patient care and operational efficiency amid growing patient volumes, an aging population and community healthcare resource shortages. For 2025, MGH has identified two key performance indicators: Emergency Department Non-Admitted Length of Stay (high acuity) and Time to Inpatient Bed. Success in these areas depends on strong interdisciplinary collaboration.

The Emergency Department will expand in 2025 to enhance efficiency, reduce congestion, improve patient experience and boost staff wellness. Specialized working groups, including a triage team, will address specific improvement areas and implement solutions. The ED will pilot innovative AI and technology solutions—such as AI scribes and automated web schedulers—to reduce administrative burdens and improve staff efficiency. Additional AI tools focused on enhancing patient experience will also be explored.

In 2025, MGH faces inpatient bed capacity challenges due to ongoing long-term redevelopment. ED wait time to inpatient bed has been selected as a key indicator because it reflects multiple operational elements, including Alternate Level of Care (ALC) throughput, Environmental Services efficiency and proactive transition care effectiveness. This comprehensive metric will help identify high-impact areas for process improvement. Specific initiatives include: Developing a portering dashboard; enhancing discharge planning through forecasting and improved Estimated Discharge Date processes; streamlining ALC processes with automated orders and education; improving staff performance through data-driven evaluations and training; and continuing Home First initiatives implementation.

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Equity and Indigenous Health

MGH has championed Equity, Diversity, Inclusion, and Belonging (EDIB) since the early 2000s. In 2020, the organization strengthened this commitment by establishing The MGH Inclusion Alliance to identify and address healthcare access inequities and barriers while promoting inclusion and safety. At MGH, equity and Anti-Oppression are viewed as shared responsibilities across hospital governance, staff and all stakeholders, requiring support and guidance from every leadership level. The organization continues to collaborate with and remain accountable to Indigenous advisors to enhance culturally appropriate care for First Nations, Inuit and Métis patients.

In partnership with the Inclusion Alliance and existing hospital working groups and sub-committees, MGH has launched and advanced several EDIB initiatives:

- Ongoing training and educational opportunities for staff and leadership to build foundational EDIB knowledge. For this year's QIP, the hospital will roll out sexual and gender diversity training to lay foundation for supporting the quality standards for gender-affirming care.
- Maintaining partnerships with Indigenous Elders and Knowledge Keepers to develop specialized care resources and offerings
- Publishing a monthly EDIB Bulletin that supports awareness, connection and community building through relevant resources, cultural/commemorative date announcements and educational content
- Working to increase both response rates and quality of the Health Equity Questionnaire in the Day/Elective Surgery (adult) program. This builds on the work from last year's QIP metric, to enhance health equity data collection at the hospital.
- Launching and enhancing Employee Resource Groups (ERGs) to support staff and credentialed clinicians in connecting around shared interests, identities, and experiences
- Incorporating EDIB-based practices into the Leadership Development Program

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Patient Experience

At MGH, we've established robust systems to gather and use patient experience feedback for continuous improvement. Our Patient Experience Survey, launched in 2023 across multiple departments, has provided valuable insights that directly inform our quality improvement initiatives. Monthly survey response dashboards are shared with leadership teams to guide targeted improvement efforts.

Looking ahead, we plan to expand our feedback collection by implementing a short-form survey for ambulatory and critical care areas, allowing us to capture more diverse patient perspectives. We anticipate incorporating Ontario Hospital Association benchmarking data to provide contextual comparisons and will analyze our survey results through an equity, diversity and inclusion lens to identify specific improvement opportunities. This year's QIP indicator carries over from last fiscal to focus on adequate information provision at discharge, and is in alignment with the guidance from Ontario Health.

Our Patient Experience Panel (PEP) is comprised of patient partners and serves as a critical advisory body for the organization. PEP members actively contribute to various hospital initiatives, including emergency preparedness protocols, disclosure policies, facility improvements and strategic planning. Their insights have already led to tangible improvements in patient-facing materials such as the Patient and Family Guide, MyChart functionality, and hospital webpages.

We're currently finalizing a toolkit for leaders on effective patient and family engagement, developed with PEP guidance, to strengthen this collaborative approach throughout the organization. In response to identified communication and transition challenges, we've partnered with our Bioethics department to adapt specialized tools that support staff in managing complex care situations, while also creating forums like Schwartz Rounds for open discussion about difficult care transitions.

Our equity-based reimbursement tool for lost belongings represents another concrete response to patient feedback. We're developing an evaluation plan to assess this tool's effectiveness and working to enhance processes for safeguarding patient belongings during hospital transitions.

By maintaining these feedback loops and collaborative partnerships with patients and families, MGH ensures that improvement initiatives directly address lived experiences and evolving patient needs.

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Provider Experience

We prioritize creating a healthy and supportive workplace for everyone in our MGH community by stabilizing our workforce, improving work-life balance, and providing growth and development opportunities for staff, leaders, and credentialed clinicians. Key initiatives include:

- Ongoing campus redevelopment with infrastructure improvements ensuring our staff have the necessary space, resources, and tools to deliver high-quality care to our patients and community.
- An Employee Referral Program that incentivizes current staff, physicians, and volunteers to refer talented candidates to key hospital roles identified by Human Resources, with referrers receiving monetary recognition.
- An annual Wellness Survey giving staff the opportunity to provide feedback on their physical, mental, financial, social, and career wellbeing, which directly informs our organization-wide wellness plan.
- Building foundational knowledge on workplace mental health through the *Essentials for Mental Health* learning modules, specifically designed to address stigma, promote psychological health and safety, and teach colleagues how to support those experiencing mental health challenges.

At MGH, we recognize our leadership team's crucial impact on workplace culture and have implemented programs ensuring leaders can create environments where teams perform at their best:

- Feedback mechanisms through our engagement survey and leadership 360 reviews ensure staff voices reach all leadership levels and receive appropriate attention.
- A newly enhanced Recruitment and Retention Dashboard gives management a comprehensive overview that helps identify trends in recruitment and retention within specific departments and across the entire hospital.

Safety

Our hospital is committed to nurturing a strong, inclusive patient safety culture through continuous improvement in incident reporting, data transparency and accountability at all levels. In alignment with Ontario Health's Never Events Hospital Reporting initiative and Healthcare Excellence Canada's Rethinking Patient Safety framework, we are enhancing our methods for collecting, analyzing and acting upon safety data to prevent harm and improve patient outcomes. The 25/26 year will be a transformative year for both patient and staff safety at MGH as we embark on our journey to high reliability.

A core focus of our Quality Improvement Plan is increasing patient safety incident reporting, especially near misses and good catches, while ensuring the reporting process remains efficient, meaningful and leads to concrete improvements. To accomplish this, we are optimizing our RL Data Systems incident reporting system by streamlining reporting fields, enabling staff to submit incidents more easily and quickly in real-time. We have added safety incident reporting as a QIP indicator with a stretch goal of improvement by 10% as we know that strong incident reporting is indicative of a positive safety culture.

