Quality Improvement Plan

Quality improvement is a priority at the Pembroke Regional Hospital (PRH). One of the ways in which we demonstrate this is through the development of an annual Quality Improvement Plan (QIP). Our QIP helps us to plan, document, and review performance in the areas of safety, effectiveness, access, patient centeredness, and integration of care. It helps us to identify new and better ways of doing things in order to improve care for our patients, increase satisfaction levels, and achieve better clinical outcomes.

The *Excellent Care for All Act, 2010* (ECFAA) requires all hospitals to produce a QIP annually, make it available to the public, and document progress.

Ontario Health has requested that hospitals select and report on some of the core indicators to support province-wide comparability where possible.

You may find some of the questions and answers below helpful in understanding the QIP process.

How is the QIP developed?

The PRH Board of Directors is responsible for overseeing the development of the QIP. The members of our Board work closely with our management team, various healthcare professionals, and patients and families to determine areas for improvement.

Once areas for improvement have been identified, targets are set for improvement.

Once the plan is finalized, it is then submitted to the Ontario Health.

What timeframe does the QIP cover?

Quality Improvement Plans are developed each fiscal year (April 1 – March 31).

How do we know if progress is being made?

We take quality improvement very seriously and are committed to achieving the targets that we set out in our annual plans.

Measuring progress against our established targets is the primary way in which we hold ourselves accountable to our stakeholders. Reports on progress are provided to our Board of Directors, Medical Advisory Committee, Quality and Patient Safety

Committees, as well our Patient and Family Advisory Council throughout the year. A summary report is posted on our website annually.

Where can I find out more information about the *Excellent Care for All Act* and quality improvement plans?

Please visit https://www.health.gov.on.ca/en/pro/programs/ecfa/legislation/act.aspx for more information about the legislation and its requirements.

OVERVIEW

In 2023/2024 Pembroke Regional Hospital (PRH) embarked on a Quality Improvement Plan (QIP) focused in improving aspects related to the patient and provider experience, and patient safety through six drivers.

We have had many successes to celebrate. We continued working on establishing new patient care team models and have been able to exceed our initial goals of reducing the number of days' nurses work without their full compliment. More importantly, we have been able to sustain this for most of 2023 and into 2024.

We have managed to train over 80 percent of our most-at-risk staff in violence prevention techniques through the driver work. This involved changes in our staffing process and providing more opportunities for staff to attend on a day that fits within their schedule.

Guided by the results of our 2023 Staff and Physician Engagement Survey, we put significant efforts into improving communication within our organization. The establishment of a weekly CEO message, lunch with the CEO, and the Senior Leadership Team's attendance at unit huddles has facilitated additional opportunities for two-way discussion between senior leaders and front-line staff and physicians.

Our discharge communication processes were also evaluated during

the 2023/2024 QIP with inpatient units and the Emergency Department tasked with identifying and improving gaps in communication. Some of the work undertaken included establishing white boards to improve communication on our Acute Mental Health Unit, and updating our patient teaching documents on the Labour and Delivery Unit. We exceeded our patient satisfaction target and will look to maintain this success in 2024/2025.

To improve patient safety, our physicians put in significant efforts in 2023/2024 to improve our medication reconciliation completion scores. With the support of our physician champions, we were able achieve our goal of having at least 80 percent of patient's undergo medication reconciliation at discharge.

Also related to patient safety was the work undertaken to prevent the occurrence of a Never Event. The work for this driver involved creating new patient safety checklists, and auditing practices. Also, a two-day training for staff and physicians was hosted by PRH to improve quality, and team communication.

The 2024/2025 QIP contains drivers focused on Equity, Patient and Staff Experience, and Patient Safety. It will continue to build on many of the successes of last year's Quality Improvement Plan, specifically continuing to improve our patient care team models, and improving discharge communication.

We also want to highlight the Patient Safety driver, focused on planning for a new electronic medical record. This will be a large undertaking over the next two years for PRH but will have significant impacts in improving patient safety. Therefore, we are limiting the number of drivers we are completing to four, to ensure the appropriate amount of time can be spent on this exciting innovation.

