Access and Flow | Timely | Custom Indicator

Indicator #5
Time to inpatient bed (Campbellford Memorial Hospital)

	Last Year		This Year	
	46.20	**40.60**	**55.20**	**NA**
	Performance (2023/24)	Target (2023/24)	Performance (2024/25)	Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Establish flow planning huddles

Process measure
- Number of huddles completed during regular hours per week

Target for process measure
- 5/week (excluding stat holidays)

Lessons Learned

Completed implementation of Daily Bed Capacity meetings 2 x daily. Learning from site visit to another organization to gain insight on how others have been focusing on flow.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Time to inpatient bed identified as a strategic priority

Process measure
- Meeting strategic goal target

Target for process measure
- 40.6 at 90th percentile

Lessons Learned

Completed QTR 3 Data is 28 hours at the 90th percentile . This metric is reported as part of CMH's strategic goals at the Board level

Change Idea #3 ☐ Implemented ☑ Not Implemented

Ensuring timely turnaround of inpatient rooms to allow for ED admit movement

Process measure

- Length of time from room clean ask to room clean completion

Target for process measure

- 90 minutes from room empty to room cleaned

Lessons Learned

This is in progress and has been impacted by CMH's continuous surge and internal capacity challenges.

Change Idea #4 ☑ Implemented ☐ Not Implemented

Ensure effective communication with primary care providers related to patient hospitalization and discharge

Process measure

- Track number of incomplete inpatient charts monthly through MAC report

Target for process measure

- 0 incomplete charts

Lessons Learned

This is ongoing and now reported at CMH's Quality of Care, Board committee, and MAC

Change Idea #5 ☐ Implemented ☑ Not Implemented

Consistently document expected date of discharge (EDD) for every patient within Epic and on the patient's communication board

Process measure

- Audit of EDD documentation

Target for process measure

- 80% compliance rate

Lessons Learned

This initiative requires further focus and change management with the interprofessional team. This will be a focus for 24/25

Equity | Equitable | Custom Indicator

Indicator #2	Last Year		This Year	
Improving knowledge at the leadership level in relation to Equity, Diversity and Inclusion (EDI) (Campbellford Memorial Hospital)	**CB**	**CB**	**10**	**NA**
	Performance (2023/24)	Target (2023/24)	Performance (2024/25)	Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Leadership team to embark on educational opportunities around 2SLGTBQ+, Indigenous, Mental Health and Ethnically diverse education

Process measure

- Number of courses attended by individuals on the leadership team

Target for process measure

- 10 courses over year

Lessons Learned

Justice, Equity, Diversity, and Inclusion Committee established QTR2 and workplan for educational opportunities developed. CMH has identified monthly focuses such as Pride, Indigenous recognition days, and culturally diverse months

Change Idea #2 ☑ Implemented ☐ Not Implemented

Understand Accreditation Canada standards as they pertain to EDI

Process measure

- Leadership team attendance at Managers Meeting where information is shared

Target for process measure

- 80% in attendance

Lessons Learned

Ongoing as onboarding to new Q mentum program

Change Idea #3 ☐ Implemented ☑ Not Implemented

Ensure appropriate policies are in place to guide practice as it relates to EDI

Process measure

- Policy development

Target for process measure

- Policy developed

Lessons Learned

This will be addressed and prioritized throughout 24/25

Change Idea #4 ☑ Implemented ☐ Not Implemented

Share learnings with broader staff

Process measure

- Number of staff who attend annual education fair

Target for process measure

- 80% compliance of FT and PT

Lessons Learned

Leadership updates at various meetings however in new phase of sharing and learning

Experience | Patient-centred | Custom Indicator

	Last Year		This Year	
Indicator #1 Did patients feel they received adequate information about their health and their care at discharge? (Campbellford Memorial Hospital)	**97.90** Performance (2023/24)	**100** Target (2023/24)	**97.90** Performance (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Discharge follow-up phone calls to reinforce discharge instructions and identify opportunities to improve upon the process

Process measure

- Percentage of patients who participate in the survey

Target for process measure

- 80% of eligible patients

Lessons Learned

Ongoing up until QTR 2. We have now moved to the Qualtrics platform which has created a lag in completion

Change Idea #2 ☑ Implemented ☐ Not Implemented

Ensure utilization of bedside patient communication boards in regards to EDD, patient/family/care team goals, and questions needing clarification

Process measure

- Audit compliance of communication board use

Target for process measure

- 80% compliance rate

Lessons Learned

This process measure has been difficult to achieve, refocus in 24/25.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Creation of a patient/family education board within the inpatient unit

Process measure

- Board implementation

Target for process measure

- Implementation complete by end of Q2

Lessons Learned

Board will be completed by end of QTR 4 as well as Palliative care cart to support education for this patient population

Change Idea #4 ☑ Implemented ☐ Not Implemented

Integration of Lexicomp patient education materials into After Visit Summary

Process measure

- Integration of Lexicomp into Epic

Target for process measure

- Integration complete by end of Q2

Lessons Learned

Integration completed. Further work on ensuring patients receive the AVS including patient education.

