Quality Improvement Plan

Quality improvement is a priority at the Pembroke Regional Hospital (PRH). One of the ways in which we demonstrate this is through the development of an annual Quality Improvement Plan (QIP). Our QIP helps us to plan, document, and review performance in the areas of safety, effectiveness, access, patient centeredness, and integration of care. It helps us to identify new and better ways of doing things in order to improve care for our patients, increase satisfaction levels, and achieve better clinical outcomes.

The *Excellent Care for All Act, 2010* (ECFAA) requires all hospitals to produce a QIP annually, make it available to the public, and document progress.

Ontario Health has requested that hospitals select and report on some of the core indicators to support province-wide comparability where possible.

You may find some of the questions and answers below helpful in understanding the QIP process.

How is the QIP developed?

The PRH Board of Directors is responsible for overseeing the development of the QIP. The members of our Board work closely with our management team, various healthcare professionals, and patients and families to determine areas for improvement.

Once areas for improvement have been identified, targets are set for improvement.

Once the plan is finalized, it is then submitted to the Ontario Health.

What timeframe does the QIP cover?

Quality Improvement Plans are developed each fiscal year (April 1 – March 31).

How do we know if progress is being made?

We take quality improvement very seriously and are committed to achieving the targets that we set out in our annual plans.

Measuring progress against our established targets is the primary way in which we hold ourselves accountable to our stakeholders. Reports on progress are provided to our Board of Directors, Medical Advisory Committee, Quality and Patient Safety

Committees, as well our Patient and Family Advisory Council throughout the year. A summary report is posted on our website annually.

Where can I find out more information about the *Excellent Care for All Act* and quality improvement plans?

Please visit https://www.health.gov.on.ca/en/pro/programs/ecfa/legislation/act.aspx for more information about the legislation and its requirements.

Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

April 1, 2025

Hôpital Régional de Pembroke Regional Hospital

Ontario Health

OVERVIEW

At Pembroke Regional Hospital (PRH), the past year was marked by both challenges and triumphs, all driven by a commitment to delivering exceptional care. A key milestone was the development of our five-year strategic plan, Together, We Care, founded on the pillars of Compassion, Collaboration, Commitment, and Courage. This plan is already shaping our daily operations and guiding future work.

Significant achievements include the grand opening of the newly renovated Surgical and Day Surgery Units, enhancing patient-centered care and the overall patient experience. The hospital also introduced Automated Dispensing Units (ADUs) for medications, improving safety and efficiency. Additionally, initiatives like redesigned in-room whiteboards and digital patient satisfaction surveys highlight our commitment to continuous improvement.

Looking ahead to the coming year, the implementation of the Epic health information system will revolutionize care delivery, marking an exciting advancement for the hospital and its services.

A key focus for quality improvement in 2025 will be on enhancing access and flow. Two Quality Improvement Plan (QIP) initiatives will aim to optimize system capacity, ensure timely access to care, and improve the overall healthcare experience for our patients. We will continue to improve patient and caregiver experience by introducing measures that enhance patient understanding of their conditions and encourage more active family and caregiver involvement in care planning and discharge discussions.

Furthermore, significant efforts were made in 2024/2025 to

enhance the provider experience, and we aim to sustain these improvements in 2025/2026, promoting health human resource recruitment and retention.

ACCESS AND FLOW

Pembroke Regional Hospital (PRH) aims to optimize system capacity, improve timely access, and enhance patient flow to better the patient experience and health outcomes. In 2025/2026, PRH will address the priority indicator of “90th percentile ambulance offload time.” By reducing offload times, PRH intends to improve patient flow, minimize delays, and enhance resource utilization within the Emergency Department (ED). This will be achieved through improved handover processes and better coordination between ambulance teams and ED staff, with the goal of meeting the provincial target of a 30-minute offload time. The initiative will be a collaborative effort with local Paramedic Services, utilizing lean methodologies to identify opportunities for improvement.

Due to health human resource constraints, PRH will not focus on the priority indicator of “90th percentile ED wait time to physician initial assessment” in 2025/2026. Instead, the focus will be on maintaining current performance while improving the patient and caregiver experience. By enhancing communication strategies in the ED, PRH aims to reduce frustration, increase transparency, and improve the overall experience during wait times.

PRH will also not address the priority indicator of “daily average number of patients waiting in ED for an inpatient bed at 8:00 am,” as performance is better than the provincial average. Resources will be focused on the two priority indicators above.

EQUITY AND INDIGENOUS HEALTH

In the summer of 2022, Pembroke Regional Hospital (PRH) took a significant step towards fostering a more inclusive and equitable environment by establishing the Equity, Diversity, and Inclusion (EDI) Committee. Composed of dedicated staff from various departments, the committee was tasked with ensuring that no group felt excluded from the hospital's employee and patient experience.

In 2025/2026, PRH will build on this foundation by enhancing healthcare provider knowledge of Indigenous culture to reduce health disparities for patients, families, and providers. Through targeted training on Indigenous culture and healthcare gaps, the aim is to equip healthcare providers with the tools needed to offer culturally sensitive care and improve outcomes for Indigenous patients.

