

**QIP Part B : Peterborough Regional Health Centre  
2026/27**

OBJECTIVE		MEASURE	MEASURE	CHANGE INITIATIVES			
Quality Dimension	Indicator	Current Performance	Target	Planned Improvement Initiative	Methods	Process Measures	Process Measure Target
Safe	<b>Reduce workplace violence</b> 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.	Q1-4: 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: 100%
	<b>Reduce time to inpatient bed</b> Measured using 90th percentile - the value such that 90% of the data points are less than it. In other words, the maximum amount of time it took 90% of patients to be admitted to an inpatient unit or moved to an operating room.	44 hrs	≤27hrs	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).	Q4: 80%
				Improve early identification of patient flow delays and implement targeted improvements.	1. Continue identification and entry of patient flow delays at the unit level. 2. Escalate delays at morning bed meetings and the Discharge Command Table. 3. Assign unit leadership responsibility for immediate action on identified barriers. 4. Display daily dashboards and share weekly compliance reports with program directors and frontline teams to drive accountability.	1. Median Time from Discharge Order to Patient Discharge Time 2. % of discharge orders completed by 11am (all inpatient areas) 3. % of units reporting identified delays for patients with outdated EDDs	Q4: 1.5 hrs Q4: 55% Q4: 100%
			Enhance discharge planning by implementing a standardized process that ensures all necessary post-discharge services, follow-up appointments, and supports are arranged prior to patient discharge.	Develop and implement streamlined process for patients who are returning for next day outpatient DI appointments.	% of discharge orders that include outpatient DI orders	Q4: 10%	
Timely	<b>Reduce 90th percentile length of stay for high acuity patients in the ED</b> Measured using 90th percentile - the value such that 90% of the data points are less than it. In other words, the maximum amount of time that 90% of high acuity patients (those triaged as CTAS 1, 2 & 3) who did not progress to admission spent in the emergency department (measured from triage end to departure event) (Priority Indicator)	8.5 hours	≤8 hours	Optimize Patient Flow in the ED Blue Zone by providing consistent physician coverage and carrying out collaborative improvement events.	1. Optimize physician coverage by improving the implementation of waterfall physician shifts (schedule which uses data modeling to match physician resources to patient arrivals) to ensure more consistent and effective staffing. 2. Develop value stream maps of workflows to identify inefficiencies (e.g., delayed imaging, lab turnaround times, stretcher turnaround time and staffing gaps) and address them with targeted interventions.	1. Trial of schedule optimization of new waterfall physician shifts with increased physician hours devoted to the Blue Zone. Ongoing refinements. 2. Completed value stream maps to identify opportunities for improvement	Q4: complete Q4: complete
				Optimize ED physician documentation in Epic.	Adoption of AI documentation tools and implement bedside documentation for physicians.	1. Implementation of bedside documentation tools for physicians 2. % of documentation completed using AI tools	Q2: complete Q4: 25%
				Partner with Diagnostic Imaging and Lab to improve x-ray, CT and bloodwork turnaround time (TAT) for high acuity ambulatory patients. By addressing access and TAT for diagnostic imaging and lab the ED can reduce high acuity patients length of stay (LOS), PIA time and improve ED throughput.	1. Examine wait time patterns in blood collection by medical lab assistants for ED patients. 2. Examine patterns in DI data (ex. PIA to order times, triaging of referrals, order to scan, scan to result, report turnaround time) to better understand consistency of DI referrals and impact on DI turnaround for ED patients. 3. Examine patterns in radiology turnaround data to determine areas that can be targeted for improvement initiatives.	1. Time from ED lab test ordered to specimen collection 2. Time from ED specimen collection to accessioned by lab 3. Time from triage to ED specimen collection. Time from collection to result reported 4. High-acuity wait times breakdown by specific test 5. Breakdown of DI referrals by assigned triage/priority level, time of day, ordering department, modality 6. Time from DI exam complete to radiology report available for ED patient (breakdown by time of day, modality) 7. Time from entry of order for imaging to DI exam start time (breakdown by time of day, modality) 8. Balancing Measure: <u>Unscheduled ED Returns within 72 hours &amp; admitted</u>	Collecting baseline
