# 2023/24 Quality Improvement Plan

**"Improvement Targets and Initiatives"**

| AIM | | Measure | | | | | | | | | Change | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Issue** | **Quality dimension** | **Measure/ Indicator** | **Type** | **Unit / Population** | **Source / Period** | **Organizati on Id** | **Current performanc** | **23/24 Target** | **Target justificatio** | **External Collaborato** | **Planned improvement initiatives (Change Ideas)** | **Methods** | **Process measures** | **Target for process measure** |
| **Theme I: Timely and Efficient Transitions** | **Timely** | LOS Optimization - average length of stay for long-stay patients minus their ALC days at discharge/forensic transfer. | C | Days/all discharged patients | In-house data collection April 1, 2023-March 31, 2024 | 969* | 209 | 171 days | Incremental improvement | n/a | 1. Ensure consistency in the designation of ALC across all programs by renewing all educational materials and standardizing processes (All Inpatient Units) | 1 ) Create consistency / standardization with ALC designation amongst all inpatient units | % compliance to standardized checklist for ALC rounds across all units | 100% Compliance to the standard process |
| | | | | | | | | | | | 2. Develop and implement Repatriation agreement template to be used to support discharge planning [DDS, EDU and ADOL] | 2a) Develop the agreement and review with Risk department | % of agreements with partner organizations signed and executed. | 100% of agreements signed & executed |
| | | | | | | | | | | | | 2b) Communicate this to referral sources as part of the admission process | % of referral sources aware of repatriation expectations set forth in repatriation agreement | 100% of referral sources are aware of repatriation expectations |
| | | | | | | | | | | | 3. Establish a commitment agreement and behavioural expectations as part of the pre-admission process for EDU | 3) Develop and implement the commitment agreement and expectations document | % of new referrals aware of the commitment agreement and behavioural expectations | 100% of new referrals are aware of the commitment agreement and behavioural expectations |
| | | | | | | | | | | | 4. Managing expectations of our community supports to ensure all discharge plans are clearly documented and to minimize unexpected challenges closer to discharge [ARP] | 4a) Standardize systematic documentation for social workers | % of completed checklists | 100% completion of the checklist |
| | | | | | | | | | | | | 4b) Collaborate with Central Intake to include critical information required for a smooth and effective discharge | % Chart Audit compliance of Long LOS clients | 90% compliance of mandatory information needed |
| | | | | | | | | | | | | 4c) ARP SW Task force to review Long LOS related to community support delays | % of long LOS patient reviews completed | 100% of long LOS patient reviews completed |
| | | | | | | | | | | | 5.Managing expectations of our teams in preparation for a satisfactory discharge plan and managing expectations of our patients and families to minimize upset and challenges with discharge plans [ARP] | 5a) Include families in meetings to discuss expectations (Welcome meetings/ 1-month check-in), and client & family members agree to expectations | % of “Expectation Forms” signed | 100% Expectation forms signed |
| | | | | | | | | | | | | 5b) Including the ethicist in discharge planning meetings for clients who require support from families or who cannot return to family | % Ethicist attendance for requested meetings | 100% attendance of requested meetings |
| | | | | | | | | | | | | 5c) Ethicist to provide consultative support for social worker’s experiencing moral injury | SW satisfaction rating with ethical consults | 100% Social Worker Satisfaction with ethical consult |
| | | | | | | | | | | | 6. Partner with Intake to identify patients ready for repatriation back to acute care hospitals. [GERIATRICS] | 6a) Geriatric Managers to regularly track and review status of those patients with repatriation agreements. Managers will inform Intake Manager of patients ready for repatriation to acute care hospitals. | % of patients ready for repatriation flagged by Clinical manager | 100% of patients ready for repatriation flagged by Clinical manager |
| | | | | | | | | | | | | 6b) Create a method to support monitoring of patients ready for repatriation | Creation of mechanism to "monitor" readiness for repatriation | Completion of the monitoring mechanism |
| | | | | | | | | | | | | 6c) Intake Manager will join daily GTA bed flow calls and flag those Geriatric patients that are ready for repatriation and inform Geriatric Managers of planned repatriation. | % of repatriations flagged by Intake manager from GTA bed flow calls | 100% of repatriations flagged by Intake manager from GTA bed flow calls |
| | | | | | | | | | | | | 6d) Develop a process in collaboration with Intake to flag those patients ready for repatriation, but not returning to a hospital within the GTA | % of home hospitals contacted by Intake for patients ready for repatriation | 100% of home hospitals contacted by Intake for patients ready for repatriation |
| | | | | | | | | | | | 7. Partner with Home and Community Care (HCC) to identify more complex patients waiting for LTC and develop a plan for their discharge/ acceptance to a LTC [GERIATRICS] | 7) Establish a process to prompt a meeting with HCC co-ordinator and HCC manager to review those long stay patients that are waiting for placement in LTC. | % of long stay patients waiting for placement who have been reviewed with HCC | 100% of long stay patients waiting for placement who have been reviewed with HCC |
| | | | | | | | | | | | 8. Standardize the Discharge Planner role within the forensic program to optimize discharge efficiencies [FORENSICS] | 8a) Create a formal referral process | % referrals to Forensics entered into Meditech | 100% referrals to Forensics entered into Meditech |
| | | | | | | | | | | | | 8b) Outline role and responsibilities of discharge planner in a checklist. Communicate role and responsibilities within forensic program | % of staff who have been formally educated on the role and responsibilities of the Discharge Planner per quarter | 100% of staff who have been formally educated on the role and responsibilities of the Discharge Planner per quarter |

