Quality Improvement Plan (QIP): 2025-2026 Progress Report

Measure/Indicator from 2025/26 (Unit, Population, Period, Data Source)	Performance as stated in previous QIP	Performance target as stated in previous QIP	Current performance	Comments (identify any challenges in meeting targets)	Results	Actions	Change ideas from last year's QIP	Was this change idea implemented as intended? (confirm status of each change idea - implemented, in progress, not implemented)	Process measures from last year's QIP	Lessons Learned: What were your successes and/or challenges?
Rate of medication reconciliation (Med Rec) at admission: Total number of admitted patients for whom a Med Rec is completed within 48 hrs of admission.	**(Q1): 44.22%; (Q2): 39.53%; (Q3): 55.85%**	**65.00%**	**2025/26 Q3 Results = 55.85%** with Dec and Jan results trending up to 61% and 63.6% respectively	Baseline data on Best Possible Medication History (BPMH) completion is required to better understand drivers of medication reconciliation performance on admission and to inform targeted improvement strategies. While Q3 results remain below the 65% target, recent months demonstrate upward trend (61% and 63.6%). Data extraction was previously deferred due to competing high-priority Business Intelligence (BI) initiatives. Discussions are underway to reassess BI capacity and confirm timelines for obtaining the required baseline data to support improvement planning.	**1) Obtain baseline data on BPMH completion to determine improvement plan for Med Rec completion rates on admission:** Work is underway with BI to determine whether a gap exists between completed BPMHs and completed Med Recs on admission. Delays in data extraction occurred due to competing BI priorities. Establishing this baseline will clarify whether performance gaps are workflow-related or documentation-related and will inform targeted interventions. **2) Complete the development of an education platform for nursing staff on LMS Dual Code:** Education strategy was updated to align with the upcoming new HIS and associated workflow changes. A revised general Med Rec education document has been developed and will be uploaded to LMS Dual Code by end of Q4. Nursing team members performing BPMH in outpatient areas will receive targeted in-person education in lieu of the LMS module. **3) Continue prescriber engagement to encourage use of implemented Pre-Printed Direct Order (PPDO) to support Med Rec:** A presentation to the Medical Advisory Committee (MAC) is scheduled for February 2026, including review of the Med Rec process and reinforcement of PPDO use for BPMH discrepancies. Section Chiefs will be offered individual section-level presentations. An education package has been developed for new prescribers and will be distributed to all current practitioners for reinforcement. **4) Determine additional resources required to improve Med Rec on admission across the organization:** Pharmacy leadership is reviewing Med Rec resource requirements as part of the broader HHR Master Plan to assess additional staffing needs required to support sustained improvement. **5) Medication Safety Officer (MSO) to utilize audit information to make further process improvement recommendations:** Audit findings are being used to inform continued process refinements, including improvements to documentation tools used throughout the Med Rec journey. Education is ongoing to reinforce appropriate documentation of discrepancies and pharmacy completion of PCS interventions to reflect prescriber-completed Med Recs.	**1)** Finalize BI data extraction to establish baseline BPMH completion and quantify BPMH-to–Med Rec conversion gap. **2)** Implement updated LMS Dual Code education module by end of Q4 and track completion rates. **3)** Deliver MAC presentation (Feb 2026) and offer targeted section-level education to reinforce PPDO utilization. **4)** Finalize pharmacy Med Rec resource review within HHR Master Plan and identify recommended staffing adjustments. **5)** Continue monthly audit review and implement targeted process refinements based on findings.	**1)** Obtain baseline data on BPMH completion to determine improvement plan for Med Rec completion rates on admission. **2)** Complete the development of an education platform for nursing staff on LMS Dual Code. **3)** Continue Prescriber engagement to encourage use of implemented Pre-Printed Direct Order (PPDO) to support Med Rec. **4)** Determine Additional resources required to improve Med Rec on admission across the organization. **5)** Medication Safety Officer (MSO) to utilize audit information to make further process improvement recommendations.	**1) In progress -** behind schedule. Data extraction was deferred due to competing high-priority BI initiatives. Discussions are underway to reassess BI capacity and confirm next steps for obtaining baseline BPMH completion data. **2) In progress -** implementation targeted for Q4 A standardized nursing education resource has been developed and is undergoing final review prior to LMS Dual Code deployment. **3) In progress -** behind schedule. A presentation to MAC is scheduled for February to reinforce the Med Rec process and PPDO utilization. **4) In progress -** on target. Data analysis is underway. Pharmacy leadership is advancing human resource planning, including identification of staffing requirements necessary to achieve admission Med Rec targets as part of the Pharmacy Human Resource Master Plan. **5) In progress -** on target. The Med Rec audit tool has been redesigned to enhance data capture and enable trend analysis. Baseline data has been collected and presented to the Med Rec Committee. Further analysis is underway to inform targeted process improvement recommendations. Audits will continue on an ongoing basis to support sustained improvement.	**1)** Gather BPMH completion rates across units to understand baseline. **2)** Utilize LMS Dual code to develop and deliver the content to support Nursing Staff. **3)** Present PPDO Refresher at MAC and at Divisional meetings as requested. **4)** Plan is completed and brought to Med Rec Committee, Operational Leadership Committee and Senior Leadership Committee. **5)** MSO to recommend improvements based on unit audit findings.	**Successes:** - On-going Pharmacist engagement implemented through Quality Huddles across patient care areas - BPMH education expanded to outpatient areas - Roaming Education For Staff (REFS) in March focused on Medication Safety, including Med Rec - Med Rec forms revised to reduce risk of errors - Med Rec completion rates demonstrate upward trend **Challenges:** - Variability in documentation of Med Rec completion at prescriber sign-off - Transition to Meditech Expanse will require workload analysis and workflow redesign to support sustainable compliance
