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**
Patient Experience **Objective** To maintain the experience of patients and families at transition from hospital to community through effective communication.	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.

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 **Objective** To maintain our performance on early detection, intervention, and management of delirium during our transition to a new electronic health record system.	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.

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 **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.	Specific ED wait time indicator to be determined post Epic Go-Live.	Collecting Baseline (CB)	To be determined	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. 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. 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.

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. [b]: Improvement opportunities are identified.	[a]: 100% [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**
Equity **Objective** To advance health care provider knowledge relating to the provision of culturally sensitive care to reduce disparities and improve the experience for all.	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.

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%