We are deepening our approach beyond reporting by using data to drive safety improvements. We will deploy real-time dashboards and unit-specific reports, providing staff and leadership with transparent, actionable insights into patient safety trends, emerging risks and completed quality improvements. This ensures that every reported incident—regardless of severity—contributes to organization-wide learning and accountability.

We continue our focus on Workplace Violence Prevention (WVP) and will evolve our QIP indicator this year to number of WVP incidents with lost time. By connecting incident tracking with follow-up action plans and leadership oversight, we reinforce that every report catalyzes meaningful change. This approach builds trust in the reporting process, engages staff in safety initiatives and ensures sustained improvements in patient care throughout the hospital.

MGH is committed to minimizing restraint use while ensuring patient and staff safety. After successfully improving documentation standards on mental health units last year, we will now implement electronic charting for restraint events in the Emergency Department. This change will provide crucial baseline data to guide targeted improvements, and for the QIP we are tracking the percentage of physical restraints longer than 4 hours in the ED. Through better documentation and analysis, we aim to further reduce restraint use across the organization, strengthening our position as a least restraint institution.

Palliative care

Our organization is committed to delivering high-quality palliative care through a comprehensive, patient-centered approach. We have implemented key initiatives that align with the Quality Standard for Palliative Care recommendations, ensuring that patients receive timely, equitable and compassionate care.

We aim to enhance organizational readiness by integrating palliative care principles across all care settings. This includes early identification of patients who would benefit from palliative care using validated screening tools and embedding palliative care consults within primary and specialty care teams.

Our services include:

- An inpatient palliative care consult team available seven days per week, that receives around 800 consults per year
- An outpatient ambulatory palliative care clinic embedded in the Chronic Lung Disease and Oncology Clinics, which received approximately 100 consults last year
- Access to home-visiting palliative care physician
- The MGH Palliative Integrated Long Term Care Program, which aims to reduce unnecessary hospital admissions with palliative care consultation from a Clinical Nurse Specialist to East Toronto long term care homes
- A 22-bed inpatient palliative care unit serving patients in their last months of life.

One key focus is prioritizing palliative care competencies of our teams through continuous education and training. Our interdisciplinary teams participate in ongoing palliative care education. In 2024, we successfully provided:

- Leadership Essentials training to staff members on our palliative care unit and included a selected hospital-wide group
- MGH Palliative Care Basics Course to staff, volunteers and community members
- Our annual MGH Palliative Care Symposium, a full day conference that included staff and volunteers from across the GTA. The focus of our Symposium, *Palliative Care at Any Stage of Serious Illness,* highlighted our commitment to striving for earlier identification of patients who would benefit from palliative care.

MGH also serves as the host organization for the Palliative Clinical Coach role, which supports the implementation of the Palliative Health Service Delivery Framework for Adults in the community. This role collaborates with primary care, long-term care and other community teams to enhance early identification, facilitate goals-of-care discussions and integrate palliative care earlier in the patient journey, while also increasing awareness of and connection to MGH's palliative care resources across East Toronto.

By proactively addressing symptom needs and advance care planning, our organization ensures timely access to appropriate services and improve patient outcomes.

Population Health Approach

MGH is an anchor partner of East Toronto Health Partners (ETHP), the Ontario Health Team (OHT) serving East Toronto. Since our OHT launched five years ago, ETHP now has more than 100 health and social care partner organizations and individual patients, caregivers and community members working together to better integrate care and improve the health of the population we serve.

ETHP serves a population of approximately 400,000 people who live and/or receive care here. East Toronto includes 21 distinct neighbourhoods, including five designated Neighbourhood Improvement Areas which include: Flemingdon Park, Oakridge, Taylor-Massey, Thorncliffe Park and Victoria Village. These five neighbourhoods face specific challenges related to the social determinants of health that contribute to poorer health outcomes for residents, including lower socioeconomic status, lack of access to affordable housing, high proportion of newcomers and immigrants, and a higher proportion of patients who are uninsured and/or lack access to primary care.

To address the gap in health equity and improve the overall health of our population, MGH, East Toronto Family Practice Network, and other ETHP partners have launched or are working together on several integrated care initiatives. Examples include:

- Conducting an assessment of primary care in East Toronto to identify where we have gaps in access and planning for further investment in health access sites such as Health Access Thorncliffe Park and Health Access Taylor Massey
- Implementing integrated care pathways for chronic diseases, starting with heart failure and COPD, as well as investing in upstream support for health and wellness
- Expanding access for youth mental health supports as a partner in two youth mental health and wellness hubs
- Launching a new community health and wellness hub in Thorncliffe Park with several community organizations to offer a comprehensive range of health and social care services in one location in the heart of the neighbourhood
- Launching a new HART Hub with South Riverdale CHC, St Michael's Homes and several other partners to better support residents who are seeking treatment for issues related to substance use

MGH continues to make integrated care and health equity a priority focus of its strategy and is committed to working with our ETHP partners to improve population health across our diverse communities.

Emergency Department Return Visit Quality Program (EDRVQP)

Quality Priorities from 2023-2024 Audits: Status Update

Mental Health Services Enhancement The Emergency Department has prioritized improving safety, support, and quality of care for mental health patients through several key initiatives. A dedicated Mental Health Partnership has been established between Emergency Department and Mental Health teams. In July 2024, the Connections Clinic was launched, providing outpatient short-term follow-up care, which has processed 257 ED referrals as of March 2025.

Geriatric Care Improvements Geriatric care initiatives have focused on comprehensive stakeholder engagement, including hospital leadership, geriatric leaders across Canada, ED/geriatric physicians, and nursing/GEM leadership. Discussions have centered on geriatric emergency department accreditation, process improvements, and specialized equipment. Notably, 130 ED nurses have completed Gentle Persuasion Training, enhancing care capabilities for elderly patients.

Pediatric Care Advancements For the pediatric population, planning has been initiated to increase and standardize discharge vitals protocols, which remains in the planning phase.

Clinical Access Improvements The new Connections Clinic established in July 2024 provides rapid access to psychiatric services from ED referrals. Additionally, a Short-term Pediatric Clinic follow-up process has been implemented. Electronic referrals and appointment booking systems are now ready for implementation, ensuring clear follow-up procedures for patients requiring continued care.

Current Quality Priorities from 2024-2025 Audits

Nursing Standards Enhancement The department has developed a nursing education plan to improve ED Standards of Care, including vital signs monitoring, documentation, and expanded computerized provider order entry systems. The Time-to-ECG initiative involves ongoing audits and triage review to support expected standards.

Outpatient Follow-up Optimization Implementation of electronic referrals and appointment booking processes is underway for ENT, Hands, and Plastics specialties, addressing previously identified suboptimal follow-up procedures.