This quality improvement initiative will be developed in collaboration with internal and external stakeholders, including the EDI Committee. The goal is to support frontline healthcare professionals in understanding and applying cultural sensitivity and safety in their care practices.

Building on the success of PRH's 2024/2025 QIP, which achieved the target of training 80% of staff in cultural competence, this initiative will further enhance cultural awareness, competence, and sensitivity within healthcare teams, ultimately improving care for all patients.

PATIENT/CLIENT/RESIDENT EXPERIENCE

In 2024/2025, Pembroke Regional Hospital (PRH) used the patient experience survey to monitor and improve the discharge process. Key successes of this initiative included updating communication tools for patients and caregivers, enhancing resources, and collaborating with internal and external stakeholders, including patient and family advisors. By implementing improved visual communication tools, such as whiteboards in patient rooms, PRH aimed to improve patient and caregiver understanding of the care plan, foster greater family/caregiver engagement, and enhance overall satisfaction with care and discharge plans.

Building on this foundation, PRH will integrate lessons learned from the 2024/2025 quality improvement work into the 2025/2026 plan. Using the patient satisfaction survey as a benchmark, PRH will focus on improving communication about discharge, with an emphasis on enhancing patient understanding of their condition and increasing satisfaction with family and caregiver involvement. This work will be further informed by collaboration with patient and family advisors, insights from the patient relations process, and engagement from frontline staff.

PROVIDER EXPERIENCE

In 2025/2026, Pembroke Regional Hospital (PRH) will focus primarily on the priority indicator of “access and flow,” and as a result, there will be no specific provider experience initiative included in the Quality Improvement Plan. However, teams will continue to strengthen and maintain the initiatives from the previous fiscal year.

Notable successes from the “Patient Care Teams” initiative include standardizing roles and responsibilities, implementing decision-making tools to determine patient distribution for nurses, enhancing the user experience for shift offers, formalizing education and training for the leadership team, and introducing new roles within the organization. These efforts led to PRH surpassing its target of improving positive response rates in the staff engagement survey, positively impacting provider experience.

Pembroke Regional Hospital will continue to focus on maintaining and building upon these improvements, further enhancing workplace culture and the staff experience at the department level in 2025/2026.

SAFETY

In 2025/2026, Pembroke Regional Hospital (PRH) aims to enhance patient safety and care quality by focusing on delirium prevention and the early identification of delirium risk. By implementing targeted prevention strategies, we aim to reduce the occurrence of delirium during hospitalization, ultimately minimizing complications and patient safety incidents such as falls and pressure injuries.

A multidisciplinary approach, informed by best practices, will be used to provide education and training to frontline teams, update processes, and monitor the effectiveness of this initiative. To prevent delirium onset, coordinated interventions addressing multiple risk factors will be implemented by all members of the healthcare team.

This quality improvement initiative will focus on early detection of patients at risk of delirium, and the implementation of prevention strategies to help prevent delirium from occurring.

In 2024/2025, PRH began preparing for the implementation of electronic charting with EPIC, aiming to enhance patient safety by providing a centralized, accurate, and easily accessible record of patient information. The goal is to support healthcare workers in making informed decisions, reducing medication errors, flagging potential risks, and improving communication among healthcare teams. While the implementation timeline has shifted due to circumstances beyond our control, PRH continues to plan and prepare for the successful implementation of EPIC in the near future.

PALLIATIVE CARE

Over the past few years, Pembroke Regional Hospital (PRH) has made significant strides in enhancing palliative care services. Key improvements include:

1. Palliative Care Rounds: A multidisciplinary initiative held bi-weekly to ensure quality end-of-life care for both our patients and the community. This includes participation from PRH team leads, palliative care coordinators, community paramedics, social work, spiritual care, and hospital staff.

2. Enhanced Training for Staff and Physicians: Frontline staff participation in the LEAP Core Course (Learning Essential Approaches to Palliative Care), equipping them with essential skills for palliative care.

3. Multidisciplinary Palliative Care Working Group: This group reviews current processes and identifies opportunities for improvement, focusing on enhancing the patient, caregiver, and family experience at end of life. Notable achievements include the introduction of a comfort cart, providing meals/snacks for loved ones at the bedside, offering parking reimbursement, and improving communication between interdisciplinary team members.

4. HOMR Flagging System: This system serves as a trigger for physicians to initiate early discussions about care goals, helping identify patients who could benefit from a palliative care approach.

Looking ahead, we will continue to expand training opportunities for staff and explore ways to further improve the caregiver and family experience. A key upcoming initiative includes the

reintroduction of a dedicated palliative care room in the medical unit to ensure our patients' dignity and comfort at the end of life.

POPULATION HEALTH MANAGEMENT

A strategic pillar for Pembroke Regional Hospital is collaborating with partners to enhance community care, focusing on those with the highest unmet needs and optimizing access to specialized services closer to home. Key initiatives over the past year include:

ICU Occupancy: Following the 2022 ICU expansion, PRH continues to focus on providing critical care locally while working with regional hospitals for patients requiring urgent dialysis, cardiac, or neurosurgical care. Efforts are ongoing to expand our ICU team and align admission rates with benchmarking targets.

