MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

QUALITY IMPROVEMENT PLAN

Progress Report, 2025/26

INTEGRATING CARE.
BOLD IMPACT.

OUR INDICATORS

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Priority	Indicator	Baseline	Target	Final
Access and Flow	ED length of stay, non-admitted, high acuity (90th)	8.1	7.9	8.7
	ED wait time to inpatient bed (90th)	19.3	18.7	20.6
Equity	Sexual and gender diversity	0%	80%	87.3%
	Health equity data collection	17.4%	19.1%	16.6%
Experience	Patients received adequate information at discharge	60.2%	64.0%	66.1%
Safety	Workplace violence incidents with lost time	12	11	22
	Physical restraint events > 4 hours in the ED	Collecting Baseline	Collecting Baseline	25.4%
	Patient safety incidents	292	321	327

ED LENGTH OF STAY

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Indicator Definition	Data Source	Baseline	Target	Final
90th Percentile Emergency Department Non-Admitted Length of Stay (high acuity) in hours	CCO / P4R iPort Dec 2024-Nov 2025	8.1	7.9	8.7

Change Idea	Progress on Change Idea	Successes and Challenges
Flow optimization	Implemented	• MRP Policy approved and updates made • New ED zone deployed • MD schedules revised to align with demand • Several partnerships established: Peer support workers; East Toronto Hart Hub; Indigenous Patient Navigator; East Toronto Primary Care Navigation Clinic • Strengthened presence of GEM+ team • Green Zone Kaizen event completion • 6S Supply room transformation completion
Improve DI and Lab turnaround times	Implemented	• Modified DI tech break coverage to better synchronize resources with demand • Finalized review of Choosing Wisely
IT and Innovation	In Progress	• CPOE digitization has not yet started • RN Web Scheduler has not yet started • AI Scribe policy finalized and Heidi implemented into practice

TIME TO INPATIENT BED

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Indicator Definition	Data Source	Baseline	Target	Final
90th Percentile Emergency Department time from disposition to bed in hours	CCO / P4R iPort Dec 2024-Nov 2025	19.3	18.7	20.6

Change Idea	Progress on Change Idea	Successes and Challenges
Teletracking (EVS)	Implemented	• Monthly report developed and reviewed by Support Service leadership • Monitor of monthly queue time, turn time for cleaning, queue time and transport time for portering have been reviewed and monitored closely by the Support Service leadership
Estimated Discharge Date (inpatients)	Implemented	• Officially launched EDD initiative with QBP guideline in Q3 • Implemented prompt EDD discussions and consistent recording on the electronic whiteboard • Forecast model piloted; however, it was later terminated due to technical system constraints
Admission and discharge process: Enhance discharge documentation (Inpatient); streamline admission to mental health & pediatric units	Implemented	• Conducted patient journey analysis and launched a streamlined discharge process to close the gap • Subsequent audits confirmed that found bed has been consistently reduced to lower than 10% • Launched PEZ unit which offers short stay admission (72 hours) under Psychiatrist MRP
Proactive transition (transition, flow, IP)	Implemented	• Achieved 27% reduction in Acute ALC annual bed equivalency and a 22% reduction in Non-Acute ALC bed equivalency between Apr to Dec compared to previous year • Achieved a 20% cumulative weekend discharge rate by Q2 • Launched new Acute-to-Rehab pathway aligned with Ontario Health guidelines • Established weekly ALC tracker for acute and non-acute placements shared with leadership to ensure close oversight of high-priority cases • Successfully integrated OHAH co-location, with Care Coordinators now attending rounds regularly

SEXUAL AND GENDER DIVERSITY

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Indicator Definition	Data Source	Baseline	Target	Final
Percent of staff and leaders completing mandatory training for Foundations of Sexual and Gender Diversity	Human Resources Jan-Dec 2025	0%	80%	87.3%

Change Idea	Progress on Change Idea	Successes and Challenges
Develop Foundations of Sexual and Gender Diversity training	Implemented	• Training collaboratively developed and reviewed by relevant stakeholders
Measure completion rate of all credentialed clinicians	Implemented	• Credentialed clinicians will complete by mid-March
Measure completion rate of all new MGH hires with a start date within the reporting period	Implemented	• Completion rates exceed target goal
Launch Foundations of Sexual and Gender Diversity training for leaders	Implemented	• Completion rates exceed target goal

HEALTH EQUITY DATA COLLECTION

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Indicator Definition	Data Source	Baseline	Target	Final
Percent of Adult Day Surgery and Adult Elective Surgical patients completing the Health Equity Questionnaire	Human Resources Jan-Dec 2025	17.4%	19.1%	16.6%

Change Idea	Progress on Change Idea	Successes and Challenges
Engage Emerging Leaders Program members in developing best practice recommendations	Implemented	• Emerging leaders successfully engaged with relevant stakeholders and conducted an environmental scan • A robust consultative report with actionable change ideas was finalized
Use new HE questionnaire	Not Implemented	• A new version of the questionnaire did not become available, and as such we were not able to implement
Distribution of HE questionnaire	Implemented	• Questionnaires were distributed by T6 nurses at discharge as a net new point of data collection • Posters with QR codes in addition to an anonymous drop box were provided to J4 for patients to complete the questionnaire in paper form or online
Engage key stakeholders	Implemented	• Stakeholders including staff and leadership on T6/J4, patient access, decision-support, privacy, facilities were engaged to determine additional opportunities for survey distribution and collection

