MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

QUALITY IMPROVEMENT PLAN

Workplan, 2026/27

INTEGRATING CARE.
BOLD IMPACT.

OUR INDICATORS

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Priority	Indicator	Baseline	Target	Target Justification
Access and Flow	ED length of stay, non-admitted, high acuity (90th)	8.4	8.3	Aim to improve performance despite projected volume pressures
	ED wait time to inpatient bed (90th)	20.3	20.3	Aim to maintain performance despite projected volume pressures
Equity	Leader participation in Indigenous Health Education	0%	100%	Aim for participation from all eligible leaders
Experience	Patients received adequate information at discharge	66.3%	66.5%	Aim for 0.2% increase year over year
Safety	Rate of workplace violence incidents with lost time	0.80	0.75	Reduce rate by the equivalent of one incident
	Physical restraint events > 4 hours in the ED	25.4%	Collecting Baseline	Set target after one year of collecting baseline
	Serious Safety Events Reporting Rate	Collecting Baseline	Collecting Baseline	Begin to collect baseline data using HPI classification system
	Leader participation in High Reliability Education	0%	100%	Aim for participation from all eligible leaders

ED LENGTH OF STAY

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Indicator Definition	Data Source	Baseline	Target	Target Justification
90th percentile emergency department length of stay for non-admitted patients with high acuity (CTAS 1-3)	Health System Insights Apr-Dec 2025	8.4	8.3	Aim to improve performance despite projected volume pressures

Change Idea	Methods	Process Measure	Target
Implement a set of improvements determined by staff during a Green Zone Kaizen event	• Evaluate and prioritize improvements identified • Determine resources required to implement improvements • Implement prioritized improvements and use iterative PDSA cycles to support continuous improvement	Percent of priority improvements implemented	100%
Review and optimize our phlebotomy practices and processes	• Create a cross-functional working group to review current practice and determine and evaluate improvement opportunities • Apply, test and evaluate new practice	Rate of hemolysis	5-10% decrease
Streamline access to CT scanners for ED patients	• Improve communication and workflows between the ED and DI to reduce avoidable delays • Assess and optimize ED CT capacity and access • Leverage a performance dashboard to enhance real-time visibility, prioritization, and triage of CT requests	Wait times for CT orders Volumes of CT orders	2.9 hours
Revamp a semi-urgent pathway for patients to receive Diagnostic Imaging (DI) service next day	• Create a cross-functional working group to review current practices and determine and evaluate improvement opportunities • Advance use of the urgent outpatient encounter for next day DI service	Percentage of patients diverted to pathway Wait time of patients in pathway	5-10% increase 10% decrease

TIME TO INPATIENT BED

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Indicator Definition	Data Source	Baseline	Target	Target Justification
90th percentile emergency department wait time to inpatient bed	Health System Insights Apr-Dec 2025	20.3	20.3	Aim to maintain performance despite projected volume pressures

Change Idea	Methods	Process Measure	Target
Transition from a 5-day model to a 7-day model to level-load discharge volumes and optimize throughput	• Standardize protocols to flag potential discharges by mid-week • Implement structured communication and handover tools for GIM teams on weekends • Align and optimize staffing level on weekends with discharge targets	ALC throughput ALC rate	>= 1 <=11%
Expand interprofessional coverage across all 5 disciplines to provide consistent weekend support and accelerate rehab transitions	• Secure additional weekend resources to ensure full 7-day coverage for all key disciplines • Implement a focused protocol to increase the volume of rehab applications submitted on weekends	Completed orders on weekends (PT/OT)	5-10% increase
Streamline discharge planning steps to accelerate transitions and enhance patient/family preparedness	• Monitor and improve Estimated Date of Discharge (EDD) and Readiness (EDRR) protocols • Deploy standardized discharge destination navigation toolkits • Formalize communication protocol to involve patient and families in the discharge timeline earlier	Deploying navigation tools and communication protocols	Jun-26
Leverage data and process improvements in cleaning and portering to accelerate bed turnover and patient flow	• Use data to identify and resolve bottlenecks in bed turnover and patient transport, optimizing individual performance and partnering with clinical teams to reduce reporting lags in bed turnover • Align cleaning and portering capacity to support the 7-day standardized discharge operations model	Average queue time for cleaning in high demand discharge windows	5% reduction

INDIGENOUS HEALTH EDUCATION

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Indicator Definition	Data Source	Baseline	Target	Target Justification
Percent of eligible leaders who have completed Indigenous Health education	HR, iLearn, Payroll Jan-Dec 2025	0%	100%	Aim for participation from all eligible leaders

Change Idea	Methods	Process Measure	Target
Design and deliver a marketing strategy for three distinct leader groups	• Hold collaborative engagements with communications team • Design targeted approaches to support each leader group to attend education sessions	Marketing strategy developed	Marketing strategy developed
Educate leaders on Indigenous Health	• Hold education sessions for Managers, Clinical Resource Leaders and Supervisors	Percentage of each eligible leader group that have completed education	100%

PATIENT EXPERIENCE

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Indicator Definition	Data Source	Baseline	Target	Target Justification
Percent of respondents who responded “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?	Qualtrics CIU, T6, T7, T8, T9 Jan-Dec 2025	66.3%	66.5%	Aiming for 0.2% increase year over year