HART (Homelessness and Addiction Recovery Treatment) Hub: In partnership with the County of Renfrew, PRH will co-lead the HART Hub, supporting primary care, mental health services, addiction support, social services, and housing. This model is set to roll out in the coming weeks, integrating existing services with community partners.

Epic Implementation: PRH is implementing an electronic charting system in collaboration with five other Champlain Region hospitals. This system will improve communication and streamline patient navigation across organizations.

Expansion of Cancer Care Services: Renovations to our pharmacy and Chemotherapy/Medical Day Care unit, along with collaboration with other health organizations, have expanded oncology services, allowing us to offer more treatments daily and keeping care closer to home for patients.

EMERGENCY DEPARTMENT RETURN VISIT QUALITY

PROGRAM (EDRVQP)

Last year's quality improvement priorities were focused on reducing the percentage of patients leaving against medical advice, and stroke management.

Left Against Medical Advice (AMA): A focus was placed on patients presenting with chest pain. Planning was understaken to implement a process to prevent patients from leaving AMA through improved door to ECG times. The goal was to reduce door to ECG time by 80 percent through a process of flagging high-risk patients waiting in the waiting room. To support staff, a standard work was created to guide the process. This initiative was successfully implemented with the 80 percent goal being achieved.

Stroke Management: Planning was undertaken with the stroke educator to determine underlying causes of variance in discharge decision making and stroke education was prioritized. Dr. Blaquiere, Regional Stroke Physician Lead, provided a stroke education session at the ED Physician Core Group meeting focusing on high risk TIAs.

Quality issues identified via this year’s return visit audit:

Dispensing Medication After Hours: There was a service gap identified for patients being discharged after hours, who are not able to access a pharmacy to have their prescriptions filled. This led to return visits due to insufficient pain management.

Observation Period for the Pediatric Population. There were gaps in consistency of observing the pediatric population who present with abnormal vital signs, prior to discharge.

Opioid Overdose Discharge Management. There was an improvement opportunity identified for the safe discharge of those presenting with an opioid overdose.

Quality initiatives we are prioritizing to address these issues:

Dispensing Medication After Hours: PRH will work with the pharmacy team to develop and implement a policy that allows ED nurses to dispense medication (including controlled substances) after hours.

Observation Period for the Pediatric Population: PRH will collaborate with the Kids Health Alliance to determine a best practice for observing this patient demographic and provide the information to the ED Physician Team Lead to guide future practice.

Opioid Overdose Discharge Management: PRH is partnering with the local Health Unit to develop/implement a Naloxone distribution program within the ED.

EXECUTIVE COMPENSATION

Our Senior Leadership Team is made up of the President and Chief Executive Officer, the Vice-President of Clinical Services/Chief Nursing Executive, the Vice-President of People, Quality, and Mental Health Services, the Vice-President of Finance and Corporate Services / Chief Financial Officer, and the Chief of Staff. For each of these executives, 5% of their total available compensation is tied to the achievements of targets identified in the annual QIP.

For 2025/2026 each member of the senior team will have 5% of the total available compensation linked to achieving the targets as set out in our 2025/2026 QIP. The outcome measures or indicators are typically weighted, and the achievement of all targets would result in 100% payout, with partial achievement of targets resulting in partial payout as determined by the Pembroke Regional Hospital Board of Directors.

CONTACT INFORMATION/DESIGNATED LEAD

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President & CEO
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613-732-2811 Ext 6156

SIGN-OFF

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan on April 1, 2025

Board Chair

N. Nicholson
Board Quality Committee Chair

Chief Executive Officer

EDRVQP lead, if applicable

Pembroke Regional Hospital

Quality Improvement Plan (QIP) 2025/2026

Care for our People – Compassion and Commitment

AIM		MEASURE			
Quality Dimension	**Objective**	**Indicator**	**Current Performance**	**Target for 2025/26**	**Target Justification**
Patient Experience	Enhance the transition experience for patients and their families from hospital to home or community by fostering effective communication and providing comprehensive health education.	Percentage of respondents who select "Always" or "Completely" to the following questions: "Were your family or friends involved as much as you wanted in decisions about your care and treatment?" "When you left the hospital, did you have a better understanding of your condition than when you entered?"	66%	75%	Effective communication and education about discharge are crucial for improving patient outcomes. Currently, 66% of patients are satisfied with our transition process. By improving patient education and communication with family/ caregivers, we expect to reach 75% satisfaction over the next year.

Change Idea

To assess and improve communication about discharge with inpatients, focusing on enhancing patient knowledge of their condition and satisfaction with family/caregiver involvement.