Enhanced Geriatric Services The Geriatric Emergency Management (GEM) team is being expanded to "GEM+" – a multidisciplinary unit including GEM nurses, occupational therapists, physical therapists, and pharmacists, with potential outpatient follow-up capabilities.

The Emergency Department remains committed to continuous quality improvement, with particular focus on vulnerable populations. Future reports will provide detailed outcome measures and patient experience data as emergency care delivery continues to be enhanced.

Executive Compensation

Our executives' at-risk compensation is impacted by the performance of our QIP, as follows:

President & CEO – maximum at-risk compensation is 15% of total annual salary. For QIP, 25% of at-risk compensation is tied to QIP performance.

Vice Presidents – maximum at-risk compensation is 10% of total annual salary. For QIP, 25% of at-risk compensation is tied to QIP performance.

Chief Officers - maximum at-risk compensation is 15% of total annual salary. For QIP, 25% of at-risk compensation is tied to QIP performance.

The 25% of variable compensation tied to our QIP will be paid out according to the proportion of QIP targets that have been achieved, as set out in the table below.

Ratio of QIP Targets Achieved:	<50%	50%	75%	100%
Proportion of 25% variable compensation paid:	0%	50%	75%	100%

Sign-off

I have reviewed and approved our organization's Quality Improvement Plan

Board Chair: Catriona Read  (signature)

Board Quality Committee Chair: Leah Myers 
(signature)

Chief Executive Officer: Melanie Kohn  (signature)

Contact Information

Laura Oxenham-Murphy

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Michael Garron Hospital

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TORONTO EAST HEALTH NETWORK

F2025/26 Quality Improvement Plan (QIP) Workplan

March 2025

Our Vision

Great care inspired by community

QIP Indicators and Targets for 2025/26

Priority Areas	QIP Indicators	Baseline 24/25	Target	Target Justification
Access and Flow	1. 90th percentile emergency department (ED) non-admitted length of stay (high acuity)	8.1	7.9	3% moderate decrease
	2. 90th percentile ED wait time to inpatient bed	19.3	18.7	3% moderate decrease
Equity	3. Rate of staff and leaders completing mandatory training for Foundations of Sexual and Gender Diversity	NA	80%	Same as target for cultural competency training
	4. Percentage of Adult Day Surgery and Adult Elective Surgical patients who have completed the Health Equity Questionnaire	17.4%	19.1%	10% increase with focused improvement efforts
Experience	5. Percentage of inpatient medicine and surgery patients reporting complete satisfaction with “Did patients feel they received adequate information about their health and their care at discharge?”	60.8%	63.8%	5% increase; same as previous year
Safety	6. WVP incidents resulting in lost time	12	11	8% decrease
	7. % physical restraint events longer than 4 hours in the ED	CB	CB	Collecting baseline (CB)
	8. Number of patient safety incidents reported per month	292	321	10% increase

2025/26 QIP Work Plan | ED Non-Admitted Length of Stay

Indicator	Unit of measure / Patient population	Data Source / Period	Baseline	Target for 2025/26	Target Justification
90th Percentile Emergency Department Non-Admitted Length of Stay (High Acuity)	**Unit of Measure** Hours from patient arrival to Left ED **Patient Population** Non admitted patients with CTAS 1-3	**Data Source** OH ED P4R Ranking Report **Reporting Period** Dec 2024 to Nov 2025 (P4R cycle)	8.1	7.9	The target of 7.9 hours represents a 3% decrease and was selected considering anticipated increases in volumes, acuity, FY 24/25 flow observations, and prior annual performance.

#	Change Idea	Methods	Measure	Target
1	Flow Optimization	• Deploy new ED zone to reduce congestion and improve flow • 6S supply room transformation *Expediate care delivery* • Triage: Working group change initiatives; forecasted eCTAS CCO upgrade • Revisit MD schedules to better align with expected demand • Reduce avoidable visits and admissions – accelerate OHT outcomes, GEM+ • Consult Turnaround Time (TAT) improvements/updated MRP policy	• % reduction under-triage CTAS 1 and 2 • PIA • Consult order to Consult Request • GEM+ target 20% admission rate	• Maintain or improve
2	Improve DI and Lab TAT	• Better synchronize resourcing with demand • Implement *Choosing Wisely* best practices to reduce avoidable tests	• DI TAT • # of DI tests performed • Lab TAT	• Maintain or improve
3	IT and Innovation	• Advance CPOE digitization roadmap to percentage completion • Digital enablement: Implement Web Scheduler for RN scheduling gains, test and implement AI Scribe, AI Bot, ED wait at home	• % project completion • % TAT reduction pre-post implementation	• 100% digital projects complete

2025/26 QIP Work Plan | Time to In-Patient Bed (1/2)

Indicator	Unit of measure / Patient population	Data Source / Period	Baseline	Target for 2025/26	Target Justification
90th Percentile ED Wait Time to Inpatient Bed	**Unit of Measure** Hours **Patient Population** All patients admitted from ED	**Data Source** National Ambulatory Care Reporting System **Reporting Period** Dec 2024 to Nov 2025 (P4R cycle)	19.3	18.7	A 3% improvement is recommended, considering upcoming ED changes and hospital-wide redevelopment resulting in an estimated loss of 30 inpatient beds.

#	Change Idea	Methods	Measure	Target
1	Teletracking (EVS)	1. Develop portering dashboard for monthly review by EVS supervisors. 2. Develop staff performance evaluation tool that incorporates multiple indicators, such as productive hours and number of completed tasks. 3. Generate monthly reports for bedtracking and portering to track progress and compare performance.	1. Date of implementation 2. % of job rejection 3. Monthly reports	1. Q1 2. 10% decrease in job rejection 3. 1 report per month for bed tracking and 1 report per month for portering
2	EDD (IP)	1. Explore new strategies to improve the % of Estimated Discharge Date (EDD) entries within 2 business days of admission. 2. Implement discharge forecasting model in Medicine department	1. % EDD entries through audits 2. Implement and improve	1. 80% of EDD entries within 2 business days 2. Implement forecast model in Q1

2025/26 QIP Work Plan | Time to In-Patient Bed (2/2)

Indicator	Unit of measure / Patient population	Data Source / Period	Baseline	Target for 2025/26	Target Justification
90th Percentile ED Wait Time to Inpatient Bed	**Unit of Measure** Hours **Patient Population** All patients admitted from ED	**Data Source** OH ED P4R Ranking Report **Reporting Period** Dec 2024 to Nov 2025 (P4R cycle)	19.3	18.7	A 3% improvement is recommended, considering upcoming ED changes and hospital-wide redevelopment resulting in an estimated loss of 30 inpatient beds.

