

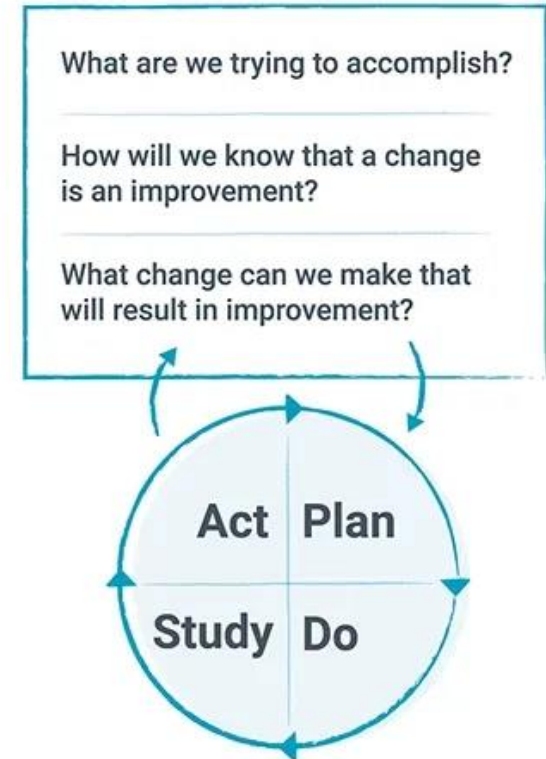
Quality Improvement Workplan 2026/27

QIP Workplan

The QIP Workplan is the forward-looking portion of the QIP that identifies the indicators, aspirational targets, and actions (i.e., change ideas) for each that an organization is committing to undertake during the upcoming year to work towards the specified targets.

The workplan has been designed to align with the Model for Improvement, with three fundamental questions driving the improvement process:

- **Aim:** What are we trying to accomplish?
- **Measure:** How do we know that a change is an improvement?
- **Change:** What changes can we make that will result in the improvements we seek?



Source: Adapted from The Improvement Guide (2009)

2026/27 QIP Indicator Description (Measures)

QIP Indicator Name	Description	Target
90th percentile emergency department wait time to inpatient bed	90th percentile wait time (hours) for patients admitted from the ED to an inpatient bed or operating room, where wait time is from Disposition Date/Time until the Date/Time Patient Left Emergency Department (ED) for admission.	39 Hours
Did patients receive adequate information about health and their care at discharge	Percentage of respondents who responded “Completely” to the following 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?”	70%
Rate of workplace violence incidents resulting in lost-time injury	Rate of reported workplace violence incidents by hospital workers that resulted in a lost-time injury within a 12-month period.	0.3%
Completion of sociodemographic data collection	Percentage of Patient Experience survey respondents who provided responses to at least 3 of the 4 specified sociodemographic questions within the most recent consecutive 12-month period.	Collecting Baseline (CB)
Sepsis – Time to Antibiotic	Percentage of patients who receive their first dose of intravenous antibiotics within the 1 hour after activation of Code Sepsis	Collecting Baseline (CB)

90th percentile emergency department wait time to inpatient bed

Director Lead: Katrina Scott
Target: 39 Hours

Definition: 90th percentile wait time (hours) for patients admitted from the ED to an inpatient bed or operating room, where wait time is from Disposition Date/Time until the Date/Time Patient Left Emergency Department (ED) for admission.