Methods	Process Measures	Target for Process Measure	Responsible Departments
Leverage feedback from the Patient Family Advisory Committee (PFAC) and unit-level advisors to identify key needs and challenges related to patient education and family/caregiver engagement.	Q1: Number of structured change processes developed and implemented across all inpatient units. Q2: Change processes are fully implemented across all inpatient units.	Q1: 2 Q2: 100%	**SLT Lead:** Sabine Mersmann **Admin Resource Lead:** To be assigned

Analyze and summarize insights from the patient relations process to identify common concerns and areas for improvement in discharge communication. Utilize the Discharge Communication Driver Working Group to conduct a comprehensive review of the discharge process across all inpatient units to identify opportunities to enhance: 1. **Patient Understanding** of their condition, treatment plan, and follow-up care, *and* 2. **Family/Caregiver Involvement** in the discharge process and care planning. Establish a method to implement structured change processes across all inpatient units to ensure consistency and quality in care delivery.	Q3: Percentage of respondents answering “always” or “completely” to the two survey questions. Q4: Percentage of respondents answering “always” or “completely” to the two survey questions.	Q3: 70% Q4: 75%	Medical ICU Rehabilitation Acute Mental Health Surgical

Care for our Community – Collaboration, Commitment and Courage

AIM		MEASURE			
Quality Dimension	**Objective**	**Indicator**	**Current Performance**	**Target for 2025/26**	**Target Justification**
Patient Safety	Enhance delirium prevention strategies and management of delirium to reduce its occurrence during hospitalization, promoting better patient outcomes and safety.	Percentage of patients at risk for delirium who have at least one prevention strategy documented in their care plan.	Not currently measured	70%	Reducing the incidence of delirium is critical to improving patient safety and promoting optimal recovery. By implementing targeted prevention strategies, we aim to minimize the occurrence of delirium during hospitalization. In addition to enhancing patient outcomes, these preventative interventions will help reduce complications such as falls and pressure injuries, as well as shorten hospital stays.

Change Idea			
Enhance the use of delirium prevention strategies and improve early identification of delirium risk to improve patient outcomes.			
Methods	**Process Measures**	**Target for Process Measure**	**Responsible Departments**
Establish a collaborative team consisting of healthcare professionals from various disciplines to review and assess current delirium prevention strategies, as well as practices for early identification and treatment.	Q1: Percentage of frontline staff who have received education on delirium risk factors, screening tool and prevention methods.	Q1: 70%	**SLT Lead**: Chief of Staff **Admin Resource Lead:** To be assigned

Formalize a method to educate frontline staff and evaluate patient risk for delirium. Establish a method for evaluating process measure(s). Leverage the expertise of the working group to identify areas for improvement and implement evidence-based practices that optimize delirium prevention. Additionally, work to enhance protocols for the early identification and timely management of delirium in at-risk patients.	Q2: Percentage of patients with delirium risk screening completed. Q3: Percentage of patients at risk for delirium who have at least one prevention strategy documented in their care plan. Q4: Percentage of patients at risk for delirium who have at least one prevention strategy documented in their care plan.	Q2: 80% Q3: 60% Q4: 70%	 ICU Medical Surgical Rehab

Care with our Partners – Collaboration and Commitment

AIM		MEASURE			
Quality Dimension	**Objective**	**Indicator**	**Current Performance**	**Target for 2025/26**	**Target Justification**
Access and Flow	To enhance patient safety, ensure optimal care, and improve overall healthcare quality by reducing ambulance offload time in the Emergency Department.	Rate of ambulance offload time (minutes).	50 minutes	30 minutes	Reducing ambulance offload times is important for enhancing patient safety and improving operational efficiency in the Emergency Department (ED). Prolonged offload times can result in treatment delays, overcrowding, and increased patient risk. By targeting a reduction in these times, we aim to optimize patient flow, minimize delays, and improve resource utilization within the ED. Achieving a 30-minute target for ambulance offload times will align PRH with the provincial target, leading to faster care and an overall improvement in service quality.

Change Idea

Reduce the time it takes to offload patients from ambulances to the Emergency Department by enhancing communication, optimizing the handover process, and improving coordination between ambulance teams and Emergency Department staff.

Methods	Process Measures	Target for Process Measure	Responsible Departments
Complete PDSA (Plan-Do-Study-Act) to identify challenges related to ambulance offload within the Emergency Department.	Q1: PDSA completed. Q2: Number of change ideas/ interventions identified through PDSA implemented.	Q1: 100% Q2: 2	**SLT Lead**: Beth Brownlee **Admin Resource Lead**: To be assigned

Collaborate with Renfrew County Paramedic Services to identify and implement opportunities for improvement. Establish a method to evaluate success.	Q3: Rate of ambulance offload time (represented in minutes). Q4: Rate of ambulance offload time (represented in minutes).	Q3: 40 Q4: 30	Emergency Department

Care with our Community – Collaboration

AIM		MEASURE			
Quality Dimension	**Objective**	**Indicator**	**Current Performance**	**Target for 2025/26**	**Target Justification**
Patient Experience	To improve communication and enhance patient satisfaction regarding the time to initial physician assessment in the Emergency Department (ED), through targeted improvements in communication processes and workflow efficiency.	Percentage of respondents who answer “very satisfied” or “satisfied” to the following survey question. “During this visit, how satisfied were you with the communication and attention you received while waiting in the emergency department?"	Not currently measured.	To be determined.	Delays in the time to initial physician assessment in the Emergency Department can lead to frustration and dissatisfaction among patients and caregivers. By improving communication strategies within the ED, we aim to reduce frustration, increase transparency during the assessment process, and ultimately enhance the overall experience for both patients and their families. A target will be determined once a baseline is established, with the goal of achieving measurable improvement over the baseline.