ACCESS AND FLOW

Although we will continue to monitor our performance related to alternate level of care (ALC) throughput, ambulance offload time, and the percentage of patients that leave our Emergency Department (ED) without being seen by a physician, PRH will not be implementing any change ideas related to access and flow in the 2024/2025 QIP.

When examining our current state, we perform better than the Provincial average for ALC throughput and will continue with our current practices. We are committed to monthly monitoring of ambulance offload time, and percentage of patients that leave ED without being seen by a physician and will establish change ideas if intervention is required.

EQUITY AND INDIGENOUS HEALTH

Ensuring a welcoming, inviting hospital to work in, or receive care is important to achieve better outcomes for workers and patients. The Equity, Diversity, and Inclusion Committee was established in 2022 at PRH, and this Committee will lead the 2024/2025 Driver focused on equity.

Through education, we aim reduce disparities that may exist and improve the experience for all. We are committed to ensuring our workforce, which includes staff and physicians, have the knowledge they need to provide equitable care. To achieve this, we are committed to completing education and training to 40 percent of all staff and physicians by the end of the fiscal year.

The Equity, Diversity, and Inclusion Committee will be tasked with researching and establishing an education program and creating an implementation plan to help us meet our goal.

PATIENT/CLIENT/RESIDENT EXPERIENCE

Preparing patients and their families for discharge is a process that begins as soon as someone is admitted to our facility. We want our patients to be knowledgeable about their condition and treatment plan when they return home. This leads to better outcomes for the patient and reduces re-admissions.

The 2023/2024 QIP was focused on identifying gaps in discharge planning for inpatient units and the emergency department, with a goal of improving our patients' satisfaction related the information they received about their condition and treatment. We were able to exceed our target of 70 percent being "completely" satisfied.

The 2024/2025 QIP will continue this work as we aim to further identify gaps and maintain our current performance of 80 percent of patients being "completely" satisfied with the information they receive about their condition and treatment.

Maintaining a focus on communication between patients, families, and the care team has consistently been a priority of our Patient and Family Advisory Council, and they have reviewed and provided feedback on our QIP.

PROVIDER EXPERIENCE

The experience of our patient care team members remains a priority in 2024/2025. Over the past two years we have had tremendous success in reducing the number of days our nurses work without their full complement each month. We have managed to reduce that number to two days per month, down from 25 days per month in 2022.

The 2024/2025 QIP will use learnings from our previous work and will focus on reducing the number of days non-nursing staff, and physicians work without their full complement of team members.

Many professionals contribute to providing the highest quality of care to our patients, and it is important that all members of our patient care team can complete their work and have a positive work experience.

A full PDSA will be undertaken to identify staffing barriers and solutions to address those barriers. Front line staff and physicians will be engaged to support our analysis and build practical solutions to meet our goal of reducing the number of days non-nursing staff and physicians are short-handed per month by 25 percent.

SAFETY

In 2024, PRH will begin the planning phase for the transition to an electronic health record system, EPIC. This is an exciting advancement, that will have a significant impact on patient safety. The implementation of EPIC will allow for better communication between many of our East Region hospital partners. It will also allow our patients to access their medical records through the online patient portal, My Chart.

Internally, EPIC will allow us to house all our patient information in one system. This will improve care coordination between all members of the care team. Furthermore, it will address challenges that come with relying on paper documentation.

This initiative will require significant efforts by all at PRH, through the planning and implementation phases. The 2024/2025 QIP driver focused on patient safety will ensure we can devote the significant amount of time that will be required to ensure a successful implementation in 2025.

POPULATION HEALTH APPROACH

PRH is an active member of the Ottawa Valley Ontario Health Team (OVOHT). We recognize the importance of engaging with our community partners in health and social services to ensure the best outcomes for our community members.

PRH always been committed to supporting the most vulnerable community members. We continued this work in 2023/2024 supporting the Warming Shelter, and continuing our partnership with The Grind, to support those in our community who are underhoused, and/or suffering from mental health and addictions issues.