Change Ideas	Methods	Process Measures	Target for Process Measure	Comments
Integrated Care Centre (ICC) Phase 2 completion	<ol style="list-style-type: none"> Develop dashboards to support patient flow (eTOA, IPAC, flow blockers, etc) Create operational model for clarity on ICC functions 	<ul style="list-style-type: none"> Number of dashboards created for use Operational model created and available 	<ul style="list-style-type: none"> ≥ 3 dashboards created and in active use operational model completed, approved, and accessible to relevant staff by March 2027 	
Standardized Bullet Rounds	<ol style="list-style-type: none"> Audit bullet rounds (5D, Attendance) Audit completion/update of estimated date of discharge (EDD) and Blaylock 	<ul style="list-style-type: none"> Completion of EDD and Blaylock Attendance rate at bullet rounds Accuracy of EDD compared to actual discharge 	<ul style="list-style-type: none"> 90% of patients have updated EDD and Blaylock by Q4 2026/27 	<ul style="list-style-type: none"> Audits completed with actions implemented by mid Q4 26/27
Implementation of Red-to-Green Safer discharge model	<ol style="list-style-type: none"> Engage physician leadership, IT for support Create working group to align expectations, determine steps necessary for implementation (IT, processes, etc.) 	<ul style="list-style-type: none"> Completion of the intervention daily 	<ul style="list-style-type: none"> >90% of patients have red-to-green elements daily 	
Implement and optimize Access and Flow Lead role	<ol style="list-style-type: none"> As ICC operational plan and dashboards are developed, optimize role to support Staff in training, expected to be onboarded into full role by March 22, 2026 	<ul style="list-style-type: none"> Coverage gaps – Access & Flow Lead role is consistently staffed during expected hours. 	<ul style="list-style-type: none"> ≥ 95% of expected hours covered (no unplanned gaps) 	
ALC 2.0 - redesign and refresh ALC processes	<ol style="list-style-type: none"> Process map current existing ALC processes and develop change ideas (complete) Working groups formed to complete identified change ideas Education provided to frontline staff, leadership, and physicians 	<ul style="list-style-type: none"> ALC LOS Absolute volume ALC Wait time information system (WTIS) corrections decreasing % ALC days 	<ul style="list-style-type: none"> Meet and sustain OH ALC target set for Southlake (currently 42 patients at main site) 	
Refine Discharge and Admission Lounge	<ol style="list-style-type: none"> In collaboration with medicine program, refine use of discharge lounge to support early movement Work with EVS to expedite bed turnovers for early movement 	<ul style="list-style-type: none"> Discharge lounge at maximum capacity by specific time and maintain a census through the shift 	<ul style="list-style-type: none"> Discharge lounge at ≥ 90% capacity by 1100h, maintained through to 1500h 	

Did patients receive adequate information about health and their care at discharge

Director Lead: Sonia Pagura
Target: 70%

Definition: Percentage of respondents who responded “Completely” to the following 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?”

Change Ideas	Methods	Process Measures	Target for Process Measure	Comments
Storytelling and learning	<ul style="list-style-type: none"> Share patient experience stories that highlight the impact of discharge communication on patient safety and confidence Integrate patient stories into unit huddles, leadership forums, and discharge education sessions Share unit-level discharge data and trends alongside patient stories to reinforce learning and accountability Celebrate positive practices and improvements to reinforce compassionate, patient-centered behaviours 	<ul style="list-style-type: none"> % of inpatient units that receive and review at least one discharge-related patient experience story per quarter 	<ul style="list-style-type: none"> ≥80% of inpatient units review at least one discharge-related patient experience story per quarter 	<ul style="list-style-type: none"> Builds empathy and reinforces the importance of effective discharge communication Connects patient stories to measurable outcomes and practice change Supports a learning culture focused on compassion, accountability, and continuous improvement
Launch a Discharge Working Group	<ul style="list-style-type: none"> Establish a multidisciplinary Discharge Working Group (physicians, nursing, pharmacy, social work, patient experience) Meet regularly to review discharge workflows, barriers, and data Use Meditech and patient experience data to guide improvements Support units with implementation and problem-solving Map the end-to-end discharge process and clinical involvement 	<ul style="list-style-type: none"> ≥90% of planned meetings held annually % of identified improvement opportunities with an implemented action or pilot End-to-end discharge process map developed and reviewed annually 	<ul style="list-style-type: none"> ≥90% of planned meetings held annually ≥80% of identified improvement opportunities have an implemented action Discharge process map completed by Q2 	
Implementation of a standardized discharge package on Meditech	<ul style="list-style-type: none"> Identify and define required components of a standardized discharge package Build a discharge checklist and documentation fields within Meditech Pilot the standardized discharge package on a selected inpatient unit Collect feedback from clinical teams and patients Refine and scale the standardized discharge package across the organization 	<ul style="list-style-type: none"> Discharge checklist and standardized documentation fields built and available in Meditech Pilot of standardized discharge package completed on at least one inpatient unit 	<ul style="list-style-type: none"> Meditech discharge checklist and documentation fields built by Q1 Pilot completed on 1–2 inpatient units by Q3 	

Rate of workplace violence incidents resulting in lost-time injury

Director Lead: Menka Anand
Target: 0.3%

Definition: Rate of reported workplace violence incidents by hospital workers that resulted in a lost-time injury within a 12-month period.

