

Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 31, 2026



OVERVIEW

The Pembroke Regional Hospital (PRH) has entered an exciting period of transformation as we work to enhance the quality, safety, and experience of care for our community. Over the coming year, we will continue strengthening initiatives introduced in our 2025/26 Quality Improvement Plan (QIP), while preparing for the implementation of a new electronic health record (EHR) system, Epic, in 2026.

This new system represents a major step forward in how we deliver care. Epic will modernize and streamline the way health information is documented, accessed, and shared across the hospital and between service providers. For patients, this means greater coordination of care, improved communication, and a more seamless healthcare journey inside and outside of the hospital. For our clinical teams, it means safer, more efficient workflows, and better tools to support decision-making. Through 2025/26, PRH has been preparing for this shift. Staff across all departments have been actively engaged in planning, training, and workflow redesigns to prepare for this transition and this work will continue into 2026/27.

As we move into the 2026/27 Quality Improvement Plan cycle, our focus will be on sustaining progress on our 2025/26 QIP initiatives, proactively preparing for organization-wide change with Epic, and identifying key quality improvement opportunities post Go-Live. While this transition will bring meaningful long-term benefits, we recognize that large-scale change also carries inherent short-term risks to workflow stability and quality. A key priority for this year will be to work to mitigate these risks through proactive planning, training, and early stabilization efforts.

Together, we are building a stronger, safer, and more connected healthcare system. Together, we care.

ACCESS AND FLOW

Pembroke Regional Hospital (PRH) remains committed to supporting timely access to care, improving patient flow, and enhancing the patient and caregiver experience. For the 2026/27 Quality Improvement Plan (QIP) cycle, PRH will focus on Emergency Department (ED) Wait Time Efficiencies as a custom indicator within Access and Flow.

With the upcoming implementation of Epic, PRH anticipates opportunities for improved workflow efficiency and enhanced data integrity within our ED. However, we also recognize changes of this magnitude carry risks that may negatively impact overall ED performance during implementation. As such, the primary focus for this driver will be to strengthen current performance on key indicators in the ED while holistically supporting staff through the transition to Epic. This includes building awareness of Epic-specific capabilities and ensuring teams are well-equipped to utilize these tools effectively. Dedicated resources will support staff education, workflow redesign, and adoption, alongside early stabilization efforts designed to minimize disruptions to access and flow throughout Epic implementation.

Additionally, this driver will help to launch a comprehensive Lean improvement project within the Emergency Department. With focused resources in place, PRH will position itself to identify quality improvement opportunities emerging following Epic go-live.

EQUITY AND INDIGENOUS HEALTH

In 2025/26, Pembroke Regional Hospital (PRH) continued in our commitment to creating a more welcoming, culturally safe, and inclusive environment for Indigenous patients, families, and communities, as well as advancing equity for all. Over the past year, PRH focused on building staff capacity through high-quality, accessible training, supporting staff in enhancing their knowledge and confidence to foster an inviting and respectful care environment. Dedicated human resources were allocated to supporting participation in these learning opportunities, and feedback from staff was actively gathered to inform future initiatives.

In 2026/27, PRH will build upon this foundation by advancing an organization-wide implementation of Ontario Health's Cultural Competence in Healthcare training. This training, which was identified as a high-value learning resource during our previous QIP cycle, will be made available through PRH's internal eLearning platform to ensure all staff can participate. This year's focus will be on widespread adoption, completion, and integration of the training into everyday practice, reinforcing PRH's commitment to culturally safe and sensitive care.

PRH also recognizes the continued value and impact of roles dedicated to supporting equity within our organization. PRH's internal Equity, Diversity, and Inclusion (EDI) Committee, established in 2022, is composed of dedicated staff from across our organization and is tasked with ensuring no group feels excluded from the hospital's employee or patient experience. The committee serves as a key advisory and leadership body in shaping PRH equity priorities and in supporting cultural safety initiatives across our organization. Our Indigenous Care Coordinator works in partnership

with a variety of healthcare providers, including the Renfrew County Diabetes Education Program and the Renfrew County Mesa Homelessness and Addiction Recovery Treatment (HART) Hub, and with Indigenous patients, caregivers, and the broader Indigenous community to enhance and improve the experience and health outcomes for those with complex health conditions. Our Spiritual Care and Ethics Coordinator works to enhance and facilitate the spiritual health of patients and their families as they mobilize spiritual health resources available to them for well-being. This helps to enable meaningful spiritual health experiences and strengthen one's dignity, values, and identity.

Ongoing collaboration with Indigenous communities and local representatives remains central to PRH's approach to equity, guiding our efforts and ensuring our work is grounded in lived experience, partnership, and respect. Ultimately, we aim to continue advancing our health care provider knowledge relating to the provision of culturally sensitive care to reduce disparities and improve the experience for all.