				Develop a manual for maximizing Clinical Decision Unit (CDU) designated patients	1. Summarize CDU limitations and benefits and develop high-value criteria for CDU placement 2. Designate responsible staff and develop process to monitor CDU patients on monthly DART	1. Optimal utilization of CDU manual with high value criteria 2. % of patients designated CDU month to month	Q1: complete Q4: 7.0%
	<b>Reduce length of stay for low acuity patients in the ED</b> Measured using 90th percentile - the value such that 90% of the data points are less than it. In other words, the maximum amount of time that 90% of low acuity patients (those triaged as CTAS 4 & 5) who did not progress to admission spent in the emergency department (measured from triage end to departure event) (Priority Indicator)	6.8 hours	≤5.5 hours	Optimize Streamline Treatment and Evaluation Pathway (STEP) utilization and documentation	Create and institute a streamlined pathway for patients with minor illness and injury	% of patients that meet target time of 90 minutes for ED LOS for Low-Acuity Non-Admit	Q4: 75%
	<b>Access and flow - 90th percentile ambulance offload times (AOT)</b> Measured using 90th percentile - the value such that 90% of the data points are less than it. In other words, the maximum amount of time that 90% of patients who arrived by ambulance are offloaded (care is transferred to the ED). (Priority Indicator)	41 minutes	≤30 minutes	Sustain and enhance ambulance offload initiatives	Monitor ambulance offload time on real-time data dashboard in ED to support monitoring and escalation processes.	% of ambulance arrivals offloaded within 30 minutes	Q4: 90%
	<b>Access and Flow</b> 90th percentile emergency department wait time to physician initial assessment. (Priority Indicator)	5.9 hrs	≤5 hours	Improve workflow and support for physician initial assessment	1. Optimize ED physician shift coverage and STEP 2. Enhance physician coverage by improving the implementation of waterfalls physician shifts to ensure more consistent and effective staffing Adoption of AI documentation tools and implement bedside documentation for physicians.	1. % incomplete coverage days 2. % utilization of new resource 3. % weekday afternoon triage shifts filled	Q4: < 5% Q4: 75% Q4: 60%
				Optimize patient flow processes to support timely discharges	1. Continue to operationalize Home First philosophy. 2. Maintain 24-hour patient flow and daily bed meetings. 3. Use predictive census/Estimated Discharge Date (EDD) forecasts to pre-assign beds. 4. Conduct weekly interdisciplinary rounds to address barriers. Optimize time when the bed is available on the inpatient units in collaboration with EVS, Collaborative Practice and Inpatient Units.	1. Implementation of AI tools 2. % of documentation completed using AI tools	Q2: complete Q4: 25%
	<b>Access and Flow</b> Daily average number of patients waiting in the emergency department for an inpatient bed at 8 a.m. (Priority Indicator)	25 patients	≤20		1. Continue to operationalize Home First philosophy. 2. Maintain 24-hour patient flow and daily bed meetings. 3. Use predictive census/Estimated Discharge Date (EDD) forecasts to pre-assign beds. 4. Conduct weekly interdisciplinary rounds to address barriers.	1. EDD documented within 48hrs of admission 2. % of discharges by 11am (all inpatient areas)	Q4: 100% Q4: 60%
					Optimize time when the bed is available on the inpatient units in collaboration with EVS, Collaborative Practice and Inpatient Units.	Time between Bed ready to patient's departure from ED	Q4: <60 mins
<b>Reduce unnecessary time spent in acute care:</b> Alternate level of care (ALC) throughput ratio.	0.92	≥1.0	Leverage the ALC Leading Practice Report to guide targeted work in ALC risk identification and individualized care plan development. Strengthen discharge planning by increasing documentation of the Estimated Discharge Date (EDD) on admission and ensuring timely updates. Embed the Institute for Healthcare Improvement 4Ms Framework What Matters, Medication, Mentation, and Mobility across all inpatient areas to reduce the risk of delirium and support functional recovery. Enhance screening and identification of potential barriers to discharge, with a focus on early intervention and multidisciplinary collaboration.	1. Implement standardized EDD documentation within 48 hours of admission with daily review and updates. 2. Integrate the IHI 4Ms into care planning, including daily mobility rounds, medication reconciliation, and cognitive screening for delirium. 3. Conduct regular audits of mobilization protocols (minimum three times per day) and Bar Code Medication Administration (BCMA) compliance.	1. % of Patients Screened for Delirium daily 2. Compliance with mobilization 3 times per day in all medical and surgical inpatient areas 3. % BCMA compliance.	Q4: ≥80% Q4: 80% Q4: ≥85%	
				1. Use EPIC tools to flag patients with an extended length of stay (>10 days) and ensure discharge delay documentation is completed. 2. Facilitate interdisciplinary rounds to proactively address discharge barriers and escalate complex cases.	% pts with LOS>10 days missing discharge delay documentation	Q4: <10%	