We also contributed input for the OVOHT QIP (cQIP) and aligned our equity driver goals with our partners on the OVOHT focusing on training and education.

EXECUTIVE COMPENSATION

Our Senior Leadership Team is made up of the President and Chief Executive Officer, the Vice President of Clinical & Support Services/Chief Nursing Executive, the Vice President of Clinical & Support Services/Partnerships & Integration, the Vice-President of Finance and Corporate Services / Chief Financial Officer, the Vice-President of Human Resources, 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 2024/2025 each member of the senior team will have 5% of the total available compensation linked to achieving the targets as set out in our 2024/2025 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 payout as determined by the Pembroke Regional Hospital Board of Directors.

CONTACT INFORMATION/DESIGNATED LEAD

Sabine Mersmann,
President & CEO
sabine.mersmann@prh.email
613-732-2811 Ext 6156

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 27, 2024

Board Chair

Board Quality Committee Chair

Chief Executive Officer

Other leadership as appropriate

Pembroke Regional Hospital

Quality Improvement Plan (QIP) 2024/2025

Patient and Family Experience

AIM		MEASURE			
Quality Dimension	**Objective**	**Indicator**	**Current Performance**	**Target for 2024/25**	**Target Justification**
Patient Experience	Maintain the experience of patients and families at transition from hospital to community through effective communication.	Percentage of respondents who select "Completely" to the following questions: "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?"	80%	80%	The target for this driver in 2023/24 was 70%. The target for the 2024/25 target has been increased by 10% to maintain our current performance.

Change Idea

Improve our patient's knowledge of their condition by identifying gaps in discharge communication for inpatients and people treated in the Emergency Department (ED).

Methods	Process Measures	Target for Process Measure	Responsible Departments
Utilize the Discharge Communication Driver Working Group to assess, implement, and evaluate discharge communication change ideas.	Q1: Number of clinical departments that identify at least one additional patient- and/or family-related gap in discharge communication and have developed plans to address gaps. Q2: Number of departments that have implemented the discharge communication improvements.	Q1: 6 Q2: 3	**SLT Lead:** Melanie Henderson **Admin Resource Lead:** Alycia Fraser Medical ICU Emergency Rehabilitation Acute Mental Health Surgical

	Q3: Number of departments that have implemented the discharge communication improvement. Q4: Number of departments that have evaluated the implementation of their discharge communication improvement.	Q3: 6 Q4: 6	

Best Health Outcomes

AIM		MEASURE			
Quality Dimension	**Objective**	**Indicator**	**Current Performance**	**Target for 2024/25**	**Target Justification**
Patient Safety	Begin the planning for EPIC (electronic health records software system) implementation.	Percentage of processes completed by quarter.	Not currently being measured.	90%	In 2024, Pembroke Regional Hospital will begin the planning process to implement EPIC. A project charter will be established with countermeasures requiring completion at each step throughout the process.

Change Idea

Ensure an effective transition to an electronic health record by beginning the planning process for the implementation of EPIC.

Methods	Process Measures	Target for Process Measure	Responsible Departments
Establish working groups to support planning. Establish a project charter. Identify processes requiring changes to facilitate transition to EPIC.	Q1: Establish an EPIC working group to support the transition. Q2: A) Creation of an EPIC project charter. B) Number of processes initiated over processes planned to be initiated; expressed as a percentage. Q3: Number of processes initiated over processes planned to be initiated, expressed as a percentage. Q4: Number of processes initiated over processes planned to be initiated, expressed as a percentage.	Q1: 1 Q2: A) 1 B) 90% Q3: 90% Q4: 90%	**SLT Lead**: Scott Coombes / Beth Brownlee **Admin Resource Lead:** Alycia Fraser Hospital-wide

Provider Experience

AIM		MEASURE			
Quality Dimension	**Objective**	**Indicator**	**Current Performance**	**Target for 2024/25**	**Target Justification**
Provider Experience	Continue to strengthen patient care teams by reducing the percentage of daily shift vacancies on clinical units among non-nursing staff and physicians.	Average number of days per month in which care teams worked without the full complement of staff and physicians.	Not currently measured.	Reduce the average number of days per month non-nursing care team members work without their full complement by 25% by June 2025.	Non-nursing staff (health care aides, allied health members, etc.), and physicians have an integral role in patient care teams. Reducing the frequency these teams work without their full complement will reduce the need for overtime and workloads.

