Quality Improvement Plan (QIP): 2024-2025 Progress Report

Measure/Indicator from 2024/25 (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	39.76%	65% by 2024/25 Q4	54.9% (Q3)	The Med Rec on Admission Target was set for 24/25 to be 10 % higher than what was achieved in 23/24 with full pharmacist staffing. The concept was that with full pharmacist staffing and the incorporation of new process document, we would be able to complete additional med recs on admission and capture the data. We anticipated MD completion of form to drive further Med Rec on admission completion. A barrier to capturing data is the recording in the EMR that it has been completed when a non pharmacy member completes the med rec as prescribers do not document interventions in the EMR. The second barrier is the continued Pharmacist resources and vacancy rates. Since June of 2024 we have been utilizing telepharmacy to help allow RPH to be on patient care areas. We continue to actively recruit and retain for our pharmacy team.	In April 2024 we initiated the new form to help communicate completed BPMHs and allow the prescriber to use that form to complete the Med Rec. We still need to understand if there is a gap between completed BPMH and completed Med Recs on admission and working with business intelligence to capture that data. This will help us identify if this is a true gap. Prescriber engagement has been completed for 50% of the section meetings as was our target. We will continue to work through all section meetings for prescribers when requested. Third target had our pharmacist team attending quality huddles on each patient care area and bringing Med Rec forward for information and sharing. This has been completed We are behind schedule with determining additional resources required across the organization as pharmacy leadership structure is finalized and the role of the Med Safety Officer leading med rec will be essential to determine the needs of the program. Great news is that we now have approval for a Medication Safety Officer Pharmacist, which amongst other responsibilities, will be the lead for our Med Rec improvements and audits. We have already determined the pharmacist who will take on this role and anticipate them starting gradually in February 2025. Full time responsibilities will require recruitment of another pharmacist.	Continue working with BI team to identify and capture data in order to better understand the gaps between completed BPMH and completed Med Recs on Admission.	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 and implementation 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 Emergency 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:** -HHR dependent process -Data collection to identify other gaps -Process for future prescriber engagement -Add LMS dual code development for nursing staff
Percentage of staff (executive-level, management, all) who have completed relevant equity, diversity, inclusion, and anti-racism education	Executives: 90% Managerial: Collecting baseline General Staff: Collecting baseline	Executives: 100% Managerial: 50% General Staff: 15%	Executives 100% Managerial 51% General Staff 5%	Weekly regular training sessions are booked in ICP-Main that is fitted for smudging ceremonial practices. Targets for executives and managers have been reached with General staff falling behind due to participant capacity (n=10) while prioritizing Executives and Managerial Staff. ICEI Department has collaborated with HR with the addition of Repairing Sacred Circle (RSC) Training to General Orientation for incoming staff until end of March 2025. This will allow general staff numbers to increase over Quarter 4.	General staff indicator has risen slightly due to adding training to the orientation schedule. This has assisted the percentage to increase and with a probability to reach at least 10% by March 31.	Regular weekly session open to all staff Additional bi-weekly General Orientation RSC from February to March with a possible continuation in the new fiscal year.	1) Adding RSC training session to General orientation. 2) Promotion of RSC on Intranet and communications. 3) CME accreditation complete for physicians for 4 sessions in the 2025 year.	1) After review of current numbers and feedback from general staff the reason they could not attend was mainly due to their shift schedules also having to attend the 3 hour session on their own time. Current best practice is to have general staff complete RSC during orientation before their regular shift schedules start. 2) Continued promotion through communication department. 3) Approved accreditation for Physicians for the following 2025 dates: February 26, April 23, October 22, and December 4.		**Successes:** -Excellent feedback on the Repairing the Sacred Circle training -Great feedback on our response to the TRC Calls to Action Report that highlighted our QIP data -Getting RSC 1 Accredited -Staff are more open to asking questions on how to increase feelings of cultural safety **Challenges:** -Finding time for professional staff to attend a 3-hour in-person training

