Access and Flow

Measure - Dimension: Timely

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile ambulance offload time	P	Minutes / Patients	CIHI NACRS / For ERNI hospitals: Dec 1, 2023, to Nov 30, 2024 (Q1 and Q2)	100.00	43.00	Average of benchmarked peer hospital performance	

Change Ideas

Change Idea #1 Develop and hardwire standardized roles and accountabilities for all roles involved in ambulance offload

Methods	Process measures	Target for process measure	Comments
ED Department leadership to develop standardized role descriptions; Implement with frontline staff; Monitor adherence; Explore barriers when deviation occurs; Modify	% of standardized roles developed exploration of barriers when deviation from standardized roles occurs	100% of all roles involved in ambulance offload time will have a documented standardized role by March 31, 2026	

Measure - Dimension: Timely

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department wait time to physician initial assessment	P	Hours / ED patients	CIHI NACRS / ERNI hospitals: Dec 1, 2023, to Nov 30, 2024/Non-ERNI hospitals: Apr 1, 2024, to Sept 30, 2024 (Q1 and Q2)	7.40	4.60	average of benchmark peer hospitals	

Change Ideas

Change Idea #1 Evaluate the arrival patterns of patients vs. current emergency department physician and nurse practitioner schedules related to provider initial assessment (PIA) performance. If required, modify schedules to maximize PIA performance.

Methods	Process measures	Target for process measure	Comments
Analyze current state scheduled hours vs. PIA performance by hour of the day; if required modify to maximize PIA performance	current state analysis completed analytical modeling of options explored if required, implement changes to maximize PIA performance	If indicated by current state analysis and analytical modeling, implement schedule changes to maximize PIA performance by March 31, 2026.	

Measure - Dimension: Timely

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th Percentile time (in hours) from Triage to Provider Initial Assessment (PIA) for Canadian Triage & Acuity Screening (CTAS) levels 1 & 2	C	90th percentile / ED patients	In house data collection / P4R Year	6.90	4.00	average performance from benchmark peer hospitals	

Change Ideas

Change Idea #1 Develop and Implement an electronic escalation process for CTAS 1&2 patients

Methods	Process measures	Target for process measure	Comments
Develop an electronic escalation process for notifying medical staff when CTAS 1&2 have arrived in the emergency department; test; modify;	Electronic escalation process developed; implemented; test for impact on PIA for CTAS 1&2 times	Develop, implement and test an electronic escalation process for CTAS 1&2 patients by March 31, 2026.	

Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 28, 2025

CAMBRIDGE MEMORIAL HOSPITAL

Ontario Health

OVERVIEW

The past year has been a year of celebrations for Cambridge Memorial Hospital (CMH)!

After 10-years, 3 major Capital Redevelopment phases, and multiple wayfinding challenges for staff and patients, CMH has moved into a newly renovated B-Wing tower. This upgrade means that all inpatient areas, emergency department, perioperative services, and most diagnostic areas are now state-of-the-art, bright and inviting. The B-Wing tower opening ceremony was co-chaired by the Chair of the Board of Directors and the Chair of Patient and Family Advisory Council; showcasing CMH's commitment to the community and strategic pillar 'Elevating Partnerships in Care'

The celebrations continued as CMH was designated as a top employer; once as Waterloo Area's Top Employer and another as Southwestern Ontario's Top Employer. These awards, and more importantly, the efforts behind them, exemplify our strategic pillar 'Joy at Work.

Having successfully achieved both Choosing Labs Wisely and Choosing Blood Wisely designations, CMH continues to advance quality initiatives that enhance patient safety and resource stewardship.

The 2022-27 CMH Strategic Plan introduced an 'Advance Health Equity' pillar. The CMH Diversity Council members have been leading the efforts outlined in the Diversity Equity and Inclusion Plan, reinforcing CMH's commitment to this crucial work.

The guiding principles for CMH's Quality Improvement Plan this

were to achieve the flow and access priorities set by Ontario Health, enabled by the collective and diverse strength of staff, physicians and midwives.

ACCESS AND FLOW

Cambridge Memorial Hospital remains dedicated to aligning the flow and access initiatives with the priorities that have been identified by community members and Ontario Health. Specifically, we will continue to focus on ambulance offload times to ensure that ambulances can return to the community promptly, and on minimizing the time between patient arrival and initial assessment by a physician.

As a strategy to ensure patients are receiving care in the most appropriate setting, Cambridge Memorial Hospital has been working closely with Ontario Health to implement a Hospital-to-Home program that provides in-home assistance to appropriate patients to avoid lengthy hospitalizations. Early feedback from patients, and providers has been extremely positive.