#	Change Idea	Methods	Measure	Target
3	Admission and discharge process: Enhance discharge documentation (IP); streamline admission to mental health & Pediatric units	1. Provide education and refresher to staff on the best practice to complete patient discharge in Cerner within 30 minutes of patient's physical departure from the building, and timely documentation on Teletracking about possible and confirmed discharges. 2. Streamline the admission process from ED to mental health and pediatric.	1. Manual audits; TeleTracking found bed availability data 2. Create streamlined workflow	1. 30 mins (manual audit) 2. 10% reduction in found beds 3. 10% reduction in dirty beds entries in Teletracking after 7pm (depending on shift schedule)
4	Proactive transition (transition, flow, IP)	• Implement automated ALC orders for Kew Beach to improve order accuracy • Continue to provide education/refresher to physicians (include CCC physicians), PA, and TN on the proper use of ALC order and Home first process. • Continue to monitor and improve weekend discharge team • Increase care coordinator attendance at rounds. • Continue to implement, improve and monitor Home first initiatives.	• Manual audit • ALC tracker tool • # of ALC patients • Weekend discharge rate • Attendance tracker	Implement, monitor and improve 80% completion of education/refresher Target average 15% cumulative weekend discharge rate

2025/26 QIP Work Plan | Equity, Diversity, Inclusion & Belonging (EDIB)

Indicator	Unit of measure / Patient population	Data Source / Period	Baseline	Target for 2025/26	Target Justification
Rate of staff and leaders completing training for Foundations of Sexual and Gender Diversity	**Unit of Measure** Completion Rate **Patient Population** All staff and leaders	**Data Source** Hospital Learning Management System (iLearn) **Reporting Period** April 2025 – March 2026	(new metric, not available)	80%	• Typical overall completion rate for mandatory learning modules • Same target from last year's mandatory EDIB training

#	Change Idea	Methods	Measure	Target
1	Develop Foundations of Sexual and Gender Diversity training	1. Create an iLearn training that examines foundational knowledge about sexual and gender diversity including definitions, Human Rights Codes, and best practices for providing affirming care	Milestone Dates	1. March 2025-April 2025
2	Measure completion rate of all credentialed clinicians	1. Include Foundations of Sexual and Gender diversity training into 2026 Credentialed Clinician Mandatory Credentialing Curriculum 2. Review completion rate of Foundations of Sexual and Gender Diversity training by credentialed clinicians at end of Credentialed Clinician Mandatory Credentialing Curriculum time period	Milestone Dates	1. January 2026 2. March 2026
3	Measure completion rate of all new MGH hires with a start date within the reporting period	1. Include Foundations of Sexual and Gender Diversity training into New Hire Training Curriculum 2. Configure iLearn Administrative dashboard to include monthly completion rate of foundations of sexual and gender diversity training 3. Review completion rate of mandatory Foundations of Sexual and Gender Diversity training by all new hires on a monthly basis throughout reporting period	Milestone Dates	1. April 2025 2. April 2025 3. April 2025-March 2026
4	Launch Foundations of Sexual and Gender Diversity training for leaders	1. Review completion rate of Foundations of Sexual and Gender Diversity for leaders training on a quarterly basis throughout reporting period	Milestone Dates	1. April 2025-March 2026

2025/26 QIP Work Plan | Equity, Diversity, Inclusion & Belonging (EDIB)

Indicator	Unit of measure / Patient population	Data Source / Period	Baseline	Target for 2025/26	Target Justification
Rate of Adult Day Surgery and Adult Elective Surgical Patients completing the Health Equity Questionnaire	**Unit of Measure** Completion Rate **Patient Population** Adult Day Surgery Patients and Adult Elective Surgical Patients	**Data Source** Health Equity Questionnaire **Reporting Period** April 2025 – March 2026	17.4	19.1	10% improvement from last year's baseline rates

#	Change Idea	Methods	Measure	Target
1	Engage Emerging Leaders Program members in developing best practice recommendations	1. ELPs conduct environmental scan/literature review of best practices for increasing HE questionnaire response rates and enhance quality of responses 2. Develop recommendations to implement to the HE QIP	Milestone Dates	1. April-June 2025 2. June-July 2025
2	Use new HE questionnaire	1. According to OH, a revised HE questionnaire will become available for use. This version has undergone vigorous consultation to update	Milestone Dates	1. May 2025-March 2026
3	Distribution of HE questionnaire	1. In addition to including the HE questionnaire in the surgery information package prior to procedure, distribute the questionnaire at various time points in the patient's journey	Milestone Dates	1. April-December 2025
4	Engage key stakeholders	1. Participate in discussions with patients, staff, and departments outside of day/elective surgery to identify best practices for survey competition	Milestone Dates	1. April-October 2025

2025/26 QIP Work Plan | Patient Satisfaction

Indicator	Unit of measure / Patient population	Data Source / Period	Baseline	Target for 2025/26	Target Justification
Percent of top box responses ("Completely") to the 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?"	**Unit of Measure** Percent **Patient Population** Survey respondents discharged from medicine, surgery and CIU units.	**Data Source** Qualtrics XM **Reporting Period** April 2025 to March 2026	60.8%	63.8%	Increase of 5% from last year's baseline; similar to last year's target calculation.

#	Change Idea	Methods	Measure	Target
1	Continue to implement PODS (Patient Oriented Discharge Summary) Framework	1. Finalize guideline that outlines how to develop, validate and review PODS. 2. Collaborate with PEP and leadership to expand the development of PODS in more clinical areas. 3. Assess the use and implementation of the PODS in care areas where PODS has been developed.	1. Guideline finalized 2. % of clinical areas that have implemented PODS 3. Assessment plan created	1. June 2025 2. 60% of clinical areas 3. December 2025
2	Improve collaboration with patients and care partners, and support readiness to transition by incorporating RNAO Transitions in Care Best Practice Guideline	1. Conduct thematic analysis of complaints received in the Patient Experience Office regarding transitions. 2. Review RNAO guideline in a PEP meeting to receive input from members on expectations and how to best collaborate with patients on implementing the guideline. 3. Work closely with clinical leadership, Ontario Health at Home and other community care partners to ensure that a written service plan, including a contact name and phone number, is provided and reviewed with patients who have complex care needs prior to leaving the hospital.	1. Analysis completed 2. Received input from PEP members 3. % of discharging patients with complex needs who receive and review a written summary of service plan	1. June 2025 2. September 2025 3. 80%
3	Apply an equity lens on patient experience data	1. Continue to work with Decision Support on analyzing patient experience data by demographic to identify opportunities to improve equitable care, including Patient Experience Survey responses and feedback received through the Patient Experience Office. 2. Explore survey options for non-English speaking patients.	1. Complete analysis 2. Number of surveys available in non-English languages	1. December 2025 2. 2 or more language options

2025/26 QIP Work Plan | Workplace Violence Prevention

Indicator	Unit of measure / Patient population	Data Source / Period	Baseline	Target for 2025/26	Target Justification
Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) with lost time within a 12 month period.	**Unit of Measure** Count **Patient Population** All patient care units	**Data Source** Hospital collected data **Reporting Period** Apr 2025 to Mar 2026	12	11	8% decrease in workplace violence incidents with lost time. This is equivalent to a decrease in one incident of workplace violence with lost time.

