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