Change Idea #5 ☑ Implemented ☐ Not Implemented

Strategic Priority of "Increase patient reported survey results for communication across the Emergency Department, Inpatient Unit, Diabetes Education Program, GAIN and Outpatient Mental Health Program to 85%"

Process measure

- Percentage of patients who respond "Yes/Always" to the survey question

Target for process measure

- 85% positive rating

Lessons Learned

87 %

Change Idea #6 ☑ Implemented ☐ Not Implemented

New survey went live Jan 2024

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

In process of auditing and improving current process for increasing response rates

Safety | Effective | Priority Indicator

Indicator #3	Last Year		This Year	
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. (Campbellford Memorial Hospital)	**83.03** Performance (2023/24)	**90** Target (2023/24)	**CB** Performance (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Re-establish process for medication reconciliation between 24-48 hours of being admitted to hospital

Process measure

- Complete education to care providers

Target for process measure

- Education completed

Lessons Learned

In progress and have met this.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Ensure focus on completion of BPMH within 24 hours of admission

Process measure

- Complete monthly audit

Target for process measure

- 80% compliance rate

Lessons Learned

This is completed through our automated process. Successful for pulling quickly and ease of access. Investment of Pharmacy HHR to support

Change Idea #3 ☑ Implemented ☐ Not Implemented

Ensure focus on completion of medication reconciliation at admission

Process measure

- Complete monthly audit

Target for process measure

- 65% compliance rate

Lessons Learned

Monthly audit is completed and work in progress to correct errors in collection tool

Change Idea #4 ☑ Implemented ☐ Not Implemented

Ensure focus on completion of medication reconciliation at discharge

Process measure

- Complete monthly audit

Target for process measure

- 80% compliance rate

Lessons Learned

This process is physician driven with pharmacy support. This metric could be improved

Safety | Safe | Priority Indicator

	Last Year		This Year	
Indicator #4 Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period. (Campbellford Memorial Hospital)	**11** **Performance (2023/24)**	**5** **Target (2023/24)**	**13** **Performance (2024/25)**	**NA** **Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Conduct a risk assessment for workplace violence utilizing Acute Care Workplace Violence Risk Assessment Tool from Public Services Health and Safety Association

Process measure

- Assessment completion

Target for process measure

- Assessment complete

Lessons Learned

This is now part of CMH's Joint Occupational Health and Safety Committee, and is conducted annually or as needed. Now a mini risk assessment tool being developed.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Staff training.

Process measure

- Number of staff identified and training completed

Target for process measure

- 80% of FT and PT patient facing staff

Lessons Learned

CMH has been in transition with the i Learn system . CMH has over achieved on this metric by 20 staff . Measure was 72 and 92 are trained

Change Idea #3 ☑ Implemented ☐ Not Implemented

Staff training.

Process measure

- Number of staff identified and training completed

Target for process measure

- 50% of FT and PT patient facing staff

Lessons Learned

40 of 45 staff are trained. Close to meeting target currently 85 %

Change Idea #4 ☐ Implemented ☑ Not Implemented

Provide opportunities for inter-professional learning by simulating a violent patient incident in a care environment

Process measure

- # of Mock Code White exercises held

Target for process measure

- 4 held per year

Lessons Learned

capacity and recruitment have made this challenging to meet the target. Plans to establish this regularly in 24/25. Simulation plans have started Q4

Change Idea #5 ☑ Implemented ☐ Not Implemented

Foster a culture of reporting in which staff report all incidents of workplace violence

Process measure

- Number of staff trained

Target for process measure

- 100% of identified staff (FT and PT)

Lessons Learned

Although there is increased reporting of workplace violence we continue to strive to have all staff trained. This will continue to be a focus moving forward

Change Idea #6 ☑ Implemented ☐ Not Implemented

Educate staff on importance of completing violence screening at triage to identify patients at risk

Process measure

- Number of staff trained on risk assessment screening by end of Q1

Target for process measure

- 80% of FT and PT ED staff

Lessons Learned

ECTAS training completed for all ED Staff which included a standardized violence risk assessment.

Change Idea #7 ☐ Implemented ☑ Not Implemented

Ensure appropriate screening of patients on admission for risk of violence

Process measure

- Complete monthly audit

Target for process measure

- 80% compliance rate

Lessons Learned

Monthly audits have not been initiated, however plans to create an electronic monthly audit in progress.

Change Idea #8 ☑ Implemented ☐ Not Implemented

Create a safe working environment by ensuring that all patients involved in a workplace violence incident are appropriately assessed and flagged within Epic

Process measure

- Percentage of patients involved in workplace violence incidents flagged appropriately in Epic post incident

Target for process measure

- 100% compliance rate

Lessons Learned

A process has been put in place through JOHSC to ensure appropriate flagging of patients is occurring. This is also documented in EPIC and is standardized regionally.