#	Change Idea	Methods	Measure	Target
1	Simplify the incident reporting process to support and encourage reporting of workplace violence incidents	• Optimize the hospital's incident reporting system by streamlining the reporting fields and ensuring only essential information is required for submission of workplace violence incidents.	• Completion date	• Q4
2	Implement methods to reinforce workers in feeling safe, prepared and supported in their work environment	• Improve physical environment/infrastructure i.e. ED Green Zone team station enclosure, addition of code white, silent alarm buttons • Improve security measures in the emergency department i.e. active screening of patients entering the department, implementation of security body cameras • Continue to provide in-person workplace violence prevention training to staff in high-risk areas (as per policy)	• Completion date • # of WPV incident reports, # of weapons identified % increase in staff attendance in WVP Training Workshop	• Q3 • TBD • 15% increase in attendance over previous fiscal year
3	Code White Committee to enhance code white response	• Implement a Code White Committee that meets with regular cadence to review all code white incidents, identifying patterns and areas for improvement, use the findings to update training, policies, and procedures for enhanced workplace violence prevention.	• Committee implementation completion date • % of code white events reviewed	• Q1 • TBD
4	Behavioural Care Plan Alert System for patient and worker safety	1. Launch a behavioural care plan in Powerchart 2. Train staff across the organization on the use of the behavioural care plan alerts (i.e. violence assessment tool and visual cues), how to create, follow, review and communicate an individualized behavioural care plan	• Completion date • # of staff that have received training	• Q2 implementation • 70% staff trained

2025/26 QIP Work Plan | Restraints

Indicator	Unit of measure / Patient population	Data Source / Period	Baseline	Target for 2025/26	Target Justification
% of physical restraints events longer than 4 hours in the ED	**Unit of Measure** Percent **Patient Population** ED patients with restraint orders	Paper chart April 2025-June 2025 Electronic chart June 2025-March 2026	Collecting baseline	Collecting baseline	New indicator, collecting baseline through electronic orders in ED

#	Change Idea	Methods	Measure	Target
1	Digitize Restraint order process in the ED	• Establish clarity of the current workflow for Physicians ordering Restraints in the ED • Build workplan to implement electronic orders • Create documentation workflow for nursing after the order is placed • Develop training and education curriculum • Roll-out training and education to the ED	• Process map for workflow of Physician orders for Restraints (current state & future state) • Workplan should include "go-live" date for electronic orders	• All Physicians in ED ordering Restraints in electronic chart by August 2025 • All subsequent documentation regarding restraints is recorded in the electronic chart by August 2025
2	Restraint committee and policy	• Develop Project Charter and Terms of Reference • Update restraints policy with evidence-based practices	• Project charter aim measurements • Policy to include procedures for different clinical areas utilizing restraints	• Updated Restraint Policy and Procedures in PolicyTech • # of evidence-based practices incorporated into policy
3	Implement TIDES training for Trauma – informed care	• Identify high risk areas and staff working in those areas for TIDES training • Develop mandatory training and education requirements as it relates to TIDES curriculum for high-risk areas • Track attendance and involve leaders of the high-risk areas to follow up with employees who require this training	• Evaluation reports provided by TIDES team based on staff satisfaction • # of staff attending training and education sessions	• 80% of staff satisfaction • 80% staff trained

2025/26 QIP Work Plan | Incident reporting

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Indicator	Unit of measure / Patient population	Data Source / Period	Baseline	Target for 2025/26	Target Justification
# of patient incidents, particularly near miss/good catch events, reported per month	# patient safety incidents	**Data Source** Hospital incident reporting system, RL **Reporting Period** Apr 2025 to Mar 2026	292	321	• 10% improvement from baseline

#	Change Idea	Methods	Measure	Target
1	Simplify and promote a user-friendly reporting process	• Conduct a workflow analysis to understand current pain points in the RL reporting process. Gather staff feedback on barriers to timely and accurate reporting. • Streamline reporting fields by ensuring only essential information is required, reducing unnecessary or redundant fields. • Introduce pre-populated drop-down menus and structured categories to improve consistency and reduce free-text entry where possible. • Encourage the "quick submit" feature where initial reports can be submitted with minimal details, allowing follow-up documentation later if needed. • Reinforce the importance of real-time, in-shift reporting through unit-based education sessions and staff engagement efforts.	• Measure the time to complete an incident report before vs. After optimization • Conduct post implementation surveys for staff to understand the percentages of staff who find the reporting process easy to use and feasible to complete on shift	• Reduce reporting time by at least 50% while maintaining accuracy and completeness • Increase the number of near miss and good catch reports by 20% within 6 months post-implementation
2	Utilize RL Data Systems for Unit Specific Dashboards and Action Tracking	• Develop unit and program specific patient safety dashboards within RL Data Systems that can summarize the number and type of incidents reported per unit/program, trends over time (i.e., safety trends, recurring issues), key themes and top safety concerns, status of action items and improvements implemented • Implement a standardized reporting structure where safety reports/dashboards are presented regularly at quality meetings, staff huddles, and leadership rounds to ensure visibility and accountability • Ensure documented action items are assigned to leadership or unit-based teams within RL and are integrated into follow up discussions to drive improvement	• Number of units using RL-based dashboards to track and discuss patient safety data • % of serious safety incidents with documented action plans • % action items completed within the target timeframe	• At least 50% of units have active patient safety dashboards within the first 6 months • 100% of serious safety events have assigned and tracked action items
3	Introduce and sustain an Executive Safety Walk Structure	• Identify process, script and schedule for executive safety walks • Train executives to support comfort with process • Schedule quarterly debriefs to discuss collective learnings and mitigations.	• % of units visited • # executives conducting at least 10 safety walks per year • % increase in incident reports from champion-led vs non-champion led units within the first 6 months of implementation	• Target is one executive safety walk per executive per month

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F2024/25 Quality Improvement Plan (QIP)

Progress Report

March 2025

Create Health. Build Community.

Table of Contents

The following pages contain a year-end progress report for each of the improvement initiatives we launched as our 2024/25 QIP. Progress reports address achievement of targets and highlight achievements and challenges.