PATIENT/CLIENT/RESIDENT EXPERIENCE

In 2025/26, Pembroke Regional Hospital (PRH) leveraged results from our patient experience surveys to monitor and support targeted improvement opportunities across our hospital. Key successes included enhancing organization-wide use of "Teach Back" skills to promote better patient and family/caregiver understanding of condition and treatment; embedding new training modules into our organizational eLearning; refining processes and expectations around early identification of a patient's preferred family member or caregiver; rolling out in-person coaching plans to reinforce relevant skills, and improving the clarity of signage in our Emergency Department.

As we move into the 2026/27 QIP cycle, PRH remains committed to sustaining the progress made throughout 2025/26 while preparing for the transition to a new electronic health record system. Our focus will begin with strengthening our understanding of the 'current state' compared to 'future state', by examining our existing workflows and processes alongside those that will be introduced with Epic. This approach will allow us to preserve and sustain existing practices and expectations that are currently working well, while also positioning us to identify opportunities to further enhance the patient experience following Epic implementation.

PRH recognizes that the transition to Epic will introduce significant process and workflow changes across our organization. As such, maintaining performance during this period will be essential to help support continuity of care, mitigate risk associated with major changes in practice, and prepare us for targeted performance improvement work in future QIP cycles.

PROVIDER EXPERIENCE

In 2025/26, Pembroke Regional Hospital (PRH) strengthened its commitment to improving provider experience by focusing on unit-level priorities across the organization. Guided by results from our most recent staff survey, departments across the hospital identified specific opportunities to address staff needs related to workplace culture, communication, and overall staff experience, among others. This approach created meaningful opportunities to implement relevant improvements in our departments.

A key initiative here was the re-establishment of a hospital-wide Wellness Committee, which has played an active role in enhancing workplace culture and staff engagement. The committee helped to deliver a variety of high-impact initiatives, including overnight wellness carts for our night-shift staff; organization-wide contests such as pumpkin and door decorating, creation of a cookbook from staff submitted recipes, wellness vision boards, and the return of the PRH 'running club' by popular demand. Initiatives are developed with staff feedback and are designed to help enhance our work environment with greater connection, recognition, and support.

Staff engagement efforts also highlighted opportunities for leadership development. As a result, PRH expanded access to professional development opportunities, enabling leaders to attend additional training and bring valuable learnings back to the organization and leader's respective teams.

From a physician recruitment perspective, PRH has strengthened its collaboration under the leadership of Dr. Rowan (Chief of Staff) and our recruitment team. Key initiatives included enhanced

engagement from our internal physician group during recruitment visits, expanded partnerships with Renfrew County, local municipalities, school boards, and business development offices, and attendance at national recruitment events such as with the Canadian Society of Physician Recruitment (CaSPR). PRH also prioritized digital exposure by enhancing our social media presence on platforms such as Facebook and Instagram to showcase PRH culture, our community, and the unique opportunities for those practicing in a rural environment. PRH also prioritized medical learner engagement through structured rotations and a highly successful "community week" program.

SAFETY

As we continue to advance quality and safety initiatives across our organization, PRH reaffirms our ongoing commitment to the prevention of never events. Patient safety remains a core priority for our hospital, and we will continue our work to strengthen processes and support our teams, patients, and community in this effort.

One such example is a comprehensive initiative aimed at preventing wrong-site surgery. Countermeasures that were developed for this initiative included standardization of surgical site marking outside of the operating room, independent validation by a second clinician, the use of clear visual cues (such as non-operative side "stop" indicators), and consistent execution of surgical pause and time-out procedures with active participation from all members of the surgical team. Compliance with these practices is routinely audited, and results are reviewed through established quality leadership teams to identify opportunities for further refinement, if needed.

PALLIATIVE CARE

Our organization integrates a palliative approach across the illness trajectory, including end-of-life care, to improve quality of life for patients with life-limiting illness and their families. Care is guided by provincial and national standards and emphasizes person-centered decision-making, early identification of palliative needs, and coordinated interdisciplinary care.

Patient involvement in decisions and shared care planning is foundational to our approach. Patients and families are actively engaged in discussions about goals of care, treatment preferences, and advance care planning, with documentation accessible to the interprofessional team. These discussions are reinforced through interdisciplinary palliative care rounds and case reviews, where clinicians from multiple disciplines, and internal and external partners, collaboratively review patient goals, symptom management needs, and care plans to ensure alignment with patient values. Ongoing conversations support individualized care plans and honour patient preferences as needs evolve including preferred setting of care and place of death.

Access to grief and bereavement support is supported through early referral and collaboration with internal and community partners. Patients and families are connected to spiritual care, social work, and external hospice and bereavement services, ensuring emotional and psychosocial support before and after death. Education and resources are provided in a consistent manner to promote continuity of care across settings.

