Pembroke Regional Hospital

Quality Improvement Plan (QIP) 2024/2025

Patient and Family Experience

AIM		MEASURE			
Quality Dimension	**Objective**	**Indicator**	**Current Performance**	**Target for 2024/25**	**Target Justification**
Patient Experience	Maintain the experience of patients and families at transition from hospital to community through effective communication.	Percentage of respondents who select "Completely" to the following questions: "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?"	80%	80%	The target for this driver in 2023/24 was 70%. The target for the 2024/25 target has been increased by 10% to maintain our current performance.

Change Idea

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

Methods	Process Measures	Target for Process Measure	Responsible Departments
Utilize the Discharge Communication Driver Working Group to assess, implement, and evaluate discharge communication change ideas.	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.	Q1: 6 Q2: 3	**SLT Lead:** Melanie Henderson **Admin Resource Lead:** Alycia Fraser Medical ICU Emergency Rehabilitation Acute Mental Health Surgical

	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.	Q3: 6 Q4: 6	

Best Health Outcomes

AIM		MEASURE			
Quality Dimension	**Objective**	**Indicator**	**Current Performance**	**Target for 2024/25**	**Target Justification**
Patient Safety	Begin the planning for EPIC (electronic health records software system) implementation.	Percentage of processes completed by quarter.	Not currently being measured.	90%	In 2024, Pembroke Regional Hospital will begin the planning process to implement EPIC. A project charter will be established with countermeasures requiring completion at each step throughout the process.

Change Idea

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

Methods	Process Measures	Target for Process Measure	Responsible Departments
Establish working groups to support planning. Establish a project charter. Identify processes requiring changes to facilitate transition to EPIC.	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.	Q1: 1 Q2: A) 1 B) 90% Q3: 90% Q4: 90%	**SLT Lead**: Scott Coombes / Beth Brownlee **Admin Resource Lead:** Alycia Fraser Hospital-wide

Provider Experience

AIM		MEASURE			
Quality Dimension	**Objective**	**Indicator**	**Current Performance**	**Target for 2024/25**	**Target Justification**
Provider Experience	Continue to strengthen patient care teams by reducing the percentage of daily shift vacancies on clinical units among non-nursing staff and physicians.	Average number of days per month in which care teams worked without the full complement of staff and physicians.	Not currently measured.	Reduce the average number of days per month non-nursing care team members work without their full complement by 25% by June 2025.	Non-nursing staff (health care aides, allied health members, etc.), and physicians have an integral role in patient care teams. Reducing the frequency these teams work without their full complement will reduce the need for overtime and workloads.

Change Idea

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

Methods	Process Measures	Target for Process Measure	Responsible Departments
Complete PDSA (Plan-Do-Study-Act) to identify staffing challenges among non-nursing patient care team members, including physicians. Identify and implement a new patient care team model.	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.	Q1: A) 3 B) 1 Q2: 3 Q3: 6 Q4: 6	**SLT Lead**: Brent McIntyre **Admin Resource Lead**: Anna Ethier Medical Emergency Surgical Rehabilitation Acute Mental Health Medical Affairs

Best Health Outcomes

AIM		MEASURE			
Quality Dimension	**Objective**	**Indicator**	**Current Performance**	**Target for 2024/25**	**Target Justification**
Equity, Diversity, and Inclusion (EDI)	Advancing equity, inclusion and diversity knowledge to reduce disparities in outcomes for patients, families, and providers.	Percentage of staff and physicians that have completed education related to equity, diversity and inclusion.	Not currently being measured.	40%	Creating a welcoming, inviting hospital to work in, or receive care is important to achieve better outcomes for workers and patients. By training 40% of all staff and physicians on EDI related issues, we can reduce disparities that may exist and improve the experience for all. Majority of the education will occur in Q3 and Q4.

Change Idea			
Improve the knowledge, through education, of EDI related issues and how to reduce disparities.			
Methods	**Process Measures**	**Target for Process Measure**	**Responsible Departments**
Identify and select appropriate education programs. Establish a method for tracking training progress among staff, and physicians. Implement the new education program.	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).	Q1: 3 Q2: 1 Q3: 20%	**SLT Lead**: Brent McIntyre **Admin Resource Lead**: Rachel Pecoskie Hospital-wide

	Q4: Percentage of staff, and physicians that have completed the selected education program(s).	Q4: 40%	