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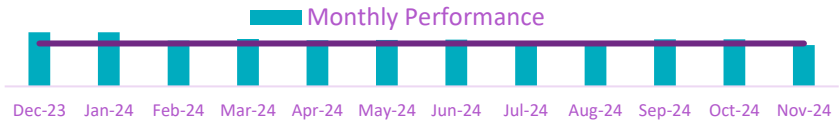
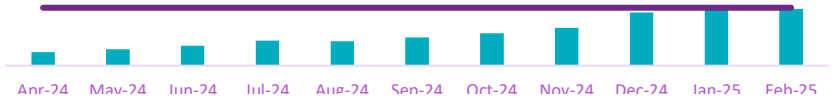
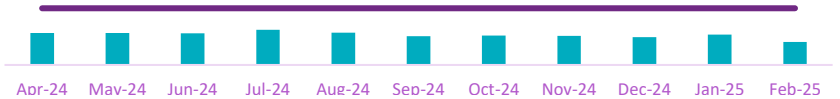
Quality Improvement Plan (QIP) Dashboard

Current as of March 28 2025

		Baseline	Target	YTD	Target
ED Admitted Length of Stay 90th Percentile Emergency Department Admitted Length of Stay *Note: Reporting is from Dec 23-Nov 24*		28.6	≤26.8	29.1 (DEC-NOV 24)	🔴
ALC Throughput ALC throughput rate *Note: Reporting is from Apr 24-Mar 25.*		1.03	>1.00	0.98 (APR-JAN 25)	🟡
EDIB: Improve Cultural Competency through Training Rate of staff and leaders completing mandatory cultural competency training		N/A (new metric)	≥ 80%	87% (APR-FEB)	🟢
EDIB: Improve Day Surgery Health Equity Questionnaire Rates Rate of Day Surgery Patients (adults) completing the Health Equity Questionnaire		22%	≥ 32%	17.0% (APR-FEB)	🔴
Patient Satisfaction % of top box responses (“Completely”) to the 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”? All survey respondents discharged from MED & SUR.		60.2%	≥63.3%	62.65% (APR-FEB)	🟡
Workplace Violence and Prevention Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12-month period. *Note: Reporting is from Jan 24-Dec 24*		17.1	≥18 /month ≥216 /year	19.17 /MONTH 230/year (JAN-DEC 24)	🟢
Restraint Use in Inpatient Mental Health Services % restraint events in inpatient mental health that have been audited by leadership within 72 hours.		N/A	≥90%	91.5% (APR-FEB)	🟢

Legend: Achieved | Close to Target | Not Achieved

2024/25 QIP Progress Report | ED Admitted Length of Stay (1/2)

Reduce Emergency Department wait times

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QIP Indicator	Baseline	Target	Current Perf	Comments
90th Percentile Emergency Department Admitted Length of Stay	28.6	≤ 26.8	29.1 (Dec 2023 – Nov 2024)	The 24/25 MGH ED Admitted LOS did not reach the target of ≤ 26.8 despite implementing all change ideas. MGH's ED faces unprecedented growth in patient volumes. Population pressures are compounded by an aging population and a shortage of community healthcare resources. IP bed capacity pressure continues to be a challenge. The team will continue to take a collaborative approach to improve flow in addition to exploring and piloting new technology tools to improve efficiency.

Change Idea	Implemented as intended? (Yes/No)	Accomplishments & Lessons Learned	Details on strategies to reach target in the future
Improved use of Teletracking	Yes	To improve bed management and patient flow, a Teletracking dashboard was developed in November 2024 and implemented in December 2024 using Power BI. Automation was prioritized, enabling EVS supervisors to easily update the dashboard monthly with minimal training. The dashboard delivers valuable hourly data on bed cleaning demand for each unit. It also tracks key staff performance indicators, including average queue time and average clean time. As a result, leadership has gained a powerful tool for staffing and scheduling optimization, leading to improved staff performance.	With the implementation of bed tracking in December 2024, we anticipate seeing improvements like reduced queue times for bed clean in the coming months. Monthly reports will be generated to track progress and compare performance. A portering dashboard is also currently in development.
Flow Optimization	Yes	**GEM+**: GEM+ consists of a multidisciplinary team (nurses, IPP) connecting elderly patients with appropriate services (pharmacy, OT, PT) to reduce avoidable admissions. The pilot has seen promising results so far, with the admission rate for patients seen by GEM+ lower than the average admission rate for this patient population **Triage Optimization:** New pathways ensuring that our CTAS scores are reflective of the acute presentations in the ED. A triage working group has also been initiated **Physician On-Call trigger:** Digitization of the On-Call Physician Form **Wait Time Clock:** Implement ED wait time clocks. In Dec 2024, the design was reviewed with the Patient Experience Panel for further feedback and iteration **Simulations, Debriefs, Rounds:** Investments in RN staff training and simulation **Minor Zone Booked Appointments:** Spread and sustainability of ED online booking functionality **Introduced AI Scribe:** Anecdotally, AI scribe results in 15% physician workflow efficiency gains through streamlining clinical documentation generation and information capture **Direct to MH zone:** Triage patients to appropriate zone, resulting in quicker assessment and improved patient safety **Increase Capacity for Admitted Patients:** Leverage temporary space adjacent to ED to increase bed capacity for admitted patients	- Expand ED footprint to improve efficiency, patient experience, and staff wellness - Tech enablement and innovation - Extend successful pilots (i.e., GEM+) - Supply chain optimization - Triage scoring optimization - Security services (detection enhancements)

2024/25 QIP Progress Report | ED Admitted Length of Stay (2/2)

Reduce Emergency Department wait times

QIP Indicator	Baseline	Target	Current Perf	Comments
90th Percentile Emergency Department Admitted Length of Stay)	28.6	≤ 26.8	29.1 (Dec 2023 – Nov 2024)	The 24/25 MGH ED Admitted LOS did not reach the target of ≤ 26.8. MGH's ED faces unprecedented growth in patient volumes. Population pressures are compounded by an aging population and a shortage of community healthcare resources. IP bed capacity pressure continues to be a challenge. The team will continue to take a collaborative approach to improve flow and explore and pilot new technology tools to improve efficiency.

Change Idea	Implemented as intended? (Yes/No)	Accomplishments & Lessons Learned	Details on strategies to reach target in the future
Consult Process Review	Yes	**MRP policy update:** Consultations not resulting in admission or discharge can be left without an MRP for an extended time. A data analysis along with an environmental scan were conducted and a revised ED MRP policy was drafted based on the findings. The policy includes a process map, roles and responsibilities, and TAT guidelines **Direct crisis referral from triage:** Exploratory work has started	- Pilot the new proposed policy - Explore regular reporting to track consult TAT metrics
Improving ED Lab Turnaround Time	Yes	**Equipment update:** Analyzer enhancement to reduce lab TAT **Reduce TAT for add-ons:** New chemistry automation system was implemented, which contributed to reduced turnaround time of testing as well as reducing sample retrieval time	- Improve hemolysis rates for ED patients
Improving Diagnostic Imaging Wait Times (CT TAT)	Yes	**DI Aide pilot:** Introduce a DI Aide to improve the flow of patients to and from Xray to improve efficiency, patient experience, and quality. The pilot showed Xray TAT decreased by 16.2%. Qualitative feedback from staff was also positive. **Discharge Limiting DI Orders:** Specific orders created to expedite discharges	- Establish a multi-disciplinary DI working group - Better synchronize resourcing with demand - Explore outpatient appointment flow

2024/25 QIP Progress Report | ALC Throughput (1/2)

Reduce Emergency Department wait times

QIP Indicator	Baseline	Target	Current Perf	Comments
ALC throughput rate	1.03	>1	0.98	The 24/25 ALC metric did not reach the target of 1.00 despite implementing all change ideas. Shortage of community resources continues to present challenges for transition capacity.