Building system capacity and cultural responsiveness through staff education, ethics consultation, and regional collaboration supports

improved identification of unmet palliative needs, strengthens generalist palliative competencies, and enhances care coordination across hospital and community settings.

POPULATION HEALTH MANAGEMENT

Aligned with our key strategic “pillars” within Pembroke Regional Hospital’s (PRH) Strategic Plan, we have continued in our collaboration 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:

Valve Screening Clinic: In collaboration with the Ottawa Heart Institute (OHI), PRH launched a new Valve Screening Clinic for adults aged 65+ at risk for undiagnosed heart conditions. Our first clinic in December filled all available spaces and generated a waitlist of more than 30 individuals. Additional clinics will run throughout 2026–27, supporting patients unattached to primary care and improving access to cardiovascular and chronic disease screening.

Skin Cancer Screening Clinic: PRH also partnered with the Ottawa Valley Ontario Health Team (OVOHT) and the Pembroke Family Medicine Teaching Unit (PMFTU) to deliver a high-demand Skin Cancer Screening Clinic in 2025. PRH coordinated supplies, bookings, and onsite navigation. We quickly exceeded capacity, highlighting a strong community need for expanded preventive services.

Pediatric Diabetes Clinic: To enhance pediatric care, PRH continued its partnership with the Phoenix Centre for Children and Families and CHEO. Through this collaboration, Dr. Milton provides onsite or

virtual pediatric diabetes consultations, supported by a Phoenix Centre social worker to deliver comprehensive, wrap-around care for children and families.

Renfrew County Mesa HART Hub: PRH was selected to co-host the Renfrew County Mesa HART Hub, one of Ontario's 27 HART Hub sites, in partnership with the County of Renfrew. This multi-agency partnership brings together healthcare, social services, Indigenous partners, first responders, and community organizations to provide integrated primary care, mental health and addictions services, social supports, and bridge housing, filling a significant gap in our region and complementing PRH's existing Mental Health Services of Renfrew County (MHSRC) program.

Future Collaboration: We are currently exploring opportunities to collaborate further with the Ottawa Heart Institute through their Million Hearts campaign and Cardiac Virtual Care program. The Million Hearts campaign emphasizes prevention by identifying and addressing modifiable risk factors to reduce the incidence and impact of heart disease. The Cardiac Virtual Care Program focuses on supporting patients with existing congestive heart failure (CHF) or those recovering from cardiac surgery, enabling care closer to home through remote monitoring delivered by OHI. In addition, we are actively participating in an OVOHT working group with local health providers (including paramedics, hospitals, and Ontario Health atHome) focused on identifying collaborative and collective action opportunities to enhance care for patients living with CHF in our communities.

EMERGENCY DEPARTMENT RETURN VISIT QUALITY PROGRAM (EDRVQP)

As part of Pembroke Regional Hospital's ongoing organizational commitment to EDRVQP and continuous quality improvement, updates from the preceding year's EDRVQP audit are as follows:

Dispensing Medications After Hours: A service gap was identified for patients discharged after regular pharmacy hours who were unable to fill their prescriptions, resulting in unnecessary return visits to the Emergency Department (ED). To address this issue, a new organizational policy was developed and implemented allowing nurses to dispense a limited supply of medications to support patients until they can access a community pharmacy.

Pediatric Observation Period Standardization: Inconsistencies were noted in the observation periods for pediatric patients presenting with abnormal vital signs prior to discharge. To ensure evidence-based practice, we collaborated with the Kids Health Alliance to review and establish best-practice guidelines. The Kids Health Alliance were invited to conduct on-site education sessions and mock scenarios to further build competence.

Opioid Overdose Discharge Management: An improvement opportunity was identified to enhance the safety of patients discharged following treatment for opioid overdose. In response, the hospital collaborated with the local public health unit to develop and implement a Naloxone distribution program, to ensure patients have immediate access to life-saving medication upon discharge.

For this year, two key quality improvement priorities have been identified, as follows:

Repeat Vital Signs: Pembroke Regional Hospital (PRH) is implementing a quality improvement initiative on the reassessment and documentation of repeat vital signs. PRH will be implementing our new electronic health record, Epic, in 2026, which will provide real-time documentation of our repeat vitals embedded into our documentation. The implementation of this new electronic health record will provide improved care quality, safety, and efficiency.

Left Against Medical Advice (AMA) Overview: Recent data indicate an increase in patients leaving without being seen (LWBS). To address this trend, a targeted initiative will be implemented to improve Emergency Department (ED) wait time efficiencies. Enhancing flow and reducing delays are expected to positively impact patient experience and subsequently decrease the number of patients leaving against medical advice.