PATIENT EXPERIENCE

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Indicator Definition	Data Source	Baseline	Target	Final
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”? All survey respondents discharged	Qualtrics Medicine & Surgery Apr 2025-Dec 2025	60.2%	64.0%	66.1%

Change Idea	Progress on Change Idea	Successes and Challenges
Continue to implement PODS (Patient Oriented Discharge Summary) Framework	Implemented	• Guideline has been drafted, reviewed and used PODS have been designed and implemented in Surgery, CIU, T9,T8 and T7 • Patient representative assisted in writing several PODS • Updates were made to support PowerChart documentation Opportunity to leverage CRLs to support more consistent distribution
Improve collaboration with patients and care partners, and support readiness to transition by incorporating RNAO (registered nurses association of Ontario) Transitions in Care Best Practice Guideline	In Progress	• PEP engagement is planned for Feb/March 2026 meetings re: RNAO guidelines
Apply an equity lens on patient experience data	Implemented	• Analysis completed by Decision Support team • Research completed on the feasibility and availability of providing surveys in non-English languages

WORKPLACE VIOLENCE

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Indicator Definition	Data Source	Baseline	Target	Final
Number of workplace violence incidents that result in a lost time reported by hospital workers (as by defined by OHSA) within a 12-month period	Parklane and HR Jan-Dec 2025	12	11	22

Change Idea	Progress on Change Idea	Successes and Challenges
Simplify the incident reporting process to encourage reporting	Implemented	• To simplify incident reporting, the QR code reporting method in the Emergency Department was removed to consolidate reporting into a single RL dataset • Select questions were also removed to reduce reporting burden, and an interpersonal conflict classification was added to better capture horizontal workplace violence
Implement methods to reinforce workers in feeling safe, prepared and supported in their work environment	Implemented	• In efforts to improve staff sense of perceived safety, body-worn cameras have been implemented and increased security presence at ED triage has been introduced
Code White Committee to enhance code white response	In Progress	• A Code White Committee Terms of Reference has been drafted • A Workplace Violence Dashboard is reviewed monthly and includes Code White activations
Behavioural Care Plan Alert System for patient and worker safety	In Progress	• Behavioural Specialists have made contextual updates to the Behavioural Care Plan, with further work underway to standardize the care plan and associated pathways across the organization

PHYSICAL RESTRAINT EVENTS

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Indicator Definition	Data Source	Baseline	Target	Final
Percent physical restraint events longer than 4 hours in the Emergency Department	Internal Apr-Dec 2025	Collecting Baseline	Collecting Baseline	25.4%

Change Idea	Progress on Change Idea	Successes and Challenges
Digitize Restraint order process in the ED	In Progress	• Changing timelines with CPOE project overall impact ability to implement electronic ordering • Modifications to paper order form made to align with existing paper charting • A staff engagement process was followed to co-design an update to paper order form which increased staff awareness and buy-in of the issue • Patient Engagement Panel engaged to ensure their perspectives were included in the paper chart
Restraint committee and policy	Implemented	• A comprehensive policy was developed and went live in April 2025 • A review of subsequent safety events highlighted the need for further practice improvements and prompted a review of the policy • Significant edits are now being documented by the Least Restraints Working Group • The goal is to have a enhanced version of the policy that will be approved June 2026
Implement TIDES training for Trauma-informed care	Implemented	• Decision made to move forward with SMG training instead of TIDES • Compliance rates with SMG training have improved significantly • A review of existing education practices highlighted that standardizing curriculum and clarifying training needs specific to roles and areas is required
Conduct random audits of restraint events in medicine	Implemented	• New insights gathered to understand staff perceptions around restraint use • Determined that the morning shift had the most orders for restraints

PATIENT SAFETY

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Indicator Definition	Data Source	Baseline	Target	Final
Number of patient safety incidents reported per month	RL Solutions Jan-Dec 2025	292	321	327

Change Idea	Progress on Change Idea	Successes and Challenges
Simplify and promote a user-friendly reporting process	Implemented	• Enhanced the quick submit forms for credentialed clinicians for ease of reporting • Enhanced the skin/tissue form to support accurate reporting of pressure injuries • Optimized several areas by standardizing the nomenclature for programs and departments • Increased number of near miss and good catch reports (14% over the same period last year)
Utilize RL Data Systems for unit specific dashboards and action tracking	In Progress	• An exploration of RL capabilities was conducted • Challenges arose including the finding that RL only allows a limited number of areas per dashboard, which prevented our ability to move forward • Plans are being drafted to use alternate systems/methods to create program-specific dashboards
Introduce and sustain an executive safety walk structure	Implemented	• A series of Executive Safety walkarounds were conducted in the Spring/Summer • Multiple leadership sessions were held to educate leaders on the value of huddles, rounding and check-ins • High Reliability Organization work was commenced and this change idea was placed on hold until it will be implemented as part of this larger strategy