Percentage of management and staff who have completed relevant equity, diversity, inclusion (EDI) and anti-racism education. ***Note:** Executive-level removed as 100% achieved during last QIP.	Q2 Managerial: **84%** General Staff: **19%**	Managerial: **75%** General Staff: **15%**	Q3 Managerial: **98%** General Staff: **23%**	Monthly regular training sessions are booked in ICP-Main that is fitted for smudging ceremonial practices. Targets for managers and general staff have been reached since Indigenous Collaboration, Equity and Inclusion (ICEI) Department has collaborated with Human Resources (HR) with the addition of Repairing the Sacred Circle (RSC) training to General Orientation for incoming staff. Challenges include staff leaving training to fulfill other obligations to their orientation assignments.	RSC training now fully implemented during General Orientation since January 2025. General staff indicator has risen due to adding training to the orientation schedule.	Regular monthly RSC session open to all staff who have not taken training during orientation. Additional bi-weekly General Orientation RSC is now ongoing.	**1)** Continue RSC training session to General Orientation. **2)** Promotion of RSC on iNtranet and communications. **3)** Change regular weekly RSC open session to monthly. **4)** CME accreditation update will be in March (will see if TBRHSC will be part of this accreditation).	**1) Implemented -** After review of current numbers and feedback from current best practice, change made to have general staff complete RSC during orientation before their regular shift schedules start to reach maximum target. **2) Implemented -** Continued promotion through communication department. **3) Implemented -** To promote general staff attendence as the reason they could not attend was due to their shift schedules and having to attend the 3-hour session on their own time. **4) In Progress:** In communication with St Joseph's Care Group (SJCG).		**Successes:** - Excellent feedback on the RSC 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%**	2025/2026 **70%**	**Q1-Q3 2025/26 = 69.2** Q1 = 71.8%, Q2 = 64%, Q3 = 70.3%	Continue to struggle with low enrollment into the qualtrics surveys thus resulting in low sample size for Q38. SMS automation disrupted in June 2026, was not resolved until December 2026 significantly impacting sample size. Post-Discharge Liaison (PDL) funding set to expire March 31, 2026.	Performance against the QIP target of 70% demonstrated variability across the reporting periods. Two quarters exceeded the established target; however, significantly lower results in Q2 reduced overall year-to-date performance. A discrepancy was noted between formal Patient Experience (PE) survey results and PDL data. PDL reporting indicates that discharge information is generally well received and understood at the time of discharge, suggesting that challenges may be related to information retention, timing, or access rather than the quality of discharge communication itself. The "Patient Resource Folder" initiative demonstrated positive impact throughout the year, with patient feedback supporting its continued use. Distribution of folders was disrupted during Q2, which aligns with the observed decline in performance during that period. Based on demonstrated value, Patient Resource Folders will be operationalized and sustained as part of the Medical-Surgical PFCC action plans. Sustainability and operational processes have been developed to support consistent implementation. To further strengthen accountability, Patient Resource Folder distribution has now been embedded within the EMR, allowing for auditability through Health Records and improved monitoring of compliance. Additionally, communication strategies such as the Teach-Back method have been reinforced across the organization to support patient understanding at discharge. Participation in roaming staff education further expanded the reach of these practices, promoting greater consistency in discharge communication and reinforcing person-centered care principles. Ongoing review has also identified gaps in available Patient Oriented Education Tools (POETs) for certain conditions. These findings highlight the need for development of additional standardized educational resources to ensure patients consistently receive condition-specific information prior to discharge.	**1)** Standarized discharge process with a teach back focus emphasized through participation in Roaming Education For Staff (REFS) monthly as well as roaming on units. **2)** Patient Resource Folder, adopted by all medical/surgical units as a tool to facilitate discharge conversation at admission and folder to store PODs, POETS and any other patient education received during admission. **3)** Medical/Surgical patients all recieve a post-discharge follow up call from PDL role, funding to expire March 31, 2026. PDL provides interventions, ongoing education and collects valuable data regarding discharge process and admission experience which is then formalized and sent to respective Unit Leads and Directors. PDL role also serves a function in ongoing enrollment for patient experience surveys thus increasing sample size. **4)** Continuous feedback, patient surveys and follow up call feedback data presented back to units monthly, bi- weekly push reports from qualtrics and reinstatement of PFCC leadership council for accountability.	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 PDL and Discharge Transition Lead however funding expiring March 31, 2026). **4)** Educate and implement teach-back communication strategy to ensure patient understanding of discharge instructions.	**1)** Implemented **2)** Implemented **3)** Implemented **4)** Implemented	Patient response to Q38 on CPESIC % of patients who have received written post discharge instructions (through health records audit and PDL statistics and interventions) % of PDL 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 Patient 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, 2025 to January 31, 2026 = **27.5 hours**		The current performance of 27.5 hours is below target. 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)** At Policy & Procedure Review Committee (P&P) for 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. - Escalation of conservable bed days. **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.