QIP Part B : Peterborough Regional Health Centre
2024-25

OBJECTIVE		MEASURE	CHANGE INITIATIVES			
Quality Dimension	**Indicator**	**Target**	**Planned Improvement Initiative**	**Methods**	**Process Measures**	**Process Measure Target**
Safe	**Reduce workplace violence** The number of reported workplace violence incidents experienced by hospital workers as defined by Occupational Health and Safety Act: 1. the exercise of physical force by a person against a worker, in a workplace, that causes or could cause physical injury to the worker; 2. an attempt to exercise physical force against a worker in a workplace, that could cause physical injury to the worker; 3. a statement or behaviour that a worker could reasonably interpret as a threat to exercise physical force against the worker, in a workplace, that could cause physical injury to the worker.	**<15/month**	Continue to provide staff with appropriate violence prevention training based on need.	Continue to provide workplace violence prevention training to all new hires. Continue to provide refresher training for staff working in high-risk areas.	% new hires that complete training within 3 months of hire. % staff working in high-risk areas that have completed refresher training.	Q4 = 100% Q4 = 80%
			Improve communication between the interdisciplinary team when risk of violence has been identified and/or an act of violence has occurred.	Improve the completion of the standardized violence risk assessments built into Epic to flag risk on admission.	% of violence risk assessments completed at triage % of violence risk assessments completed on admission	Q3 = 60% Q3 = 60%
				Incident review feedback reviewed by Workplace Violence Committee and improvements identified and implemented.	Number of improvements identifed and implemented.	1 per quarter
Timely	**Reduce time to inpatient bed** The maximum amount of time it took 90% of patients to be admitted to an inpatient unit or moved to an operating room**.**	**<27hrs**	Improve comprehensive discharge planning across all in-patient units.	Implement, support and monitor use of virtual discharge rounding tool across all in-patient units. EDD - Estimated Discharge Date	% patients with EDD documented in patient chart. % patients with EDD documented on patient care board.	Q2 = 80% Q4 = 80%
			Reduce inpatient and Emergecy Department (ED) wait times for diagnostic imaging.	Implement formal process for identification and escalation of discharge delays across all in-patient units. Increase inpatient and ED access to diagnostic imaging.	% patients whose EDD has expired who have a documented discharge delay. % Inpatient and ED CT orders completed by 0800 Monday.	Q4 = 100% Q4 = 90%
	Reduce unnecessary time spent in acute care: Percentage of inpatient days that beds were occupied by patients who could have been receiving care elsewhere.	**<18%**	Utilize the 2023 ALC leading practice report to guide work related to ALC risk identification and care plan development.	Assess and Restore + Team will establish accurate functional baseline assessment data for patients upon hospital admission and set collaborative functional goals with patients and their caregivers.	% patients enrolled in Assess and Restore Program who are supported to return to the community with appropriate referrals for post-admission care. Number of patients enrolled in Assess & Restore.	Q4 = >80% Q4 = 10% increase
				Improve consistent and early communication of Estimated Discharge Dates with patients and caregivers.	% patients with EDD documented on the patient care board.	Q4 = 80%
				Develop care plans, goals and expected results in collaboration with all members of the care team, the older adult and their designated caregiver that are flexible and patient-centred.	Annual number of patients aged 65 or older with documented use of the standardized, collaborative *Adult General* care planning tool in Epic.	Q4 = 375
			Continue to leverage community partnerships.	Maximize occupancy of transitional care units and Senior Supportive Housing for patients designated as ALC. Ongoing collaboration with the sub-regional Central East ALC working group.	% of transitional care beds filled with PRHC patients designated ALC. % of Senior Supportive Housing beds filled with PRHC patients designated ALC. Improvements identified and implemented.	Q4 = 100% Q4 = 100% Q4 = 2
			Continue to support PRHC at Home Program for complex, older adults.	Sustain the PRHC at Home integrated comprehensive care program for appropriate patients.	% of enrolled patients offered support by remote monitoring program. Patient caregiver satisfaction. 30-day readmission rate for patients enrolled in the program.	Q4 = 100% Q4 = 90% Q4 = <20%
Effective	**Improve medication reconciliation at discharge** Percentage of discharged admitted patients with length of stay >24hrs with a completed discharge medication reconciliation.	**>90%** (discharged admitted patients with length of stay >24hrs)	Improve Epic medication reconciliation workflows and adoption.	Monitor provider adoption and implement targeted improvements.	Interprofessional participation in relevant regional working groups. Provider-level medication reconcilation adoption.	Q4 = ongoing Q4 = 100%
Equitable	**Improve respect for patient cultural beliefs and preferences** Number of patients that respond 'no' to the Post-Discharge Phone Call question "Were staff respectful of your unique preferences and cultural beliefs?"	**<5/quarter**	Implement health equity, diversity and inclusion (HEDI) best practices.	Develop organizational Equity, Diversity, Inclusion and Anti-Racism framework and action plan aligned to strategic plan. Develop HEDI measurement and reporting strategy.	Framework developed. Action plan developed. Measurement and reporting strategy developed and implemented.	Q1 = complete Q1 = complete Q2 = complete
			Provide equity, diversity, inclusion and anti-racism training and indigenous cultural safety training to staff, physicians and volunteers.	Continue cultural competence/cultural safety training for new staff hires. Develop and pilot physician-focused training approach. Develop and implement staff and volunteer refresher training model. Develop and implement leadership-focused training	% staff that complete training within 1 year of hire. Training plan developed and pilot implemented with one department. Refresher training model developed and implemented. % staff that complete refresher training. % leaders that complete training.	Q4 = 100% Q4 = complete Q4 = complete Q4 = 100% Q2 = 100%
Patient-Centered	**Improve patient experience:** Percentage of inpatients that chose 8,9 or 10 when asked to rate their Overall Experience. 0 - I had a very poor experience 10 - I had a very good experience Post-Discharge Phone Call + Digital Survey	**>90%**	Utilize all sources of patient feedback to drive improvement.	Utilize feedback from patient experience rounding, surveys and post-discharge phone calls to identify improvements.	Number of improvements made based on recommendations by the Patient and Family Advisory Council (PFAC).	1 per quarter
			Expand patient experience survey program.	Align post discharge phone call survey questions with digital patient experience survey questions. Increase number of inpatient surveys Expand surveys to include ambulatory areas.	Survey questions aligned. Number of surveys completed. Survey implemented in two ambulatory areas.	Q1 = complete Q4 = increase by 1000 annual surveys completed Q2 = implemented
	Improve patient experience: Percentage of inpatients who responded positively to the question "Did you receive enough information from hospital staff if you were worried about your condition or treatment after you left the hospital? Post-Discharge Phone Call + Digital Survey - includes 'completely' and 'quite a bit'	**>90%**	Improve comprehensive discharge planning across all in-patient units.	Utilize feedback from patient experience rounding, surveys and post-discharge phone calls to identify discharge-specific improvements and increase patient engagment in improvement co-design.	Integrate discharge-specfic patient feedback at relevant oversight committees (PFAC, Acute Length of Stay Committee). Recruit 1-2 PFPs to join Acute Length of Stay Committee.	Q1 = complete Q1 = complete
				Increase MyChart activation.	% patients enrolled in MyChart.	Q4 = increase from 15% to 20%