EXECUTIVE COMPENSATION

Our Senior Leadership Team (SLT) is made up of the President and Chief Executive Officer; the Vice President of Clinical Services and Chief Nursing Executive; the Vice President of People, Quality, and Mental Health Service; the Vice-President of Corporate & Support Services and 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 2026/2027, each member of the senior team will have 5% of the total available compensation linked to achieving the targets as set out in our 2026/2027 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 payouts as determined by the Pembroke Regional Hospital Board of Directors.

CONTACT INFORMATION/DESIGNATED LEAD

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SIGN-OFF

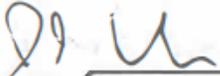
It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan on

March 25, 2026



Board Chair



Board Quality Committee Chair



Chief Executive Officer



EDRVQP lead, if applicable



Pembroke Regional Hospital

Quality Improvement Plan (QIP) 2026/2027

Care for our People – Compassion and Commitment

AIM	MEASURE			
Quality Dimension	Indicator	Current Performance	26/27 Target	Target Justification
Objective	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?	Collecting Baseline (CB)	70%	Effective communication helps patients understand when and how to seek help if they are worried about their condition after leaving hospital; reduces unnecessary return visits; and reduces delays in seeking additional care. In 2026/27, Pembroke Regional Hospital will be implementing a new electronic health record (Epic), which will introduce significant process/workflow changes throughout our hospital. Maintaining patient communication performance during this period will help to support continuity of care, reduce risk associated with major changes in practice, and promote readiness for targeted performance improvement in subsequent QIP cycles.
Patient Experience To maintain the experience of patients and families at transition from hospital to community through effective communication.				

Change Ideas	Responsible Departments	
#1. Sustain existing patient communication practices in preparation for the Epic transition. #2. Prepare staff for Epic-enabled patient communication workflows. #3. Support Epic implementation and early stabilization. #4. Evaluate and optimize patient communication post Epic implementation.	Medical Rehabilitation Acute Mental Health Surgical SLT Lead: Sabine Mersmann	
Methods	Process Measures	Target for Process Measure
#1. Continue unit-level audits focused on Teach Back method use. Complete a current state vs. future-state workflow review relevant to patient communication, identifying how Epic workflow changes may impact patient communication.	Current-state vs future-state patient communication workflow review completed.	100%
#2. Engage staff in focused training on Epic changes related to patient communication, to enhance understanding of anticipated future state post Epic Go-Live.	Focused Epic training sessions relevant to patient communication completed.	To be determined
#3. Provide super-user support for departments teams during Epic go-live to promote stabilization.	Staff and physician Epic end-user training completed.	90%
#4. Review patient communication performance post Epic implementation and audit findings. Adjust processes, provide targeted coaching, or refine workflows if performance is not meeting targets.	Completion of post Epic Go-Live evaluation and adjustments implemented, if not meeting target.	100%

Care for our Community – Collaboration, Commitment and Courage

AIM	MEASURE			
Quality Dimension	Indicator	Current Performance	26/27 Target	Target Justification
Patient Safety	Percentage of patients with a Confusion Assessment Method (CAM) positive screening who have at least one intervention strategy documented.	Collecting Baseline (CB)	90%	Effectively managing delirium is essential to patient safety and recovery. Early delirium screening and intervention helps reduce complications such as falls, confusion, extended hospital stays, and delays in return to baseline function. Maintaining strong delirium management practices also helps to ensure patients receive attentive, safe, and supportive care throughout their stay. In 2026/27, Pembroke Regional Hospital will be implementing a new electronic health record, which will introduce significant changes to processes/workflows throughout our hospital. Our goal is to maintain our current level of performance in delirium management throughout this major transition.
Objective				
To maintain our performance on early detection, intervention, and management of delirium during our transition to a new electronic health record system.				

Change Ideas	Responsible Departments	
#1. Sustain existing Delirium Management practices and prepare for Epic transition. #2. Prepare staff for Epic-enabled Delirium Management workflows. #3. Support Epic implementation and early stabilization. #4. Evaluate and optimize Delirium Management post Epic implementation.	Intensive Care Unit (ICU) Medical Surgical Geriatric Mental Health (GMH) SLT Lead: Dr. Declan Rowan	
Methods	Process Measures	Target for Process Measure
#1. Maintain and reinforce delirium management processes established in the 2025/26 QIP. Complete current-state vs future-state workflow review to identify how Epic will support delirium management workflows.	Current-state vs future-state workflow review completed.	100%
#2. Train staff and physicians on future-state delirium workflows enabled by Epic. Provide better understanding of Epic tools/capabilities relating to delirium management, documentation, etc.	Focused Epic training sessions relevant to delirium management completed.	To be determined
#3. Provide super-user support for teams during Epic go-live to promote stabilization. Reinforce consistent use of Epic tools relevant to delirium management.	Staff and physician Epic end-user training completed.	90%
#4. Analyze delirium screening and intervention performance post Epic Go-Live. Implement targeted improvements where performance is not meeting expectations.	Completion of post Epic Go-Live evaluation and adjustments implemented if not meeting target.	100%