Change Idea	Methods	Process Measure	Target
Implement a core set of Patient Oriented Discharge Summaries (PODS) in medicine	• Conduct a workflow analysis to identify opportunities to simplify the discharge planning process • Identify and establish multiple points of patient communication throughout the discharge process • Explore and assess opportunities to digitize and track PODS utilization • Increase staff training opportunities related to patient communications	Percentage of eligible patients discharged with a PODS	75%
Develop a sustainability plan to integrate PODS utilization within operations	• Establish a cross-functional Steering Committee to oversee discharge planning across the hospital • Develop a routine cadence and standard operating procedure for designing and assessing the use of PODS • Identify and clarify roles and responsibilities (i.e. CRL role) to support continuous implementation • Establish a framework / checklist for the ideal discharge planning process • Gather and review discharge planning toolkits • Prioritize a list of improvement opportunities based on patient safety risk, impact on length of stay, readmission rate	Standard operating procedure drafted	Mar-27

WORKPLACE VIOLENCE

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Indicator Definition	Data Source	Baseline	Target	Target Justification
Number of workplace violence incidents that result in lost time reported by hospital workers per 100 full-time equivalent workers	Parklane, HR Jan-Dec 2025	0.80	0.75	Aiming to reduce our rate by the equivalent of one incident

Change Idea	Methods	Process Measure	Target
Enhance our staff education in workplace violence	• Design a 2-tiered training model that includes a) existing SMG training and b) supplementary training for higher risk areas • Embed SMG material into new nursing / clinical orientation curriculum • Ensure alignment between SMG material and current Mock Code White Procedures	Percentage of staff in higher risk areas who have completed training	30%
Invest in and implement leadership support tools and education	• Reinforce SAFER-R, Emotional Response, workplace violence prevention training into existing LEEP modules • Design, monitor and track compliance with a structured incident follow-up process and checklist (including action items)	Incident follow-up process designed and tested	Dec-26
Co-design and implement a violence risk screening and care planning framework	• Conduct a current state assessment of behavioural support resources, care planning practices and risk screening approaches across the organization • Co-design a standardized Care Plan Framework informed by the current state assessment • Integrate violence risk screening and care planning processes into priority areas	Current state assessment complete Number of areas where framework is implemented	Aug-26 3

LEAST RESTRAINTS

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Indicator Definition	Data Source	Baseline	Target	Target Justification
Percentage of physical restraint events longer than 4 hours in the ED	Chart Review Apr-Dec 2025	25.4%	Collecting Baseline	Set target after one year of collecting baseline

Change Idea	Methods	Process Measure	Target
Implement an executive-level incident review process	• Design a comprehensive review process • Develop and implement action items resulting from each review	Percent of incidents reviewed by CEO	100%
Implement electronic charting of restraint orders and nursing documentation	• Establish workflow to support electronic restraint orders for physicians • Establish workflow to enable nursing documentation after a restraint order is placed • Develop and roll-out training and education curriculum	Process maps complete	Oct-26
Identify and implement evidence-based practices	• Identify evidence-based practices to incorporate into Policy • Implement a collaborative training protocol to ensure staff that are most responsible for emergency restraint application train together • Implement standardized location of PINEL restraints and keys • Build an iLearn to support point-of-care staff	Policy updated iLearn launched	Mar-27
Establish a toolkit and pathway for Least Restraint approaches to patients 65 or older and/or those with Delerium	• Review patients with restraint events to confirm Delirium screening • Provide training on recognizing the early warning signs of Delirium • Establish a pathway where patients who are screening positive for Delirium have documented alternatives to restraints • Establish a communication and consent protocol for SDM/caregiver family member of patients 65 or older who had a restraint event >4hrs	Percent of events that have a documented consult	70%

SERIOUS SAFETY EVENTS

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Indicator Definition	Data Source	Baseline	Target	Target Justification
Number of Serious Safety Events (SSEs) per 1,000 patient days	RL Solutions Jan-Dec 2025	Collecting Baseline	Collecting Baseline	Begin to collect baseline using HPI classification system

Change Idea	Methods	Process Measure	Target
Train our leaders to proactively maintain safety using High Reliability-Informed Education	• Deliver standardized high reliability organization (HRO) education to leaders, clinical staff and credentialed clinicians • Integrate required HRO education into onboarding and refreshers • Establish an HRO Implementation Committee to implement roll-out strategy	Percent of eligible leaders who have completed HRO education	100%
Implement a unit-based Safety Coach program to reinforce reliable safety practices	• Identify a Safety Coach for each high-impact inpatient care area • Build a standard Safety Coach approach and structure to enact system • Provide standardized training, certification and orientation for all identified Safety Coaches	Percent of Safety Coaches who have completed certification within 3 months	100%
Strengthen consistency and effectiveness of daily safety conversations through tiered huddles	• Establish tiered daily huddles across patient care units using a standardized structure, agenda and guidelines • Formalize escalation pathways for identified safety risks from unit huddles to the Daily Safety Check • Provide ongoing coaching to unit leaders on huddle consistency, quality of escalation and rigour through implementation	Percent of units with huddles implemented Number of safety issues identified and escalated to the Daily Safety Check per month	80% 10

HIGH RELIABILITY EDUCATION

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Indicator Definition	Data Source	Baseline	Target	Target Justification
Percent of eligible leaders who have completed High Reliability Organization training	Internal Jan-Dec 2025	0%	100%	Aiming for participation from all eligible leaders

Change Idea	Methods	Process Measure	Target
Train our leaders to proactively maintain safety using High Reliability-Informed Education	• Deliver standardized high reliability organization (HRO) education to leaders, clinical staff and credentialed clinicians • Integrate required HRO education into onboarding and refreshers • Establish an HRO Implementation Committee to implement roll-out strategy	Percent of eligible leaders who have completed HRO education	100%