Change Ideas	Methods	Process Measures	Target for Process Measure	Comments
Implement new WPV tiered training to better reflect the patient population and risk profile within each clinical environment.	Deliver a blended Workplace Violence Prevention (WPV) training model that includes both e-learning and in-person practical components tailored to clinical areas with higher exposure to patients diagnosed with dementia or experiencing symptoms of delirium.	<ul style="list-style-type: none"> Introduction of Gentle Persuasion Approach (GPA) training into New Staff Orientation Introduction of restraint training into New Staff Orientation 	<ul style="list-style-type: none"> GPA training incorporated into 100% of applicable New Staff Orientation sessions Restraint training incorporated into 100% of applicable New Staff Orientation sessions 	<ul style="list-style-type: none"> Roll-out of the tiered WPV training model (outside of orientation) is occurring in alignment with Safe Management Group (SMG) certification expiry to support a phased implementation approach.
Conduct mock Code White exercises to improve team response to workplace violence incidents.	Complete interdisciplinary mock Code White simulations in identified high-risk clinical areas to support staff preparedness and reinforce appropriate response to escalating patient behaviours.	<ul style="list-style-type: none"> Completion of six (6) interdisciplinary mock Code White exercises in identified high-risk clinical areas 	<ul style="list-style-type: none"> Six (6) mock Code White exercises completed by end of 2026-27 	<ul style="list-style-type: none"> Mock Code White simulations provide staff with an opportunity to practice coordinated response to behaviours, with the goal of improving response effectiveness and reducing WPV-related lost time.

Completion of sociodemographic data collection

Director Lead: Chantelle Vernon
Target: Collecting Baseline

Definition: Percentage of Patient Experience survey respondents who provided responses to at least 3 of the 4 specified socio demographic questions within the most recent consecutive 12-month period.

Change Ideas	Methods	Process Measures	Target for Process Measure	Comments
Increase patient awareness of the survey and the importance of the sociodemographic questions in collaboration with patient experience department and PXPs and discharge planning	<ol style="list-style-type: none"> Posters across hospital and patient areas including information of why we are asking sociodemographic questions. Engage staff (ex. Discharge staff) to provide information to patient about the experience survey 	<ol style="list-style-type: none"> # of posters displayed across hospital Rounding to engage staff 	<ol style="list-style-type: none"> To be established in partnership with Corporate Communications 90% compliance with rounding once per month 	
Community engagement – engage the wider community to increase awareness and build trust	<ol style="list-style-type: none"> Engage the community about the survey via website and social media Share examples of how the data improves care equity Partner with corporate communications to create a video for social media 	<ol style="list-style-type: none"> # of social media posts Social media video published 	<ol style="list-style-type: none"> Minimum 1 post per quarter Video completed and published by end of Q3 	Capture # of views/clicks to evaluate reach and engagement

Sepsis – Time to Antibiotic

Director Lead: Alyson McQueen
Target: Collecting Baseline

Definition: Percentage of patients who receive their first dose of intravenous antibiotics within the 1 hour after activation of Code Sepsis

Change Ideas	Methods	Process Measures	Target for Process Measure	Comments
Enhance Existing Sepsis Dashboard with 'Exception-Reporting' Functionality	Collaborate with Decision Support to implement automated exception-reporting functionality within the current sepsis dashboard that flags two categories of data quality failures in real time: (1) negative-time cases where antibiotic administration timestamps precede the Code Sepsis activation, and (2) duplicate activations for the same patient within 60 minutes. As a foundational step prior to dashboard enhancement, conduct a structured 3-month retrospective chart audit of all existing negative/zero time-to-antibiotic cases to classify each as: (a) patient already on antibiotics at time of code, (b) code called retrospectively for documentation, (c) timestamp entry error, or (d) genuine rapid antibiotic administration.	<ul style="list-style-type: none"> • % of negative/zero time-to-antibiotic cases classified and reviewed within the 3-month baseline audit period. • % of dashboard-flagged cases audited by clinical leads within 7 days of identification. • % of audited cases where EMR-extracted Time Zero matches manual clinical chart review (data accuracy rate). 	<ul style="list-style-type: none"> • 100% of baseline cases reviewed and classified; audit report presented to Steering Group by end of Q1. • 100% of flagged cases audited within 7 days of identification. • >95% data accuracy match. 	
Align EMR Activation with Protocol Exclusion Criteria	Implement a mandatory prompt within the EMR Code Sepsis activation module asking: 'Is the patient currently receiving treatment for a confirmed infection?' If staff select 'Yes,' the EMR redirects them to a standard deterioration/MRP escalation pathway rather than starting the 1-hour Code Sepsis timer.	<ul style="list-style-type: none"> • % of Code Sepsis activations where the patient was NOT already receiving antibiotics prior to the call. 	<ul style="list-style-type: none"> • >90% (Ensures the Code is used primarily for treatment-naive patients, matching the protocol). 	
Implement a Unit-Level Data Feedback Loop	Utilize the exception-reporting dashboard to identify specific clinical units with high rates of duplicate activations or pre-treated Code Sepsis calls. Distribute targeted, unit-specific data scorecards to unit managers monthly, identifying patterns and driving localized re-education on proper activation criteria and protocol compliance.	<ul style="list-style-type: none"> • Number of targeted data feedback reports distributed to clinical managers. 	<ul style="list-style-type: none"> • 1 report per targeted unit, per month. 	