EQUITY AND INDIGENOUS HEALTH

Cambridge Memorial Hospital remains unwavering in our commitment to the strategic pillar 'Advance Health Equity'. CMH has an active and engaged Diversity Council (DC) that is comprised of staff from varied backgrounds who collectively advise on, and promote, DEI initiatives across the organization. We celebrate and honour diversity through a cadence of 3 – 5 holidays and observations per month, many of which are personalized through an article series titled 'Voices of CMH' that highlight stories from CMH staff and physicians about their unique journeys.

All leaders are expected to participate in the San'yas Indigenous Cultural Safety training which is also regularly offered to interested staff. The leadership team has participated in the Blanket Exercise, a powerful experiential workshop that explores the historical relationships between Indigenous and non-Indigenous peoples in Canada. CMH has welcomed Indigenous Elders to the hospital to lead drum circles, hawk feather nourishing ceremonies, and sacred fire ceremonies. CMH is represented on a regional Indigenous health council, has incorporated a smudging policy, and has access to an Indigenous Navigator role through Southwestern Ontario Aboriginal Health Access Network (SOAHAC).

Beginning in 2025-26 the organization will start to voluntarily collect sociodemographic data through an electronic survey from patients to better understand the diverse backgrounds of the population we serve. This information will assist with service and care delivery planning.

PATIENT/CLIENT/RESIDENT EXPERIENCE

Over the past year, Patient and Family Advisory Council (PFAC) members have been active in refreshing the Patient Declaration of Values, advising on flow and access challenges, and advocating for easier patient access to personal health information with a common goal of impacting the patient experience positively.

The updated Patient Declaration of Values is a modernized version of the one from 2018; adding emphasis on diversity, equity and inclusion and a focus on timely access to, and confidentiality of, their personal health information.

PROVIDER EXPERIENCE

The verdict is in - Cambridge Memorial Hospital is a fantastic place to work! This past year CMH was designated as a top employer twice; once as Waterloo Area's Top Employer and as Southwestern Ontario's Top Employer. Collectively these awards, and more importantly, the work behind them, embody the strategic pillar 'Joy at Work'. This is the culmination of efforts over a number of years when the organization adopted the Institute for Healthcare Improvement's (IHI) Joy at Work Framework.

A few uniquely "CMH" staff supports are as follows:
• Employee Engagement Council which is a group of staff from various roles and departments that advise leadership.
• Ember, CMH's facility dog. CMH is the first hospital in North America to have a facility dog who 'attends' work daily with their handler, rounds frequently to various departments, attends all post-code debriefs, and is available ad hoc to support staff.
• Enhanced mental health coverage for all staff (full and part time) and physicians for the past 3 years.
• A monthly wellness calendar that combines Wellness, Learning, and DEI appreciation events both at CMH, and in the broader community.
• Rotation of staff appreciation events throughout the calendar year (Children's holiday event, Thank-you event to coincide with Valentine's Day, Summer BBQ, holiday meal) organized and delivered by rotating teams of leaders.
• Many values (Caring, Collaboration, Accountability, Innovation, Respect = CCAIR) based events – staff swag jackets with value of choice on the back; I-CCAIR peer to peer recognition award; values based performance appraisals

SAFETY

Some key achievements from the Patient Safety office over the past year include:

• Standardized incident management processes with a focus on Just Culture, including the introduction of a new patient safety dashboard, launch of a Just Culture policy, and a new patient safety newsletter, all aimed at improving transparency, engagement, and accountability.

• The patient safety newsletter, Safe-T-Cast, is published six times per year and highlights/disseminates learnings from case reviews, policy updates, and individuals or teams doing great work.

• In partnership with Professional Practice, established an inter-professional Best Practice Committee in 2024 to

promote cross-profession and cross-program collaboration. By engaging frontline staff through the use of quality improvement and project management tools to focus on implementing clinical best practices, the committee fosters Joy in Work and cultivates a culture of continuous improvement ultimately focused on enhancing patient safety.

• The hospital's Choosing Wisely Oversight Committee ensures a focused and sustainable approach, embedding best practices into daily operations. As part of its next steps, CMH is actively working through a Quality Improvement project led by the Pharmacy team to reduce unnecessary proton pump inhibitor (PPI) use, further optimizing medication stewardship. As CMH progresses towards Choosing Wisely Leadership designation, it remains dedicated to continuous quality improvement and responsible healthcare delivery.

PALLIATIVE CARE

Supporting patients and their family during their palliative care journey is important to staff at CMH. Below are examples of initiatives that the organization is doing that demonstrate the commitment to offering high-quality palliative care:

1. Palliative care carts that enhance the patient/family experience while the patient is receiving palliative or end of life care. Each cart has a kettle, coffee machine, mood lighting, personal hygiene products, and snacks. Each cart also has a quilt that has been donated. The quilt is given to the patient to accompany them to the funeral home or the family may keep it as a keepsake. All supplies are donated.