Change Idea

Implement targeted communication improvements to provide clear, transparent updates to patients and caregivers during wait times in the Emergency Department. This will reduce frustration and enhance overall patient and family satisfaction.

Methods	Process Measures	Target for Process Measure	Responsible Departments
Apply lean management principles to assess current processes and identify opportunities for improvement.	Q1: A formalized approach has been established to define and measure success.	Q1: 100%	**SLT Lead**: Scott Coombes **Admin Resource Lead**: To be assigned

Collaborate with stakeholders, including physicians, to gather feedback on existing workflows, challenges, and potential solutions. Focus on identifying areas to improve communication and optimize physician resource utilization. Develop strategies to address these issues, with the goal of enhancing the overall patient and caregiver experience. Establish a method to survey patients to obtain feedback and monitor for success.	Q2: Number of opportunities for improvement identified and implemented. Q3: Number of opportunities implemented that have been formally evaluated for success. Q4: Monitor and evaluate ongoing success of change processes.	Q2: 2 Q3: 2 Q4: 100%	Emergency Department

Care for our People - Compassion

AIM		MEASURE			
Quality Dimension	**Objective**	**Indicator**	**Current Performance**	**Target for 2025/26**	**Target Justification**
Equity, Diversity, and Inclusion (EDI)	Advancing the health care provider knowledge of indigenous culture to reduce disparities in outcomes for patients, families, and providers.	Survey question: "On a scale 1-10, where 10 is the highest knowledge, how would you rate your knowledge base regarding the provision of culturally sensitive care?"	Not currently being measured.	To be determined.	Creating a welcoming, inviting hospital to work in, or receive care is important to achieve better outcomes for workers and patients. By training staff on indigenous culture, we can reduce disparities that may exist and improve the experience for all. The target will be established after determining the baseline and will aim for measurable improvement over that baseline.

Change Idea			
Improve the knowledge, through training/education, of Indigenous culture and health care gaps, and how to reduce disparities.			
Methods	**Process Measures**	**Target for Process Measure**	**Responsible Departments**
Identify and select appropriate education programs. Select population for completion of training(s). Establish a method for tracking training progress among staff, and physicians.	Q1: Indigenous cultural training programs identified. Target group for training identified. Q2: Number of employees from target group who have completed the Indigenous cultural training.	Q1: 100% Q2: 25%	**SLT Lead**: Brent McIntyre **Admin Resource Lead**: To be assigned

Implement the new education program(s).	Q3: Number of employees from target group who have completed the Indigenous cultural training. Q4: Number of employees from target group who have completed the Indigenous cultural training.	Q3: 60% Q4: 80%	Target Group

Equity | Equitable | Custom Indicator

	Last Year		This Year		
Indicator #4 Percentage of staff and physicians that have completed education related to equity, diversity and inclusion. (Pembroke Regional Hospital Inc.)	**CB** Performance (2024/25)	**40** Target (2024/25)	**83.00** Performance (2025/26)	**--** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Improve the knowledge, through education, of EDI related issues and how to reduce disparities.

Process measure

•Q1: Number of education programs that were reviewed by the Equity, Diversity, and Inclusion Committee. Q2: Number of education programs selected for completion by staff and physicians in Q3 and Q4. Q3: Percentage of staff, and physicians that have completed the selected education program(s). Q4: Percentage of staff, and physicians that have completed the selected education program(s).