Change Idea

Establish new staffing / physician models for non-nursing patient care team members.

Methods	Process Measures	Target for Process Measure	Responsible Departments
Complete PDSA (Plan-Do-Study-Act) to identify staffing challenges among non-nursing patient care team members, including physicians. Identify and implement a new patient care team model.	Q1: A) Number of non-nursing patient care team roles selected for QIP Driver. B) Establishing recruitment process for physicians based on highest need. Q2: Number of staffing barriers identified for each role selected, including physicians. Q3: Number of responsible departments with patient care team model implementation plans for non-nursing roles. Q4: Number of responsible departments that have completed the implementation phase for non-nursing patient care team models.	Q1: A) 3 B) 1 Q2: 3 Q3: 6 Q4: 6	**SLT Lead**: Brent McIntyre **Admin Resource Lead**: Tyler Graveline Medical Emergency Surgical Rehabilitation Acute Mental Health Medical Affairs

Best Health Outcomes

AIM		MEASURE			
Quality Dimension	**Objective**	**Indicator**	**Current Performance**	**Target for 2024/25**	**Target Justification**
Equity, Diversity, and Inclusion (EDI)	Advancing equity, inclusion and diversity knowledge to reduce disparities in outcomes for patients, families, and providers.	Percentage of staff and physicians that have completed education related to equity, diversity and inclusion.	Not currently being measured.	40%	Creating a welcoming, inviting hospital to work in, or receive care is important to achieve better outcomes for workers and patients. By training 40% of all staff and physicians on EDI related issues, we can reduce disparities that may exist and improve the experience for all. Majority of the education will occur in Q3 and Q4.

Change Idea

Improve the knowledge, through education, of EDI related issues and how to reduce disparities.

Methods	Process Measures	Target for Process Measure	Responsible Departments
Identify and select appropriate education programs. Establish a method for tracking training progress among staff, and physicians. Implement the new education program.	Q1: Number of education programs that were reviewed by the Equity, Diversity, and Inclusion Committee. Q2: Number of education programs selected for completion by staff and physicians in Q3 and Q4. Q3: Percentage of staff, and physicians that have completed the selected education program(s).	Q1: 3 Q2: 1 Q3: 20%	**SLT Lead**: Brent McIntyre **Admin Resource Lead**: Anna Ethier Hospital-wide

	Q4: Percentage of staff, and physicians that have completed the selected education program(s).	Q4: 40%	

Experience | Patient-centred | Custom Indicator

	Last Year		This Year	
Indicator #5	**CB**	**CB**	**80**	**NA**
Percentage of respondents who select “Completely” to the following questions: “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?” (Pembroke Regional Hospital Inc.)	**Performance (2023/24)**	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Improve patient’s knowledge of their condition by identifying gaps in discharge communication for inpatients and people treated in the Emergency Department.

Process measure

- Q1: By the end of Q1, complete all remaining change ideas from 2022/2023 QIP related to Communication and Family Involvement Driver. Q2: By the end of Q2, number of clinical departments that identify at least one additional patient- and/or family-related gap in discharge communication and have developed plans to address gaps. Q3: By the end of Q3, number of departments that have implemented discharge communication improvements over the number of departments with plans. Q4: By the end of Q4, percentage of departments that have implemented discharge communication improvement.