Care with our Partners – Collaboration and Commitment

AIM	MEASURE			
Quality Dimension	Indicator	Current Performance	26/27 Target	Target Justification
Access and Flow	Specific ED wait time indicator to be determined post Epic Go-Live.	Collecting Baseline (CB)	To be determined	<p>Efficient ED flow is essential to patient safety, timely access to care, and overall patient experience. Excessive wait times, whether for initial assessment or overall length of stay (LOS), contribute to treatment delays, overcrowding, increased patient dissatisfaction, higher rates of patients leaving without being seen.</p> <p>In 2026/27, PRH will be implementing a new electronic health record system (Epic) that will substantially change workflows/processes across our entire organization. While Epic is expected, ultimately, to improve efficiencies, data accuracy, and team communication over time, there are inherent short-term risks during implementation that may negatively affect ED performance. Prioritizing early stabilization is essential to maintaining safe and reliable care for patients.</p> <p>Given the above, PRH’s primary aim for this 2026/27 QIP is to support safe and stable ED operations throughout Epic implementation. Post Epic Go-Live, PRH will be investing in Lean resources within our ED to support the application of Lean methodologies to identify and implement opportunities for improvement of wait time metrics while also positioning us for further improvements in subsequent QIP cycles.</p>
Objective				
To launch a multi-year focused Lean improvement project in our Emergency Department (ED). In year 1, to evaluate ED wait time efficiencies post-implementation of Epic and determine priorities for improvement on wait time indicators.				

Change Ideas		Responsible Department
#1. Understand impacts of Epic on ED workflows in preparation for October 2026 Go-Live. #2. Prepare and engage staff and physicians in education around future-state Epic workflows. #3. Support Epic implementation and early stabilization. Prepare for dedicated Lean improvement work in the ED. #4. Evaluate ED Wait Time Efficiency metrics post Epic Go-Live and adjust plan if not meeting target.		Emergency Department (ED) SLT Lead: Beth Brownlee
Methods	Process Measures	Target for Process Measure
#1. Conduct a current-state versus future-state workflow review to understand how Epic may impact ED wait time efficiencies and data capture.	Current-state versus future-state review completed.	100%
#2. Provide education around relevant workflow changes. Incorporate identified process changes into Epic training.	Focused relevant Epic training sessions completed.	To be determined
#3. Provide super-user support for ED teams during Epic go-live to promote stabilization and validation. Implement a full dedicated Lean Management project in our Emergency Department.	[a]: Complete a value stream map capturing from triage to disposition.	[a]: 100%
	[b]: Improvement opportunities are identified.	[b]: 2
#4. Obtain relevant data through new electronic health record and sustain a full Lean Management project in our Emergency Department.	Implement targeted Plan, Do, Study, Act (PDSA) to support quality improvement (QI) opportunities identified.	100%

Care for our People - Compassion

AIM	MEASURE			
Quality Dimension	Indicator	Current Performance	26/27 Target	Target Justification
Objective	Percentage of identified staff who have completed the relevant education related to equity, diversity, inclusion, and anti-racism (EDIAR).	Not currently measured	75%	Creating a welcoming and inviting hospital to work or receive care is important to achieve better outcomes for workers and patients. Through the enhancement of standardized staff training, we aim to reduce disparities and improve the experience for all. For the 2026/27 QIP year, we will be incorporating learnings from our 2025/26 QIP which identified a high-quality online training module ("Cultural Competence in Healthcare"). We will work to embed this training within our internal eLearning platform and have more staff trained across our organization.
To advance health care provider knowledge relating to the provision of culturally sensitive care to reduce disparities and improve the experience for all.				

Change Idea		Responsible Department
#1. Assign and track Equity, Diversity, Inclusion, and Anti-Racism (EDIAR) training modules via the Surge eLearning platform for identified hospital staff.		Organization-wide SLT Lead: Brent McIntyre
Methods	Process Measures	Target for Process Measure
To embed the selected training program from our 2025/26 EDI QIP into our Surge eLearning platform for organization-wide implementation. Establish a method for tracking training progress among identified staff.	1[a]: Ensure that the selected education program has been embedded into Surge eLearning platform. 1[b]: Communication has been sent to staff and training has begun. 2: (Q2) Percentage of selected staff who have completed the selected education program. Adjust plan if not meeting target. 3: (Q3) Percentage of selected staff who have completed the selected education program. Adjust plan if not meeting target. 4: (Q4) Percentage of selected staff who have completed the selected education program. Adjust plan if not meeting target.	1[a]: 100% 1[b]: 100% 2: 25% 3: 50% 4: 75%

Access and Flow | Timely | Priority Indicator

Indicator #1	Last Year		This Year		
	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)
90th percentile ambulance offload time (Pembroke Regional Hospital Inc.)	50.00	30	53.00	-6.00%	NA

Change Idea #1 Implemented Not Implemented In Progress

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.