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?	64.00%	Collect Baseline	69.28% Q1-3 2024/25	Continue to struggle with low enrollment into the qualtrics surveys thus resulting in low sample size for Q38		Staff Education: Developed and implemented an admission and discharge video, now available on the staff resource page. Additionally, facilitated a Soft Skills Day tailored for internationally trained nurses to enhance their communication and patient engagement skills. PFCC Engagement: Actively participate in monthly REFs and roaming rounds, emphasizing key discharge processes, including PODS/POETS, Teach-Back, and SMARTT goals to reinforce effective patient education and transition planning. Patient Resource Folders: Successfully rolled out across all units to provide consistent and accessible patient education materials. Pre-Discharge Educator Pilot: Implemented a three-month pilot on Unit 2B to enhance communication, Teach-Back methods, post-discharge support, and patient confidence in their discharge plan. Compliance Monitoring & Auditing: Ongoing audits and compliance tracking are conducted through the PDL role to ensure adherence to best practices. Post-Discharge Follow-Up: All patients discharged from medical and surgical units receive follow-up calls within 74 hours post-discharge to assess needs, reinforce education, and provide additional support as required.	Ensure all patients are provided and understand discharge paperwork, patient education regarding condition and are provided the appropriate tools to manage care post discharge. 1) Develop plan for staff education of standardized discharge process, as well as plan to implement standardization into workflow at bedside. 2) Extend patient resource folder trial to all units as a means to close health literacy gap, assist in retention of education for patients, increase care partner involvement and ultimately improve patient experience. 3) Maintain auditing compliance regarding discharge process (currently being conducted by Post Discharge Liaison (PDL) and Discharge Transition Lead however funding expiring (March 31, 24). 4) Educate and implement teach back communication strategy to ensure patient understanding of discharge instructions.	Yes for all	Patient response to Q. 38 on CPESIC, % of patients who have received written post discharge instructions (through health records audit and PDL statistics and interventions), percent of post discharge liaison intervention (suspect decrease of interventions needed if proper discharge process followed).	Many nurses are experiencing confusion regarding documentation standards and the appropriate location for entering discharge notes. Additionally, the uptake of the resource folder has been challenging due to workflow constraints and unclear responsibilities. However, when the folder is distributed, it has proven to be beneficial, as confirmed by feedback from patients during our post-discharge callbacks. Notably, adding a callback number to the folder has contributed to preventing several adverse events. Furthermore, our post-discharge callback data indicates that the majority of patients are receiving PODs/POETs; however, this is not consistently reflected in our patient experience surveys, likely due to a low sample size. To address these gaps, ongoing education on teach-back methods and effective communication techniques remains essential.
90th percentile emergency department (ED) wait time to inpatient bed	34.3 hours	30 hours	Average from April 1, 2024 to December 31, 2024 = 34.5 hours		The current performance of 34.5 hours is above target, despite actions for improvement. One of the biggest contributing factors affecting ED wait times for inpatient beds is bed availability due to high occupancy rates, hospital capacity, and surge demand related to seasonal spikes (e.g., flu, COVID-19).		1) Revise the Bed Utilization Management (UM-Util-01) policy. 2) Daily bed rounds - forum to discuss and resolve bed flow challenges 3) Ensure all inpatient beds are assigned within a timely manner by the admitting clerk. 4) Improve the 1100 hr. discharge time. 5) Share and seek guidance from the Patient Flow Steering Committee for improvement opportunities.	1) The bed utilization management policy has been revised and is currently circulating for consultation and then approval. 2) The daily bed rounds forum has been completely revised to focus on identifying barriers to discharging patients, by inviting all key players to attend rounds, barriers are identified in real-time and actioned for follow-up resulting in improved discharge rates for admitted in-patients. 3) Complete 4) Ongoing 5) Complete	Time to inpatient bed for ED patients - 90th percentile	**Successes** - revision of bed rounds format has been instrumental to facilitate inpatient discharges (proactive approach). - admission avoidance strategies such as CDU implementation, CT midnight pilot, and ultrasound booking process for ED patients **Challenges** - health care capacity challenges at regional hospitals results in repatriation backlog, ALC patients in acute care beds, physician accountability for admitting and discharging patients.