Target for process measure

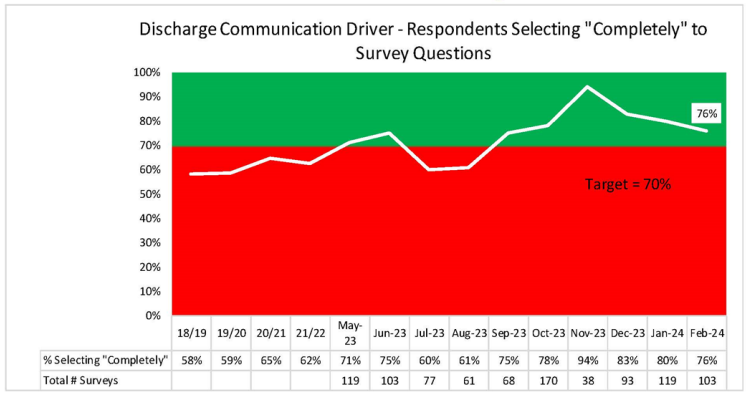
- By the End of Q1: 100% By the End of Q2: 6 By the End of Q3: 3/6 By the End of Q4: 100%

Lessons Learned

Successes:
- Implementation of patient whiteboards on Acute Mental Health Unit, and gap tool implementation on Rehabilitation and Medical Units.
- In Emergency Department (ED) and Intensive Care Unit (ICU) a Referral Communication Sheet was implemented.
- One of our Patient Experience Advisors joined the Working Group for this initiative.

Results

Communications QIP Driver



	18/19	19/20	20/21	21/22	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
% Selecting "Completely"	58%	59%	65%	62%	71%	75%	60%	61%	75%	78%	94%	83%	80%	76%
Total # Surveys					119	103	77	61	68	170	38	93	119	103

Qualtrics Data used Nov-23 onwards

ED: Before you left the emergency department, did you understand what symptoms or health problems to look out for when you left the emergency department?
Inpatient: 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?

Posted Date: March 18, 2024

Safety | Safe | Custom Indicator

Indicator #4

Number of violence incidents over the total number of violence reports in a 12 month period, expressed as a percentage. (Pembroke Regional Hospital Inc.)

Last Year		This Year	
35.50	**35**	**NA**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Report Accessed: April 02, 2024

Change Idea #1 ☐ Implemented ☑ Not Implemented

Increase the number of staff and physicians who have received violence prevention training.

Process measure

- Q1: A) By the end of Q1, identification of what positions by department require violence prevention training. B) By the end of Q1, identification of which staff and physicians have not received violence prevention training, dependent on their job duties. Q2: By the end of Q2, development of a training plan for identified staff and physicians to receive violence prevention training. Q3: By the end of Q3, number of training opportunities provided to identified staff and physicians. Q4: By the end of Q4, Percentage of identified staff and physicians requiring violence prevention training that received training.

Target for process measure

- Q1: A) 100% B) 100% Q2: 100% Q3: To be determined (TBD) Q4: 85%

Lessons Learned

In Q1 we recognized our outcome measure needed to change because we were lacking an effective manner for tracking whether staff were up to date on training. Therefore, we focused on establishing an effective tracking process in Q1 / Q2 and focused on training in Q3 / Q4.

Staffing processes needed to change in order to ensure protected time for staff to attend training.

Additional training times were required in order to allow staff to attend training sessions to fit their schedules.

New process was developed so that staff receive training on a regular shift scheduled day and that they are backfilled therefore, not being pulled to a unit to work.

Increased number of training sessions scheduled per month.

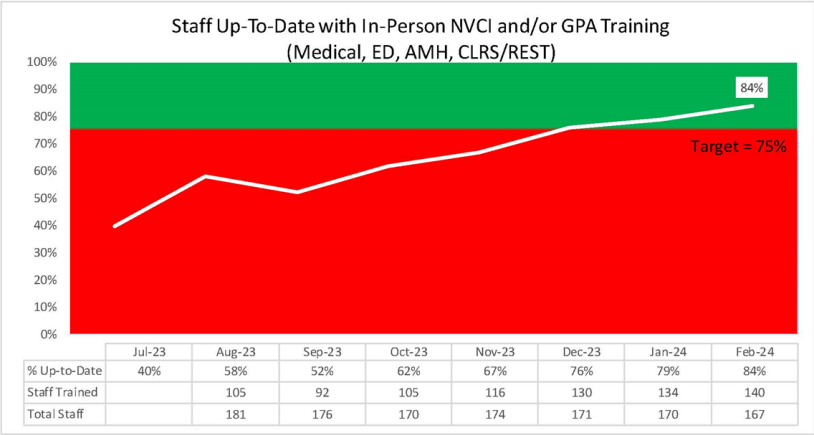
New Outcome Measure:
Percentage of identified staff requiring violence prevention training that complete training.