Process measure

- Q1: PDSA completed. Q2: Number of change ideas/ interventions identified through PDSA implemented. Q3: Rate of ambulance offload time (represented in minutes). Q4: Rate of ambulance offload time (represented in minutes).

Target for process measure

- Q1: 100% Q2: 2 Q3: 40 Q4: 30

Lessons Learned

This year's Ambulance Offload Time (AOT) QIP reinforced the importance of adaptability. As the QIP progressed, several planned interventions required additional refinement. For example, our updated paramedic arrival notification process saw multiple iterations, ultimately taking more time than was anticipated. Detailed reviews also identified the need for more accurate and consistent data capture to reflect true AOT performance, highlighting further opportunities for improvement. External factors influenced progress as well, such as the temporary unavailability of the on-site primary care paramedic during a critical period (October to January). Overall, these experiences emphasized that while we may begin with a specific plan, change idea, or countermeasure, we also must be willing to adapt. When an approach is not producing desired results, it is essential to explore and test alternatives co-designed with those doing the work and using a structured problem-solving approach.

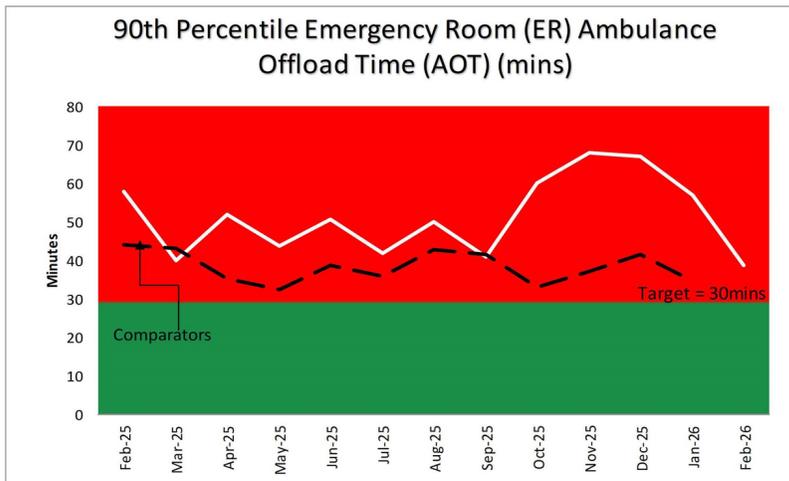
Comment

Please note that, as of February 2026, PRH's 90th percentile AOT performance has improved to 39min. See attached for a month-by-month breakdown of AOT performance for FY 25/26.

This QIP driver has positioned PRH for continued improvement in offload time performance. Key accomplishments include the development of a county-wide Fit2Sit program; offload huddle implementation; arrival notification process enhancements; and our new "direct to CT" pathway for eligible patients. Fit2Sit, initially a PRH-specific initiative developed in collaboration with our paramedic partners, has since expanded across the county and has shown early signs of positive patient response and improved paramedic turnaround. The addition of "offload huddles", bringing together EMS, the PRH Triage RN, and the Primary Care Paramedic, has reduced duplication in handover, strengthened communication, and further optimized transfer of care in the ED. Additionally, gains were achieved through enhancements to our ambulance arrival-notification processes and implementation of our "direct-to-CT" pathway for eligible interfacility arrivals to support faster diagnostics and improved patient flow.

Results

Ambulance Offload QIP Driver



Posted Date: March 17, 2026

Access and Flow | Timely | Custom Indicator

Indicator #3	Last Year		This Year		
	CB	CB	88.00	--	NA
Percentage of respondents who answer “very satisfied” or “satisfied” to the following survey question.	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)
“During this visit, how satisfied were you with the communication and attention you received while waiting in the emergency department? (Pembroke Regional Hospital Inc.)					

Change Idea #1 Implemented Not Implemented In Progress

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.

Process measure

- Q1: A formalized approach has been established to define and measure 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.

