QIP Part B : Peterborough Regional Health Centre
2025/26

OBJECTIVE		MEASURE	MEASURE	CHANGE INITIATIVES			
Quality Dimension	**Indicator**	**Current Performance**	**Target**	**Planned Improvement Initiative**	**Methods**	**Process Measures**	**Process Measure Target**
Safe	**Reduce workplace violence** The number of lost time injury events as the result of workplace violence (WPV) incidents experienced by hospital workers as defined by the Occupational Health and Safety Act.	**2/quarter**	**≤2/quarter**	Continue to provide staff with appropriate violence prevention training based on need.	Continue to provide workplace violence prevention training to all new hires.	% new hires that complete training within 3 weeks of hire.	Q4: 100%
					Continue to provide refresher training for staff working in high-risk areas.	% staff working in high-risk areas that have completed refresher training.	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 within 24hrs of admission (all inpatient areas).	Q3: 60%
					Develop standardized process for the collection, review and escalation of information gathered following workplace violence events to support continuous improvement.	Process developed and implemented.	Q2: complete
	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.	**45.3 hrs**	**≤27hrs**	Improve Occupational and Physical Therapy workflow to support timely discharge	Complete an evaluation of Occupational and Physical Therapy workflow specific to response time for initial assessment.	Response time from initial referral to first assessment Workload measurement score	Q4: 24hrs Q4: 80%
				Improve early identification of patient flow delays and implement targeted improvements.	Continue identification and entry of patient flow delays at the unit level and escalation at morning bed meetings and the Discharge Command Table.	EDD documented within 24hrs of admission % of discharges by 12pm (all inpatient areas)	Q4: 100% Q4: 60%
Timely	**Access and flow** 90th percentile ambulance offload time. (Priority Indicator)	**65 minutes**	**≤45 minutes**	Sustain and enhance ambulance offload initiatives	Refresh Fit-to-Sit criteria and Nurse Policy with staff education and ongoing collaboration with Emergency Medical Services partners.	Completion of policy and staff training on policy	Q1: complete
					Implement offload bed utilization strategy.	Completion of Escalation Pathway ED Charge Nurses trained	Q1: complete Q1: 100%
					Install real-time data dashboard in ED to support monitoring and escalation processes.	Real-time dashboard installation at ED carestation.	Q1: complete
	Access and Flow 90th percentile emergency department wait time to physician initial assessment. (Priority Indicator)	**6.4 hrs**	**≤5 hours**	Improve workflow and support for physician initial assessment	Optimize ED physician shift coverage.	% of base shifts filled % of days when increased coverage is added	Q2 :100% Q2: 50%
					Optimize physician extender role in ED.	# of patients seen	Q4: >1000
					Implement technology to support collection of patient information.	Technology implemented # of patients who have used technology	Q2: complete Q4: 100
					Optimize Epic Clinical Information System to support physician workflow.	Working group established	Q1: complete
	Access and Flow Daily average number of patients waiting in the emergency department for an inpatient bed at 8 a.m. (Priority Indicator)	**24 patients**	**≤20**	Optimize patient flow to support timely admission	Continue to operationalize Home First philosophy.	Completion of weekly root-cause-analysis (TRAC) meetings	Q4:100%
					Develop and implement Medicine Program Surge Protocol.	Protocol implemented	Q1: complete
					Continue 24-hour patient flow and daily bed meetings.	EDD documented within 24hrs of admission % of discharges by 12pm (all inpatient areas)	Q4: 100% Q4:60%
	Reduce unnecessary time spent in acute care: Alternate level of care (ALC) throughput ratio.	**1.03**	**≥1.0**	Utilize the 2023 ALC leading practice report to guide work related to ALC risk identification and care plan development.	Improve consistent and early communication of Estimated Discharge Dates with patients and caregivers.	% patients with EDD documented on the patient care board.	Q4: 80%
					Expand best practices in use in Reactivation Centre across PRHC.	Number of patients aged 65 or older with documented use of the standardized, collaborative Adult General care planning tool in Epic.	Q4: 90
				Continue to leverage community partnerships.	Maximize occupancy of transitional care units and Senior Supportive Housing for patients designated as ALC.	% of transitional care beds filled with PRHC patients designated ALC. % of Senior Supportive Housing beds filled with PRHC patients designated ALC.	Q4: 100% Q : 100%
					Ongoing collaboration with the sub-regional Central East ALC working group.	Number of improvements identified and implemented.	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. 7-day readmissions for program patients 30-day readmissions for program patients ALC days saved	Q4: 100% Q4: 90% Q4: <20% Q1-4: >30days saved per patient
Equity	**Improve experience of care as reported by patients that identify as Indigenous (First Nations, Inuit, Metis)** % of patients that identify as Indigenous that chose 8, 9, or 10 when asked to rate their overall experience from 0-10. *Post-Discharge Phone Call + Digital Survey (Inpatient + ED)*	**61%**	**≥80.0%**	Improve provision of culturally appropriate care and services	Expand training specific to Indigenous Cultural Safety (ICS).	% of staff and volunteers that have completed Indigenous Cultural Safety Training % of new hires that have completed ICS training within 2 months of hire % of leaders that have completed equity training (Managers, Directors, ST, Chiefs)	Q4: >90% Q4: 100% Q3: 100%
					Expand collection and reporting of demographic data aligned to patient experience and safety data.	% of new patient registrations asked for demographic information Impact event reporting system revised Patient experience reports updated to include demographic data	Q3: >90% Q2: complete Q2: complete
					Establish formal PRHC outreach model to First Nations community.	Outreach model in place with meetings scheduled.	Q1: complete
					Implement Indigenous Patient Navigator role.	Role developed and implemented.	Q1: complete
Patient-Centred	**Improve patient experience:** % of patients 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 (Inpatient + ED)*	**71%**	**≥80%**	Expand opportunities for patient feedback collection and reporting to drive decision-making specific to improvements in care.	Increase the incorporation of patient feedback data in decision-making.	Patient feedback data incorporated in Program Quality Committee agendas.	Q2: 100%
					Increase Experience Partner collaboration in decision-making.	% Program Quality Committees with Experience Partner representation.	Q2: 100%
					Increase patient feedback through implementation of real-time patient surveying.	Number of patients for whom a real-time survey was completed.	Q2: 100
	Improve patient experience: % 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 (Inpatient) (- includes 'completely' & 'quite a bit')*	**82%**	**≥90%**	Improve comprehensive discharge communications 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 engagement in improvement co- design.	Integrate discharge-specific patient feedback at relevant committees (Acute Length of Stay, Program Quality Committees).	Q1: complete
					Refresh the purpose and use of the white boards on units.	% of whiteboards that are up-to-date and reflect estimated discharge date and discharge planning information (Medicine Program).	Q4: > 80%