Target: 75%

We were able to identify and train more than 80% of staff who previously did not receive training, or their certification had expired.

Results

Prevention of Violence QIP Driver



	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
% Up-to-Date	40%	58%	52%	62%	67%	76%	79%	84%
Staff Trained		105	92	105	116	130	134	140
Total Staff		181	176	170	174	171	170	167

Posted Date: March 18, 2024

Indicator #3

Number of Never Events reported over 12-month period. (Pembroke Regional Hospital Inc.)

Last Year		This Year	
1	**0**	**0**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Report Accessed: April 02, 2024

Change Idea #1 ☑ **Implemented** ☐ **Not Implemented**

Prevent future Never Events by implementing the five (5) remaining recommendations from the Quality Review, related to the 2023 Never Event.

Process measure

- Q1: By the end of Q1, interdisciplinary working group established, and a plan completed for how recommendations will be implemented. Q2: By end of Q2, Number of recommendations implemented. Q3: By end Q3, number of operating room (O.R.) process compliance audits completed. Q4: By the end of Q4, number of operating room (O.R.) process compliance audits completed.

Target for process measure

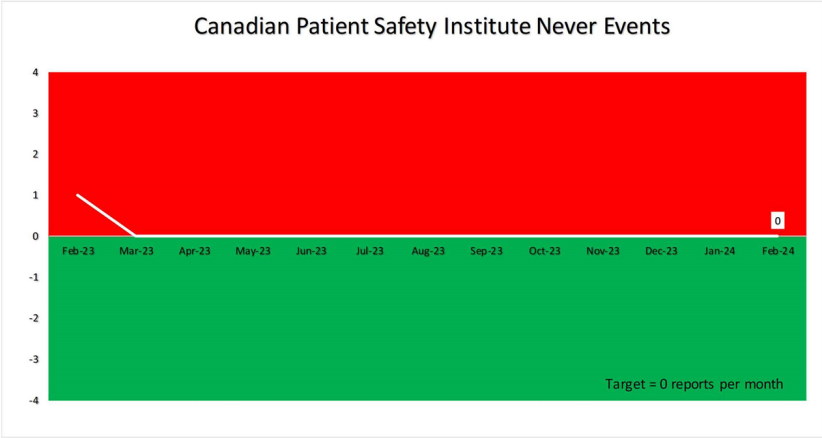
- Q1: 100% Q2: 5 Q3: 8 Q4: 8

Lessons Learned

Successes:
- New pre-surgical check list was created, implementation and audited.
- Training occurred regarding quality improvement (QI) and teamwork which included Operating Room (OR) team members (both Physicians and Nurses).

Results

Never Events QIP Driver



Posted Date: March 18, 2024

Safety | Effective | Custom Indicator

	Last Year		This Year	
Indicator #1 Average number of days per month in which care teams worked without the full complement of staff. (Pembroke Regional Hospital Inc.)	**20** **Performance (2023/24)**	**10** **Target (2023/24)**	**2** **Performance (2024/25)**	**NA** **Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Implement staffing models to stabilize the workforce.

Process measure

- Q1: A) By the end of Q1, percentage of responsible departments from 2022-2023 QIP that have fully implemented innovative staffing models. B)By the end of Q1, percentage of responsible departments from 2022-2023 QIP with an evaluation plan for their innovative staffing model. Q2: By the end of Q2, percentage of responsible departments that have evaluated the effectiveness of their innovative staffing model. Q3: By the end of Q3, percentage of responsible departments that have implemented changes to their innovative staffing model based on evaluation. Q4: By the end of Q4, percentage of responsible departments that have re-evaluated the effectiveness of their innovative staff model, utilizing Q1 evaluation plan.