Target for process measure

- Q1: 100% Q2: 2 Q3: 2 Q4: 100%

Lessons Learned

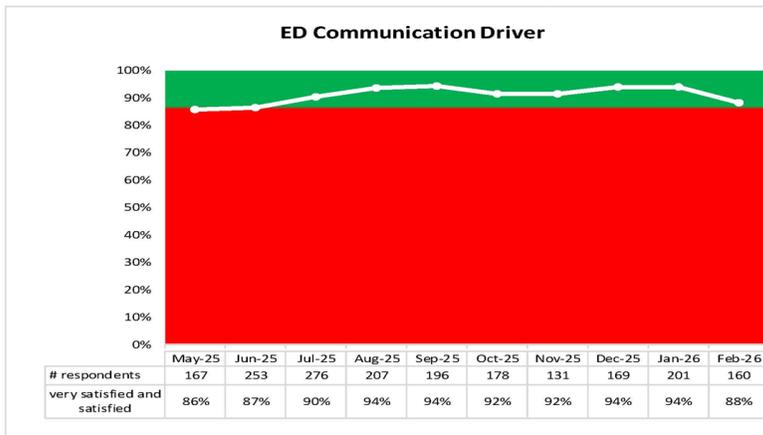
Over the course of the year, several key lessons emerged from our Patient Experience in the Emergency Department (ED) driver. While our frontline-developed Q&A resource to improve messaging consistency was well-received pre-implementation, formal evaluation post-implementation highlighted a need for deeper understanding and a potential redesign to optimize value. We also learned our evaluation timelines were insufficient. Delays and limited dedicated time for formal evaluation left too little time to thoroughly evaluate effectiveness of some interventions. Additionally, stronger-than-anticipated baseline patient experience data reduced room for measurable quantitative improvement, prompting a shift toward qualitative data analysis to identify opportunities for improvement while aiming to maintain quantitative patient survey performance.

Comment

Despite challenges, this QIP project highlighted the critical importance of engaging all areas of the ED in shaping, refining, and implementing improvement efforts. Patient feedback guided us beyond communication-focused initiatives, prompting practical enhancements such as better climate control and access to cellphone chargers in the department. Although the initial target was to implement two improvements, ongoing feedback revealed additional opportunities. Ultimately, we implemented eight improvement ideas including improved signage, registration tablet usability improvements, and refinements to staff assignments in the ED to better support the overall patient experience.

Results

ED Communication QIP Driver



Survey Question: During this visit, how satisfied were you with the ongoing communication and attention you received while waiting in the emergency department (very satisfied and satisfied)

Posted Date: March 17, 2026

Equity | Equitable | Custom Indicator

Indicator #5 Survey Question:	Last Year		This Year		
	CB Performance (2025/26)	CB Target (2025/26)	7.20 Performance (2026/27)	-- Percentage Improvement (2026/27)	NA Target (2026/27)
“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?” (Pembroke Regional Hospital Inc.)					

Change Idea #1 Implemented Not Implemented In Progress

Improve the knowledge, through training/education, of Indigenous culture and health care gaps, and how to reduce disparities.

Process measure

- 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. 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.

Target for process measure

- Q1: 100% Q2: 25% Q3: 60% Q4: 80%

Lessons Learned

The 25/26 EDI QIP provided a clearer understanding of our staff's baseline knowledge along the EDI learning continuum, and helped us to better recognize what meaningful growth may look like throughout the year. Completion of two identified trainings, including a virtual training through Ontario Health and in-person Indigenous Cultural Safety training through the Wabano Centre - Indigenous Centre for Excellence, was followed by well-attended staff debrief sessions. These debriefs celebrated key learnings, identified gaps in knowledge, and shaped planning for future QIP cycles. Valuable insights from these discussions will guide our approach for the upcoming 26/27 QIP year. We were encouraged by the strong representation from many departments across our organization, reinforcing the importance of organization-wide EDI work. The process also further integrated our Spiritual Care Coordinator into this work, building important relationships that will be essential to sustaining future efforts.

Comment

Note: pre-training data from staff surveys indicated a baseline score of 4.9 on the following 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?. Based upon this data, PRH established a target of 8 out of 10. By the end of the 25/26 cycle, results on this survey improved to 7.2 out of 10, demonstrating meaningful improvement though remaining below target.

Ongoing priorities include strengthening partnerships with local community organizations to deepen our understanding of local needs and support related work happening beyond the walls of our hospital. Moving forward to the 26/27 QIP cycle, we aim to carry forward this year's learnings to continue expanding EDI education and engagement across the organization.

Experience | Patient-centred | Custom Indicator

	Last Year		This Year		
Indicator #4	66.00	75	70.00	--	NA
Percentage of respondents who select “Always” or “Completely” to the following questions:	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)
“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?” (Pembroke Regional Hospital Inc.)					

Change Idea #1 Implemented Not Implemented In Progress

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

Process measure

- Q1: Number of structured change processes developed and implemented across all inpatient units. Q2: Change processes are fully implemented across all inpatient units. 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.

