Quality Improvement Plan (QIP): 2023-2024 Progress Report (Q3)
Updated February 6, 2024

Measure/Indicator from 2023/24 (Unit, Population, Period, Data Source)	Performance as stated in previous QIP	Performance Target as stated in previous QIP	Current Performance	Comments	Results	Actions	Change ideas from last year's QIP	Was this change idea implemented as intended	Process measures from last year's QIP	Lessons Learned: What were your successes and/or challenges?
Medication reconciliation at admission: Total number of admitted patients for whom medication reconciliation is completed within 48 hrs of admission as a proportion of the total number of patients admitted	26.53%	57.50%	39.76%	Pharmacy has now hired its full complement of pharmacy technicians and additional resources are allocated to obtaining a BPMH as new staff are trained to release staff into this specialized role. The completion of Med Rec relies heavily on pharmacists and to a lesser extent prescribers – in the early fall the hospital hired 5 new pharmacists who have started working independently and contributing to Med Rec since November. The stats for Q3 reflect this increased contribution by the new team members. Pharmacy still has a 32% vacancy rate for inpatient care.	Below target indicator but an increase of 21% (18.76% to 39.76%) from Q2- Q3. This is a correlation to decreased vacancy rates for Pharmacists and Pharmacy Technicians which allow for increased dedication towards Best Possible Medication History and Med Rec. Completion rates for collecting BPMH and completing Med Rec by pharmacy team are promising and trending up.	Increased Pharmacy Technician's performing BPMH Development of Pre-Printed Direct Order (PPDO) – Pharmacy Best Possible Medication History Primary Home Medication Form	1) Increase number of staff performing BPMH (Registered Pharmacy Technicians and Students) and completing medication reconciliation (Pharmacists). 2) Improve process for completing medication reconciliation on admission. 3) Educate staff and professional staff on role in completing medication reconciliation on admission (transfer and discharge). Continue to provide education to student medical learners and residents.	1) Full complement of pharmacy techs hired. Results will hopefully continue upwards as the techs become more efficient in collecting BPMH. Five new Pharmacists hired and results reflect this as more resources are now allocated to completing med rec. 2) Multidisciplinary design event held and identified gaps and duplication in roles and responsibilities. Development of PPDO to allow prescribers to reconcile and generate new medication orders – will also signal pharmacy to complete the Med Rec on admission intervention. Overall goal is to increase compliance data for work that is currently not being captured. More efficient and effective process for patients admitted via emerge department with new Primary Home Medication Form. 3) Not yet completed. Target to educate professional staff tied to final approvals of new PPDO for BPMH.	% medication reconciliation completed for all admitted patients to all units / total hospital admissions to all units	**Successes:** -Increased HHR for BPMH -BPMH Pharmacy Completion Rate -Pharmacists completion of Med Rec -Increased Awareness of Med Rec throughout organization **Challenges:** -Resource Limitations including dedicated leadership for med rec -HHR dependent process -Data collection to identify other gaps -Process for future prescriber engagement
Ratio of reported behavioural incidents in the Emergency Department to severe behavioural incidents in the Emergency Department (first aid, lost time or other health care intervention needed)	Collecting baseline	Decrease 3%	Q3 performance- 59.30% of incidents are severe	Current performance of ratio of severe to total reported incidents in the Emergency Department may be impacted by the decrease in total reporting in the department. Progress continues to be tracked while considering under-reporting of non-severe incidents as well as the analysis of trending severe incidents only and behavioural incidents reported through the Incident Learning System.	Below target indicator	Continue to analyze reporting trends within the department. Continue to encourage incident reporting within the department.	Continue advancing the work of the Emergency Department Workplace Violence Prevention Committee and Emergency Department Task Force to advise and implement workplace violence prevention initiatives/programs/processes in TBRHSC's Emergency Department that are based on staff experience, evidence and best practice	Work of the Emergency Department Workplace Violence Prevention Committee and Emergency Department Task Force has been progressing as planned. Phase 2 projects are near completion.	% completion of identified initiatives	**Successes:** -Public Antiviolence Campaign -Mental Health enhancements including access to a part-time peer support worker in the Emergency Department -Security Staff training complete -Creation of de-escalation room -Improvement in 2022-23 QIP Indicator Staff Experience Survey question "My organization takes effective action to prevent violence in the workplace" -Recruitment of Indigenous Patient Navigator with experience working with Mental Health and Addictions -Police presence in the department from 1700-0500 hrs **Challenges** -Continued decline in non-severe incident reporting -Awaiting response from MOH/OH on funding for evening and weekend coverage for supportive roles in the ED
Percentage of respondents (Inpatient and Emergency Department) who responded 'completely' to the following question: Were your experience, views and beliefs acknowledged?	60.30%	61.50%	Collecting baseline	CPESIC survey distribution interrupted with NRC discontinuation. Onboarding, procurement and implementation of new vendor included delays outside of control. As a result, survey distribution began June 2023 with low sample size. Other technological issues on vendor side have also caused disruptions in data collection and have significantly impacted Q3 results.			1) Establish an EDI steering committee to both guide and inform ongoing improvement efforts. 2) Review and adjust current policies and procedures to reflect the principles of the Truth & Reconciliation call to Action. 3) Implement cultural safety training for all staff. 4) Adjust admission processes to include a discussion between staff and patients about each patient's experience, views and beliefs and how these can be addressed in their care.	1) EDI steering committee has been implemented and operationalized 2) 6 policies have been reviewed and process for including EDI steering committee in policy and procedure process review has been established 3) Cultural Safety Training implemented and plans for further implementation underway 4) Led through PFCC	Given some "methods" will extend beyond March 2024, process measure will be status of identified methods that reflect expected level of progress.	**Successes:** - Operationalization of EDI steering committee to identify gaps and develop strategies for improvement in our hospital - Partnership with Well Living House to conduct research project and review policies - Implementation of Repairing the Sacred Circle Cultural Safety Training - Various other Cultural Safety Trainings implemented throughout our hospital - Awareness of Indigenous Collaboration, Equity and Inclusion portfolio and initiatives **Challenges:** - Ensuring EDI voices are heard - Receiving grant funding - Various competing priorities