Target for process measure

- Q1: A) 100% B) 100% Q2: 100% Q3: 100% Q4: 100%

Lessons Learned

Successes:
- Patient care team models were evaluated with staff feedback guiding improvement opportunities. Staff highly value new team members such as, healthcare aids and advance care paramedics.
- We far surpassed our target of having less than 10-days per month that units work without their full compliment.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Implement strategies to address staff retention challenges.

Process measure

- Q1: By the end of Q1, completion of assessment regarding staff retention challenges. Q2: By the end of Q2, development of plan to address challenges in retaining staff. Q3: By the end of Q3, percentage of staff retention strategies identified in plan that have been implemented. Q4: By the end of Q4, percentage of staff retention strategies identified in plan that have been implemented.

Target for process measure

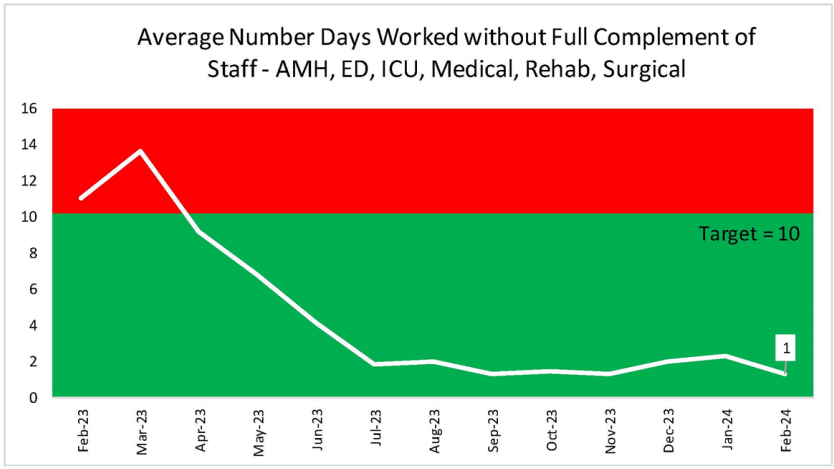
- Q1: 100% Q2: 100% Q3: 25% Q4: 75%

Lessons Learned

Successes:
- Nursing staff retention rates have improved since implementing this initiative.
- Senior Leadership Team (SLT) ...

Results

Patient Care Teams QIP Driver



Posted Date: March 18, 2024

Indicator #6

Score related to identified staff and physician engagement survey questions. (Pembroke Regional Hospital Inc.)

Last Year		This Year	
CB	**CB**	**57.33**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Report Accessed: April 02, 2024

Change Idea #1 ☑ **Implemented** ☐ **Not Implemented**

Improve the experience of staff and physicians by choosing two (2) areas for improvement based on the 2023 staff and physician engagement survey results.

Process measure

- Q1: By the end of Q1, identification of improvement ideas related to the staff and physician engagement survey results. Q2: By the end of Q2, plan developed to improve two provider experience ideas. Q3: By the end of Q3, number of countermeasures identified in plan implemented, over total number of countermeasures in plan. Q4: By the end of Q4, number of countermeasures identified in plan implemented, over total number of countermeasures in plan.

Target for process measure

- Q1: 2 Q2: 100% Q3: 50% Q4: 75%

Lessons Learned

By reviewing 2023 Staff and Physician Engagement Survey results, three questions were identified to improve scores:
-The Senior Leaders communicate organization plans openly with employees.

-I understand what the goals are for the organization this year.

-Visual displays of my department's performance data are regularly reviewed and used to identify improvement areas.

Success:

Significant increases in the number Lean huddles the Senior Leadership Team (SLT) attended.

Establishment of weekly CEO message to all staff and physicians; and monthly lunch with the CEO.