Change Idea	Implemented as intended? (Yes/No)	Accomplishments & Lessons Learned	Details on strategies to reach target in the future
Proactive Transitions #8	Yes	- Weekend discharge team: Inpatient Weekend discharge team was deployed since May 2024. An evaluation of weekend discharge team from May 2024 to November 2024 has shown a significant increase on the number of patients being discharged before Monday. With volume adjusted, an estimated 350 additional patients (approx. 244,000CAD assuming only one bed day saved per patient discharged on the weekend) were discharged during the pilot project period indicated above. - ED Gem+ team has seen 583 patients (with 91% of them being 65+) since implementation period from October 2025 to Jan 2025, with only 24% admission rate. During the implementation period, the Gem+ team which consists of PT, OT and pharmacy, has proved to be very effective preventing unnecessary admission, heling with ALC diversion and home communities' involvement. - Updating surge policy: Updated hospital Surge Alert Policy with detailed responsibilities listed for each unit leadership (supervisor, manager, and director). The new policy was launched in November 2024. Surge threshold was refreshed based on recent year's volume. Some surge items are effective in helping ALC such as ad-hoc ALC meetings to identify barrier.	Weekend discharge team: As of Feb 2025, we are short 1 PA and are actively working to fill the position. Gem+ & Surge policy: change idea implemented, continue to monitor its effectiveness and implement further improvements as needed.

2024/25 QIP Progress Report | ALC Throughput (2/2)

Change Idea	Implemented as intended? (Yes/No)	Accomplishments & Lessons Learned	Details on strategies to reach target in the future
When to recommend an ALC designation	Yes	GIM and PA staff received refresher training on ALC orders and the importance of accurate ALC destination information. An automated ALC order process is under development for patients transferred to Kew Beach to further improve accuracy. TN also received refresher/training on ALC orders on modifying the orders and patient communications and engagements.	Further refresher is required for the rest of the physicians; auto ALC order will be implemented for Kew beach, which should help with ALC accuracy in the long term. No major error has been seen in the past year. We continue to do chart audits and track ALC patient volume and destinations. Decision support provides weekly report on ALC patient waiting for placement by destination, which flags ALC patients missing discharge destinations. We have seen a decrease in the number of discharge without destination in the past year.
There is a process for establishing the Estimated Discharge Date (EDD). This process must be specific to each older adult and not dependent upon blanket EDD assumptions.	Yes	- Minute rounds observations were conducted on each medicine and surgery unit in 2024. These rounds follow a standard guideline of approximately 1 minute per patient. In the new building, the electronic whiteboards are used. In the old building, physical whiteboards are used. How promptly the EDD is discussed in each round varies significantly from team to team. In some units, the supervisors proactively ask and record EDD, while in some units, the EDD is often not addressed. - Developed a tool to forecast the confirmed discharges and possible in Inpatient Units for 9:30 bed meetings (to be implemented)	- Barriers in prompting EDD entries have been identified, explore new strategies to help improve the EDD entries. - Implement discharge forecast model in the medicine department level to help with staffing, managing surges in patient volume, and improving EDD accuracy.
Collaborate with Ontario Health at Home (formally HCCSS) to support the implementation of required actions as laid out in the Jan 30, 2024 OH memo "Actions for Streamlining Referrals to Home and Community Care"	Yes	- Implemented the Home First process in Oct 2024, as of Feb 2025, it has been updated it to align with the rest of the province. - ALC rounds process has been improved and divided into 2 streams (Tuesday for TN, Thurs with OH at home managers and unit leadership). OH leadership now has access to our ALC tracker so they can follow up with their team promptly. - As of February 2025, the OH at Home care coordinators are assigned to specific units and are required to attend minute rounds. To enhance collaboration with Transition Navigators and communication with patients, care coordinators are now officed within their assigned units, leveraging the proximity to improve efficiency and responsiveness.	Change ideas implemented, continue to monitor its effectiveness and implement further improvements as needed.

2024/25 QIP Progress Report | Workplace Violence Prevention

Increase reporting of workplace violence incidents

QIP Indicator	Baseline	Target	Current Perf	Comments
Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.	17.1	≥18	19.2	As a result of the efforts made to address and prevent workplace violence, there has been a significant rise in the reporting of incidents.

Change Idea	Implemented as intended? (Yes/No)	Accomplishments & Lessons Learned	Details on strategies to reach target in the future
Implement processes to support and encourage the reporting of workplace violence incidents	No	An initial pilot of a rapid workplace violence reporting form was introduced and initially successful in increasing reporting in the emergency department, however, there have been barriers to its success. These barriers are mainly attributed to concerns with privacy (ability to include patient information in the report), and therefore the inability for leaders to effectively follow-up and investigate.	A different approach will be taken to simplify the incident reporting process, by optimizing our organization's incident management system instead of creating new, external reporting processes.
Implement methods to reinforce workers in feeling safe, prepared and supported in their work environment	Yes	Work has been performed to optimize the use of Real-time locating system (RTLS), including: - Installation of RTLS badge testing kiosks for staff to check the status of their RTLS staff duress badge prior to their shift - A new overhead announcement system has been launched in high-risk areas. When a staff member activates their RTLS duress button, the system will automatically make an overhead announcement, enabling a quicker response from the local team. Our leadership teams continue to adjust security presence in the Emergency Department based on patient volumes and level of risk.	We will continue to explore further measures that can be taken to proactively address safety concerns in the environment.
Behavioral Care Plan Alert for Patient and Worker Safety	No	A lot of progress has been made on this initiative in the last year. There has been lots of stakeholder engagement, and work with clinical informatics to build an electronic behavioural care plan in the EMR which is linked to a risk screening tool.	This work will continue into 2025/26, with further stakeholder engagement and a thoughtful implementation plan.