				Continue to leverage community partnerships and maximize strategies related to support timely acute care transitions to post-acute care beds to support access and flow efficiencies.	1. Maximize occupancy of transitional care units and Senior Supportive Housing for patients designated as ALC. 2. Monitor daily occupancy rates and length of stay. 3. Conduct weekly interdisciplinary rounds to resolve transition barriers. 4. Collaborate with community partners for wraparound supports.	% of transitional care beds filled with PRHC patients designated ALC.	Q4: 100%
				Continue the collaboration and integration with the Peterborough Ontario Health Team partners and support PRHC at Home Program for complex, older adults.	1. Sustain and expand the PRHC at Home integrated comprehensive care program for eligible patients. 2. Track enrollment and outcomes for PRHC at Home patients. 3. Implement first visit within 24 hours of discharge from hospital. 4. Monitor readmission rates and patient satisfaction. 5. Collaborate with community partners for wraparound supports.	1. 7-day unplanned hospitalization for PRHC@Home program patients 2. 30-day unplanned hospitalization for PRHC@Home program patients 3. ALC days saved	Q4: <30% Q4: <20% Q1-4: >30days saved per patient
<b>Equity</b>	<b>Improve experience of care as reported by patients that identify as Indigenous (First Nations, Inuit, Metis)</b> % of patients that identify as Indigenous that chose 8, 9, or 10 when asked to rate their overall experience from 0-10. <i>Post-Discharge Phone Call + Digital Survey (Inpatient + ED)</i>	65%	≥80.0%	Improve provision of culturally appropriate care and services	Co-design and develop Indigenous Cultural Safety (ICS) training with community partners and offer multiple methods to engage staff and volunteers in Indigenous Cultural Safety Training.  Increase collection of patient surveys by encouraging patients who identify as Indigenous to share their experiences.  Develop and implement workflow and referral process for the Indigenous Program Navigator (IPN) role to support patient and families identifying as Indigenous.  Develop a Truth and Reconciliation Action (TRA) Plan in collaboration with First Nations communities and Indigenous patients and families.  Endorse and integrate Peterborough-Nogojwanong Workplace Inclusion Charter	1. Additional training methods developed 2. % of staff and volunteers that have completed Indigenous Cultural Safety Training 3. % of leaders that have completed ICS training (Managers, Directors, ST, Chiefs)  Number of surveys completed  Process implemented  1. Complete leadership training 2. Complete community consultation 3. Publish TRA Plan  1. Develop and implement action plan aligned to charter commitments 2. Explore development of on-site healing space 3. Create and implement an organizational approach to Land Acknowledgement	Q2: Complete Q4: 100% Q2: 100%  Q4: 200  Q1: complete  Q2: complete Q2: complete Q3: complete  Q4: complete Q1: complete Q1: complete
<b>Patient-Centred</b>	<b>Improve patient experience:</b> % of patients that chose 8,9 or 10 when asked to rate their overall experience. 0 - 1 had a very poor experience 10 - 1 had a very good experience <i>Post-Discharge Phone Call + Digital Survey (Inpatient + ED)</i>	78%	≥80%	Expand opportunities for patient feedback collection and reporting to drive improvements specific to communication.	Increase the collection of patient feedback on identified inpatient units by refreshing the purpose and practice of leader patient experience rounding. Provide training and support to inpatient unit leaders to conduct regular leader patient experience rounding.  Co-design and implement best practices on communicating with compassion in care delivery.	Number of documented patient experience rounds completed  1. % of patients that chose Yes when asked the leader patient experience rounding question: "Did the communication with staff meet your needs" 2. % of patients that chose 10, 9 or 8 to question: "Were you treated with respect and dignity while you were in the hospital?"	Q4: 200  Q4: 90% Q4: 100%
	<b>Improve patient experience:</b> % 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?" <i>Post-Discharge Phone Call + Digital Survey (Inpatient) (- includes 'completely' &amp; 'quite a bit')</i>	86%	≥90%	Improve comprehensive discharge communications across all inpatient units.	Spread leader patient experience rounding to improve discharge communication with patients to all inpatient units.  Enhance documentation of What Matters Most to the patient on patient white board	Number of documented patient experience rounds completed  % of patients with documented What Matters Most on white board (all areas)	Q4: 200  Q4: > 80%