All QIP progress visually displayed on each unit Lean huddle board; results reviewed a huddles and unit leadership meetings.

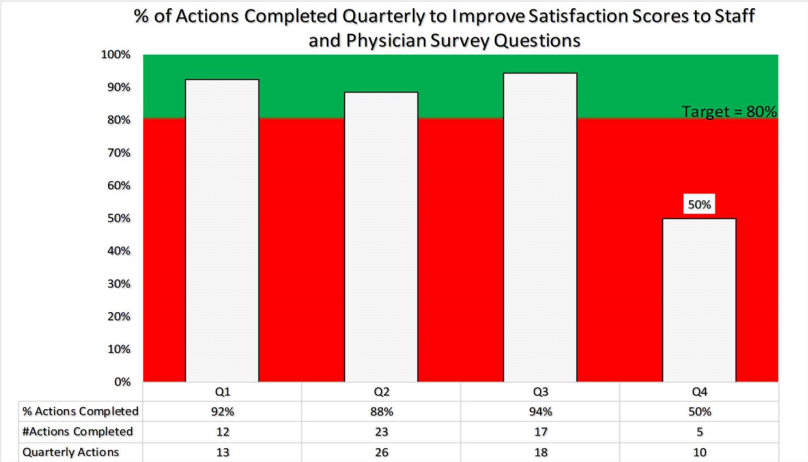
Scores in the 2024 Staff and Physician Engagement Survey improved for each of the three questions.

Comment

Image attached was a process measure tracking tool for countermeasures per quarter.

Results

Staff Engagement QIP Driver



	Q1	Q2	Q3	Q4
% Actions Completed	92%	88%	94%	50%
#Actions Completed	12	23	17	5
Quarterly Actions	13	26	18	10

Posted Date: March 18, 2024

Safety | Effective | Priority Indicator

Indicator #2

Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged. (Pembroke Regional Hospital Inc.)

Last Year		This Year	
50.58	**80**	**80.85**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ **Implemented** ☐ **Not Implemented**

Improve method for capturing the percentage of medication reconciliation completed for discharged patients and identify improvements to increase completion of medication reconciliation.

Process measure

- Q1: A) By the end of Q1, re-establish a working group for medication reconciliation. B) By the end of Q1, identify opportunities to improve data collection and completion rates related to medication reconciliation. Q2: A) By the of Q2, implement data collection improvements. B) By the end of Q2, implement medication reconciliation process improvements.

Target for process measure

- Q1: A) 100% B) 100% Q2: A) 100% B) 80%

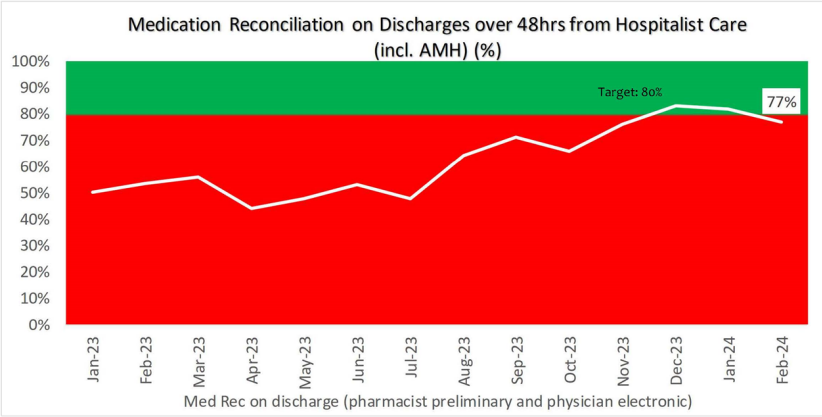
Lessons Learned

Successes:
- Able to identify Physician champions.
- Able to get all of Hospitalists trained on using the PRH medication reconciliation tool.

Challenges:
- For Acute Mental Health patients their discharge sometimes occurs before Hospitalist rounds and therefore, medication reconciliation was not completed.

Results

Medication Reconciliation QIP Driver



Posted Date: March 18, 2024