Target for process measure

- Q1: 2 Q2: 100% Q3: 70% Q4: 75%

Lessons Learned

A number of key lessons learned emerged from this year's Discharge Communication QIP, including:

1. **Value of the Teach Back Method:** Consistent use of the Teach Back method has been identified as an important skill in enhancing patient and family/caregiver discharge communication. The Teach Back method helps staff understand how to communicate information meaningfully by having patients/caregivers repeat education back, in their own words. This also provides in-the-moment feedback to staff on opportunities to revise their approach and strengthen subsequent teaching. Patient and staff feedback indicate that broader use of this method can improve comprehension and confidence.
2. **Consistent Use of Patient Whiteboards:** Patient and caregiver feedback emphasized how important patient whiteboards are as a communication tool. For example, our whiteboards can help to identify who a patient wants involved in their care; enhance communication between patient/family/caregivers and care team; and provide valuable and accessible key updates at-a-glance. Continued focus is needed to support reliable, organization-wide adoption of whiteboard practices to ensure patients receive these important updates more consistently.
3. **Identifying and leveraging Family/Caregiver "Key Moments":** Work with frontline teams identified many "Key Moments" when engaging family/caregivers may have the greatest impact. These insights helped determine department-specific and organization-wide opportunities for enhancing family/caregiver involvement; however, momentum on this decreased over the course of the year to focus on other priorities for this QIP driver. Sustained and renewed attention may help to maximize the benefits of these insights.
4. **Balancing Competing Priorities During Quality Improvement Work:** Teams initially planned regular QIP-related discussions during departmental quality improvement huddles, though operational demands at times reduced the frequency and depth of these conversations over the course of the year. This affected frontline engagement and overall progress on implementation of change ideas. Finding more sustainable balance, combined with exploring additional opportunities for frontline engagement, may improve consistency and performance moving forward.

Comment

While our performance on this indicator did improve compared to baseline, we did not meet our target and recognize the need for continued focus in this area. Meaningful progress was made in advancing several foundational initiatives; however, challenges with consistent application across units became apparent. Throughout the year we gained clarity on impactful strategies, such as standardizing use of teach back method and ensuring reliable use of patient whiteboards. These efforts have laid important groundwork; though looking ahead to the 2026/27 QIP cycle, also indicate a need to continue to adapt our approach in implementing these strategies fully across our hospital.

Safety | Safe | Custom Indicator

Indicator #2	Last Year		This Year		
	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)
Percentage of patients at risk for delirium who have at least one prevention strategy documented in their care plan. (Pembroke Regional Hospital Inc.)	CB	70	NA	--	NA

Change Idea #1 Implemented Not Implemented In Progress

Enhance the use of delirium prevention strategies and improve early identification of delirium risk to improve patient outcomes.

Process measure

- Q1: Percentage of frontline staff who have received education on delirium risk factors, screening tool and prevention methods.
- 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.

Target for process measure

- Q1: 70% Q2: 80% Q3: 60% Q4: 70%

Lessons Learned

N/A

Change Idea #2 **Implemented** **Not Implemented** **In Progress**

Enhance delirium early detection, intervention strategies, and management of delirium to reduce its impact during hospitalization, reducing the severity of delirium and promoting better patient outcomes and safety.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Please note: PRH's delirium QIP driver changed significantly over the course of 25/26. Our revised methods and process measures for this were as follows:

Methods: Establish a collaborative team consisting of healthcare professionals from various disciplines to review and assess current delirium management strategies. Formalize a method to educate frontline staff and evaluate patient screening for delirium. Establish a process 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 intervention. Additionally, work to enhance protocols for early identification and timely management of delirium.

Process measures:

- Percentage of frontline staff who have received education on delirium risk factors, screening tools, and prevention methods. Target: 70%
- Percentage of patients with CAM positive screening who have at least one intervention strategy documented. Q3 Target: 60%
- Percentage of patients with CAM positive screening who have at least one intervention strategy documented. Q4 Target: 70%

Over the course of this year, our Delirium Prevention QIP revealed an important gap between established delirium screening practices and variability in managing delirium for patients who screen positive. This recognition prompted a key shift in our objective from identifying delirium risk to strengthening delirium management. Education to staff was foundational for this driver. Focusing on delivering content in a manner that was consistent, paced, and predictable helped to prevent overwhelming staff. Additional "just-in-time" coaching complemented education to enhance learnings and the application of knowledge. Anecdotally, we have also observed more purposeful use of the Confusion Assessment Method (CAM) tool across our hospital in assessing for delirium.

Comment

As PRH prepares for significant workflow changes with the upcoming 2026 Epic implementation, this year's work has helped consolidate improvements in delirium management that we aim to preserve through this transition. Our focus is on ensuring gains are carried forward and integrated into new processes post Epic Go-Live.