Target for process measure

- Q1: 3 Q2: 1 Q3: 20% Q4: 40%

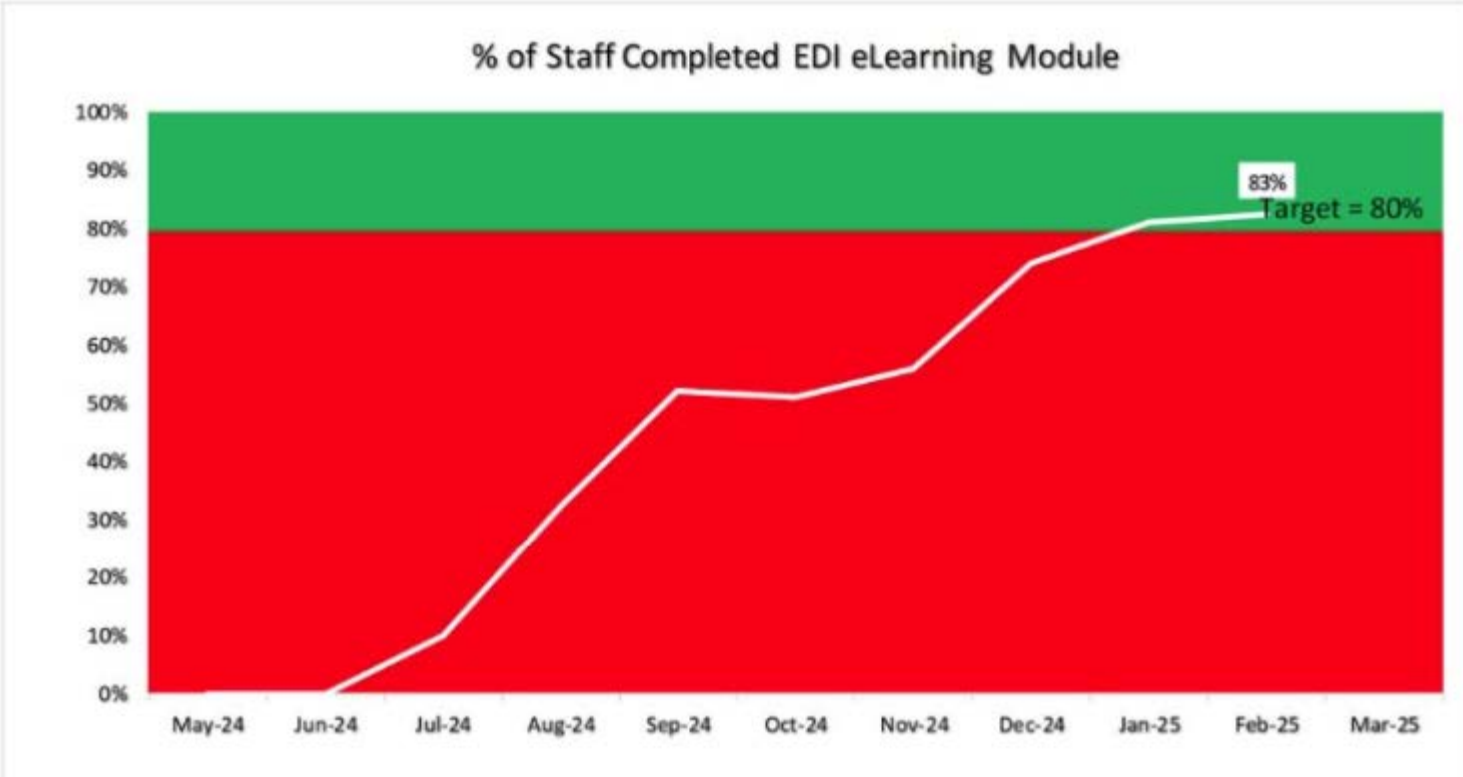
Lessons Learned

Utilizing an electronic eLearning module to provide education and training on equity, diversity, and inclusion helped staff better understand and appreciate the importance of these values in the workplace. It also highlighted how essential they are in providing quality care for our patients, community, and each other. This method proved effective and enabled us to exceed our initial training goals.

Comment

We will build upon this training foundation in 2025-2026 to further enhance healthcare providers' knowledge of equity, diversity, and inclusion, ensuring that frontline staff have the necessary training to deliver culturally sensitive care.

Results



Experience | Patient-centred | Custom Indicator

Indicator #1

Average number of days per month in which care teams worked without the full complement of staff and physicians. (Pembroke Regional Hospital Inc.)

Last Year		This Year		
CB	**CB**	**NA**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☐ Implemented ☑ Not Implemented

Establish new staffing/physician models for non-nursing patient care team members.

Process measure

•Q1: A) Number of non-nursing patient care team roles selected for QIP driver. B) Establishing recruitment process for physicians based on highest need. Q2: Number of staffing barriers identified for each role selected, including physicians. Q3: Number of responsible departments with patient care team model implementation plans for non-nursing roles. Q4: Number of responsible departments that have completed the implementation phase for non-nursing patient care team models.

Target for process measure

- Q1: A) 3 B) 1 Q2: 3 Q3: 6 Q4: 6

Lessons Learned

As efforts to enhance the patient care team model progressed, it became clear that the initially established measure was no longer suitable for the task. As a result, the team revised the quality initiative and selected a new measure that more accurately reflects progress toward the goal.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Continue to strengthen patient care teams by improving the staffing and efficiencies of the non-nursing patient care team members.