2024/25 QIP Progress Report | Restraint Use in Inpatient Mental Health Services

Improve compliance with new restraint policy in inpatient Mental Health

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QIP Indicator	Baseline	Target	Current Perf	Comments
% restraint events that have been audited by leadership within 72 hrs	**N/A**	≥90%	91.5%	- All audits for restraint events in inpatient mental health are being conducted by the clinical scholar on the unit - Since the audit process shifted from Quality Lead to Unit designate the process has continued to improvement and allow for quickly implementation of practice changes - This indicator will be evolving to focus on ED on our QIP for this upcoming year

Change Idea	Implemented as intended? (Yes/No)	Accomplishments & Lessons Learned	Details on strategies to reach target in the future
Design effective processes to review audit findings with leadership and staff	yes	- Using electronic charting to order restraints and document treatment provided insight into current practices - Audits allowed for leaders to follow up with team about improvements to process	- By reviewing audit findings with leadership and staff we have identified areas for improvement in documentation - Strategy to continue with implementing this similar approach in the ED
Expand new restraint process to MHEAZ/ED and begin chart audits	No	- The success of this implementation on inpatient mental health will be replicated with the MHEAZ/ED team - Chart audits will follow a similar process in MHEAZ/ED	- By replicating a successful process in inpatient mental health to MHEAZ and ED areas we can scale and spread the approach - Strategy to continue the audit process will bring insights into current practices and identify areas for improvement
Establish and roll out education in trauma informed care and least-restraint culture	No	- Through engagement with our hospital partners at CAMH the procurement of a comprehensive training and education program called TIDES will be coming to MGH and implemented across high risk areas starting Spring 2025	- By leveraging an existing program with documented success we are engaging with subject matter experts on clinical processes to build best practices into our process - This opportunity will also bring the possibility for research and other publications on implementation and learning to further help health care systems
Launch organization wide least-restraint policy and practices using learnings from mental health	No	- Established Least Restraint Working Group with key stakeholders across the organization to update policy and procedures with best practices	- Policy and procedures around restraints need to be updated to reflect best practices and recommendations from RNAO, etc. As well as legislative requirements - Building on existing bodies of literature will be incorporated into this process

2024/25 QIP Progress Report | Patient Satisfaction

Improve patient satisfaction with information provided at discharge

QIP Indicator	Baseline	Target	Current Perf	Comments
Percent of top box responses ("Completely") to the 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?"	60 %	63.3 %	61.7 % (Jan)	Over the last year, we have continued our work on PODS, collaborating with patients, leadership and clinicians to ensure that the PODS effectively provide information that will support a patient's transition out of the hospital. We have developed more PODS over the past year, many of which were in response to gaps identified through complaints received in the Patient Experience Office. Unfortunately, our target of 5% increase in top box responses was not achieved, but this metric will be carried forward in our QIP. Our team has redeveloped our plan while still using the RNAO's Transitions in Care Best Practice Guideline to achieve our goal this year with the patient in the centre of our efforts.

Change Idea	Implemented as intended? (Yes/No)	Accomplishments & Lessons Learned	Details on strategies to reach target in the future
Continue to implement the PODS Framework	Yes	Through feedback received through the Patient Experience Office, the team was able to identify more opportunities to develop PODS. These PODS were developed and implemented in various clinical areas.	While the PODS have so far been successful, there are other clinical areas that have yet to incorporate PODS in their practice. We hope to identify these areas through feedback through the Patient Experience Office and from PEP, in addition to discussing with clinical leadership teams.
Improve collaboration with patients and caregivers and support readiness to transition through implementing elements of the RNAO Transitions in Care Best Practice Guideline	No	Our Patient Experience Specialists continue to work with patients, families, care partners and leadership to address any discharge-related concerns, which included educating on policies, collaborative problem-solving, and brokering discussions between patients/families and care teams. We have also collaborated with Ontario Health at Home to resolve gaps in service.	Our team continues to foster relationships with patients, families, leadership and external community care partners to ensure that patients with complex care needs are well supported as they leave the hospital, in accordance with the RNAO Transitions in Care Best Practice Guidelines. We also hope to gain more understanding of patient expectations and concerns regarding discharges to guide QI initiatives this year.
Understand survey responses by demographic	No	As the Patient Experience team tried to undertake this effort, we recognized a need for external support in completing the statistical analysis.	We are working with Decision Support (DS) to accomplish this change idea this year. Data has been shared, and DS is starting preliminary analysis.
Increase community awareness of survey availability	Yes	Survey collection rates have increased over the past year with over 10,000 responses received since it was first implemented in 2023, up from 3,400 surveys last year. This can be attributed to increased awareness by informing patients of the availability of surveys through TV displays in waiting areas, MGH's external website and the Patient and Family Guide.	Despite the increased awareness of the surveys and good response rates, the survey remains only available in English. Our team is exploring options to make the survey available in more languages to ensure that our response data appropriately represents the diversity of the community and patient population we serve. We will also be launching the Patient Experience survey in ambulatory and critical care areas this year.

2024/25 QIP Progress Report |Equity, Diversity, Inclusion and Belonging

Improve cultural competency through training

QIP Indicator	Baseline	Target	Current Perf	Comments
Rate of staff and leaders completing mandatory cultural competency training	(new metric, not available)	80 %	87%	As of February 2025, the number of staff and leaders completing this training has exceeded our target goal. 87% of our staff and 90% of our leaders successfully completed this training.

Change Idea	Implemented as intended? (Yes/No)	Accomplishments & Lessons Learned	Details on strategies to reach target in the future
Measure completion rate of all credentialed clinicians	Yes	Cultural Competency training successfully incorporated into the credentialed clinicians mandatory training curriculum.	A similar approach will be taken in the future for additional Equity, Diversity, Inclusion and Belonging focused training with perhaps an earlier required completion date.
Measure completion rate of all new MGH hires with a start date within the reporting period	Yes	Cultural Competency training successfully incorporated into the new hire onboarding curriculum to ensure the learning is sustained as new staff join MGH. The iLearn Administrative dashboard was also configured to include monthly completion rate of the Cultural Competency training.	A similar approach will be taken in the future for additional Equity, Diversity, Inclusion and Belonging focused training.
Launch more comprehensive training on cultural competency for leaders	Yes	Cultural Competency training successfully incorporated into the leaders' mandatory training curriculum. Completion rates were above target.	A similar approach will be taken in the future for additional Equity, Diversity, Inclusion and Belonging focused training.

2024/25 QIP Progress Report |Equity, Diversity, Inclusion and Belonging

Improve Day Surgery Health Equity Questionnaire response rate

QIP Indicator	Baseline	Target	Current Perf	Comments
Rate of Day Surgery Patients (adults) completing the Health Equity Questionnaire	22% (Apr 2022 – Dec 2023)	≥ 32%	17%	The target of 32% was quite ambitious and not achieved. Some factors may have impacted the completion rates of HE questionnaire such as delays to including the HE questionnaire in day surgery packages. Since this change idea is now well established, we will continue with this QIP for the next fiscal with additional change ideas.

Change Idea	Implemented as intended? (Yes/No)	Accomplishments & Lessons Learned	Details on strategies to reach target in the future
Increase patient education and awareness of Health Equity Questionnaire	Yes	"We ask because we care" campaigned launched	Followed OH recommendations for campaign. May include additional campaign efforts to broaden reach and understand of HE questionnaire.
Review and revise current process for collecting Health Equity Questionnaires	No	Began including HE questionnaire in all day surgery information packages	• Engaging with MGH Emerging Leaders Program members to develop additional change ideas • Using revised OH HE questionnaire when available • Plan to distribute questionnaire at different time points • Engage with invested parties (i.e., patients) for additional perspectives
Increase frequency of reporting of completion rate for the Health Equity Questionnaire	Yes	Reported completion rates monthly	Will continue to complete rates monthly