2. With consent, a consistent symbol is placed on the door of all patients receiving palliative care to inform all team members.

3. 20 Registered staff received funding to complete the de Souza certification in 2024 and 18 staff completed the mini LEAP education in April of 2024.

4. A staff led, multi-disciplinary, Palliative Care committee was developed. Education has been developed on how to provide as well as how to document when palliative care has been delivered. The team has planned the delivery of this education to the medicine team in the spring of 2025 with a plan to spread wherever palliative care is delivered. throughout the organization.

5. Finally, the newly constructed and renovated patient care areas with over 80% private rooms, ensure that the m majority of palliative care and end of life patients can receive care in a private room.

POPULATION HEALTH MANAGEMENT

Beginning in 2025-26 the organization will start to voluntarily collect sociodemographic data from patients through an electronic survey to better understand the diverse backgrounds of the population we serve. This will support and enhance the work already underway at CMH to understand the variation in health status and access points/frequency of the population we serve.

Collectively this information will help in collaboration with community partners to achieve the strategic pillar of 'Reimagine Community Health' enabling the plan and delivery of services and care best suited to Cambridge and North Dumfries.

CMH has strong community partnerships in our Cambridge North Dumfries Ontario Health Team (CND-OHT), Collaborating Communities, Primary Care Networks, Ontario Health at Home and the many organizations that support patients as they transition to their discharge destination.

EMERGENCY DEPARTMENT RETURN VISIT QUALITY PROGRAM (EDRVQP)

Status Update for 2 Quality Improvement Priorities from preceding year:

A.) Opportunities for improvements in the provisions of care for frail seniors

Complete a gap analysis of the organization's Senior Friendly Plan to ensure strategies are incorporated into ED standards of care. - Completed

- Collaborating with St. Mary's Hospital and Grand River Hospital on the use the Assessment Urgency Algorithm (AUA) designed to prioritize care and assessment for older adults. To be included in new HIS system so all 3 hospitals communicate the same way. – in progress: being done with HIS system project work
- Incorporate the AUA in ED Nursing Assessment form or stand-alone paper format. – in progress
- Involvement from the Geriatric Emergency Management (GEM) nurse that is in ED 7 days per week. – completed

Incorporating components of Dr. Don Melady's "A Senior Friendly ED Checklist" and The Geriatric Emergency Department Guidelines – completed and 3 opportunities have been identified: policy to promote mobility, policy to minimize NPO designation and to promote access to food and drink, protocol for pain management – environmental scan in progress

Lessons learnt:
1. Ensure GEM FTE accommodates for vacations, absences etc. so all shifts are covered with no gaps in scheduled
2. Challenges in recruitment due to limited number of candidates with GEM requirements and experience

B.) Implementing a left against medical advice form specifically for use in the Emergency Department.

Incorporating education to all staff and physicians around the appropriate disposition use of left without being seen, left without being registered, and left without being treated. – completed

Left Against Medical Advice Policy assumed by Risk and policy

updated with new form for organizational use - completed

Quality Issues Identified During this Year's Audit
17/49 audits reflected QI opportunities. Of the 17, 6 reflected opportunities for improvements in the provisions of care for frail seniors which remains in progress, 3 reflected delays in discharge consultation follow-up, and 2 reflected imaging/testing availability. The remaining were 6 had varied underlying causes. The 5 sentinel charts were events included 2 MI (no further analysis required), 1 pediatric sepsis (physician specific follow up) and 2 coded as sentinel that do not meet this programs definition (no further analysis required).

QI initiatives for 2025/2026:
1. Continue the Frail Senior work outlined in 2024
2. Collaborate with our Laboratory and DI partners in improving imaging and testing availability after hours
3. Collaborate with our Diagnostic Imaging partners to improve the current DI discrepancy/call back process.

EXECUTIVE COMPENSATION

For the CEO, the total performance-based compensation represents 10% of the annual salary for the position. The total amount of performance-based compensation available for each executive is reflected in the employment arrangements with each of them. For the CEO, Chief of Staff and Vice Presidents up to 25% of their performance-based compensation will be linked to improvement on the quality measures that is reflected in the QIP and other quality and performance metrics for the organization.

CONTACT INFORMATION/DESIGNATED LEAD

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SIGN-OFF

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan on _____

_____
Board Chair

_____
Board Quality Committee Chair

_____
Chief Executive Officer

_____
EDRVQP lead, if applicable

_____