Process measure

- No process measure entered

Target for process measure

- No target entered

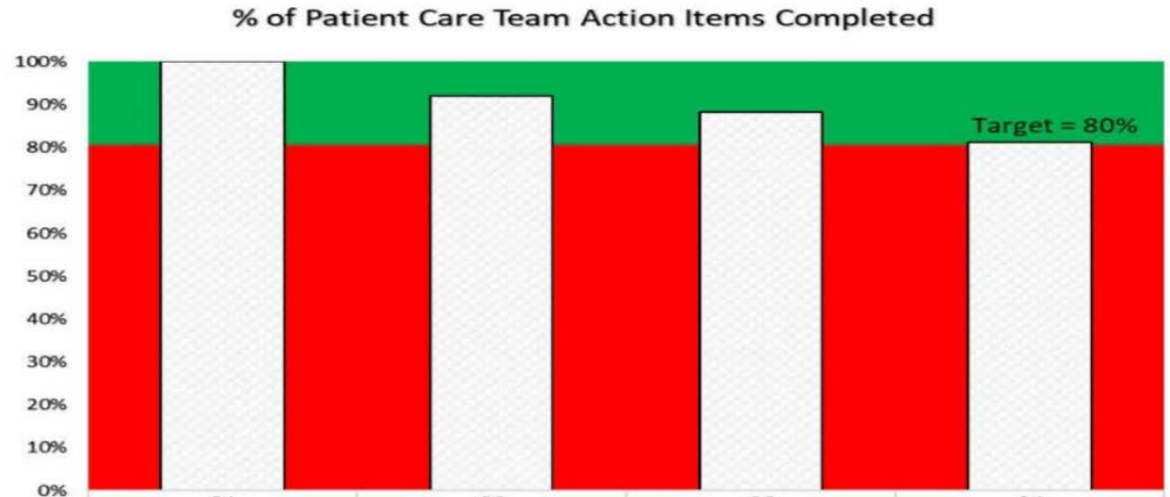
Lessons Learned

Monitor the percentage of staff and physicians who ‘strongly agree’ or ‘agree’ to the following survey questions:
1.I am satisfied with the quality of care/client service provided by myself, my team, and my department.
2. I would recommend my department/my program to my family and friends as a place to work.
3.Overall, how satisfied are you working at PRH.

Comment

With a current performance of 63% on the two survey questions, PRH set a goal to achieve a 5% increase in employee response, targeting 68% by June 2025. This target was surpassed, with a 7% increase achieved.

Results



	Q1	Q2	Q3	Q4
% Actions Completed	100%	92%	88%	81%
# Actions Completed	16	23	15	13
Quarterly Action Items	16	25	17	16

Experience | Patient-centred | Optional Indicator

Indicator #3

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? (Pembroke Regional Hospital Inc.)

Last Year		This Year		
CB	80	80.58	--	NA
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Improve our patient’s knowledge of their condition by identifying gaps in discharge communication for inpatients and people treated in the Emergency Department (ED).

Process measure

•Q1: Number of clinical departments that identify at least one additional patient- and/or family-related gap in discharge communication and have developed plans to address gaps. Q2: Number of departments that have implemented the discharge communication improvements. Q3: Number of departments that have implemented the discharge communication improvement. Q4: Number of departments that have evaluated the implementation of their discharge communication improvement.

Target for process measure

- Q1: 6 Q2: 3 Q3: 6 Q4: 6

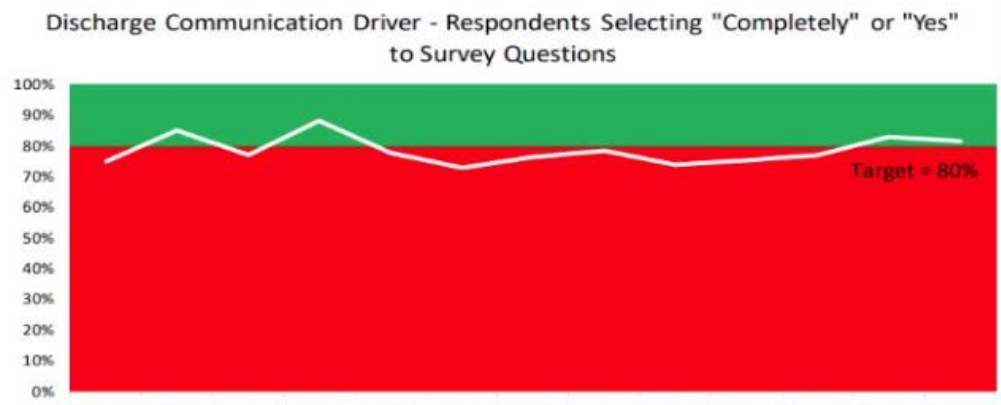
Lessons Learned

Utilizing patient experience surveys as a benchmark for success posed a challenge at the beginning of the quality improvement project due to recent changes in the survey process, shifting from hard copy to electronic formats. The initial focus was on increasing the number of completed surveys to ensure an adequate sample size and accurate representation of progress and success with the initiative.
By using a unit-specific approach and a variety of methods, our departments successfully implemented processes to improve communication during discharge.

Comment

In 2025-2026, PRH will build upon this foundation to further enhance the patient experience by focusing on improving patient understanding of their condition and care plan, as well as increasing the involvement of family members and caregivers in care plan and discharge discussions.

Results



	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
% Selecting "Completely"	75%	85%	77%	88%	78%	73%	76%	78%	74%	75%	77%	83%	82%
Total # Surveys	103	80	144	126	189	185	237	205	210	213	169	203	159

OPOC Data added May 2024

ED: Before you left the emergency department, did you understand what symptoms or health problems to look out for when you left the emergency department?
Inpatient: 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?
OPOC: Staff helped me develop a plan for when I finish the program/treatment

Safety | Safe | Custom Indicator

Indicator #2

Begin the planning for EPIC (electronic health records software system) implementation.

Percentage of processes completed by quarter. (Pembroke Regional Hospital Inc.)

Last Year			This Year		
CB	90		100.00	--	NA
Performance (2024/25)	Target (2024/25)		Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Ensure an effective transition to an electronic health record by beginning the planning process for the implementation of EPIC.

Process measure

•Q1: Establish an EPIC working group to support the transition. Q2: A) Creation of an EPIC project charter. B) Number of processes initiated over processes planned to be initiated; expressed as a percentage. Q3: Number of processes initiated over processes planned to be initiated, expressed as a percentage. Q4: Number of processes initiated over processes planned to be initiated, expressed as a percentage.

Target for process measure

- Q1: 1 Q2: A) 1 B) 90% Q3: 90% Q4: 90%

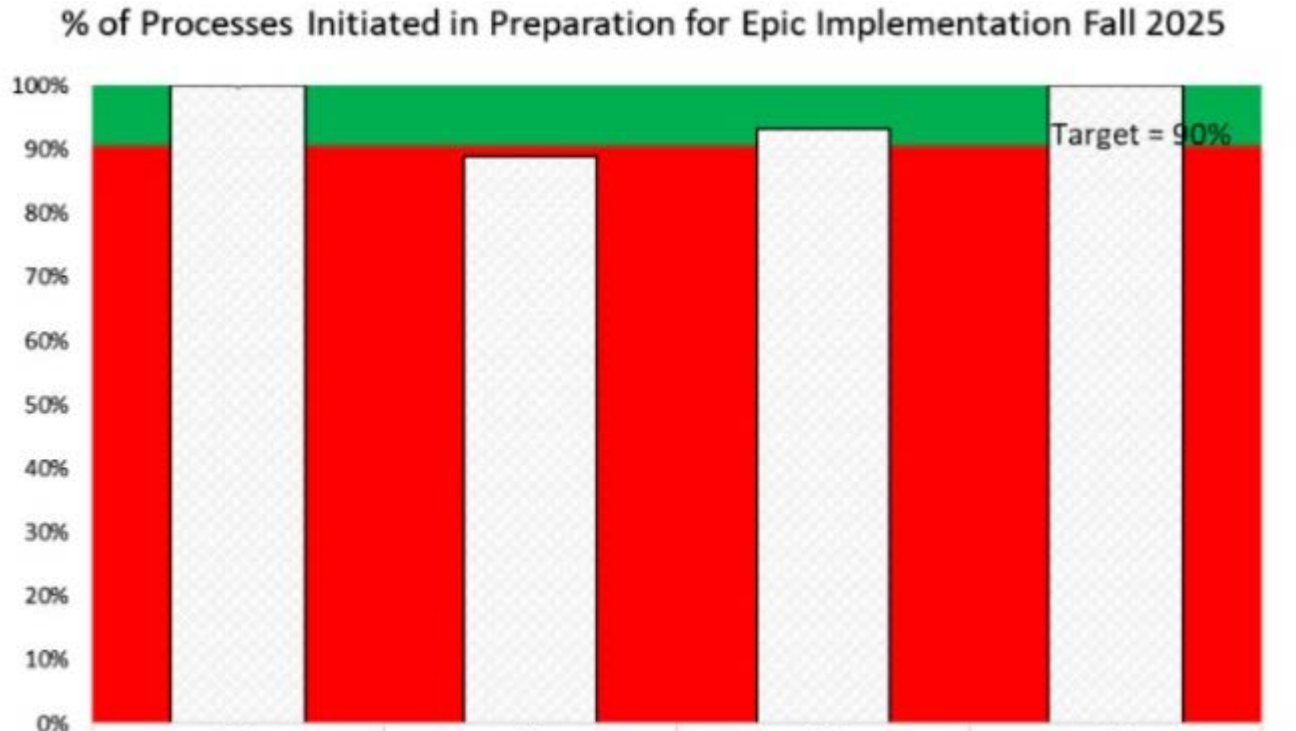
Lessons Learned

Initial targets for this QI project were met; however, relying on external stakeholders for the program's launch led to delays and factors beyond our control. Despite this, the preparatory work has resulted in streamlined processes, improved electronic modalities, and enhanced patient safety.

Comment

Due to circumstances beyond our control, the implementation of the Epic platform has been delayed to allow for a regional rollout across multiple sites. Throughout the year, PRH continued implementing measures in preparation for the launch. Initial progress with process implementation was on track with the monthly target. However, the delayed launch halted our ability to complete some preparatory processes. PRH remains committed to preparing for and looks forward to the upcoming implementation of this program.

Results



	Q1	Q2	Q3	Q4
% Actions Completed	100%	89%	93%	100%
# Actions Completed	1	8	14	15
Quarterly Action Items	1	9	15	15