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| | | | | | | | | | | | 9. Refining our data validation process, including exclusion of Keep Fit orders from this measure.[FORENSICS] | 9) Create a formal process where "change in status" can be updated in real time | % of monthly validations completed | 100% of monthly validations completed |
| **Theme III: Safe and Effective Care** | **Safe** | Total Seclusion Duration Hours | C | Total hours/all inpatients | In-house data collection April 1, 2023- March 31, 2024 | 969* | 397.7 | 370 hours | Incremental improvement | n/a | 1. Revise Admission criteria and intake process [EDU] | 1a) Revise the criteria and establish the commitment criteria | Criteria complete | 100% Criteria complete |
| | | | | | | | | | | | | 1b) Communicate these changes to external stakeholders | % of appropriate referrals | 100% of referrals are appropriate |
| | | | | | | | | | | | | 1c) Develop clear expectations for appropriate behaviour on unit | Code of conduct approved | 100% Code of Conduct approved |
| | | | | | | | | | | | 2. Obtain all relevant clinical documentation including treatment history at intake and provide to MRP prior to admission for [ADOL] | 2a) Adol intake worker to obtain this information at admission | % of times MRP has the clinical information prior to the patient arriving on the unit | MRP indicates they have needed information prior to patient arrival 100% of the time |
| | | | | | | | | | | | 3. Proactive treatment planning for patient's admitted to the PICA. PCF and available staff complete a chart review and create a safety plan prior to patient's arrival on the unit. Safety plan would include looking at activities, behavioural needs, sensory items etc. and ensuring resources are available for the patient prior to their arrival on the unit | 3a) PCF and available staff complete a chart review prior to the patient's arrival on the unit. | % of PICA patients with a plan of care prior to admission | 100% of PICA patients have a plan formulated prior to admission |
| | | | | | | | | | | | | 3b) Ensure safety plan and resources are in place prior to patient's arrival on the unit. | % of PICA patients who have resources in place | Safety Plan explained to each PICA patient 100% of the time. |
| | | | | | | | | | | | | 3c) The Patient being aware of the safety plan would be updated in the POC. | % of PICA patients who have been explained the safety plan | Ensure resources are in place 90% - 100% of the time. |
| | | | | | | | | | | | | 3d) Plans of care (POC) are updated and are accurate and complete.<br><br>POC will include the safety plan along with the resources that will be provided to the patient. | % of sampled POC that are accurate and complete.<br><br>Evaluating the effectiveness of the safety plan. | 100% of sampled POC are accurate<br><br>Safety plan is 100% current in the POC. |
| | | | | | | | | | | | 4. Integrate violence prevention assessments and interventions in the day-to-day clinical decision making. [CGP D and FAU] | 4a) Integrate evidenced-based violence predictive tools (DASA risk assessment) into daily nursing assessments. | DASA assessments are completed and documented on a on a daily basis in Meditech | 100% DASA completion |
| | | | | | | | | | | | | 4b) BI tool utilized to flag the number of patients with DASA scores 4 or greater. | % of Crisis Prevention Plans with documented violence prevention interventions in the APP scale | 90% of clients with documented violence prevention intervention |
| | | | | | | | | | | | | 4c) Daily reporting of the DASA scores in rounds/ huddles along with symptoms presented by patients that are showing early signs/ symptoms of agitation/ aggression. | % of times in huddles the DASA scores are presented. | Scores are reported 90% - 100% of the time. |
| | | | | | | | | | | | | 4d) Depending on the level of risk of violence, integrate violence prevention interventions | Violence prevention interventions that correspond to the DASA scores are documented in the APP scale (found in the crisis prevention plan). | Violence prevention interventions corresponding to the DASA score are documented in the APP scale (found in the crises prevention plan) 95 % - 100 % of the time. |
| | | | | | | | | | | | 5. To utilize 1:1 therapeutic rapport and Montessori activities as a preventative measure to reduce the likelihood of seclusion once patient is displaying precursor behaviours. [GERIATRICS] | 5) Continue to build capacity and education around the use of the Montessori room to reduce seclusion events by improving quality of life and leverage technology to prompt and support ongoing monitoring. | Per patient: # of visits to the Montessori room per week vs. # of seclusion hours per week<br><br>Total duration in the Montessori room for the patient vs. total seclusion hours for the patient | Each appropriate patient will visit the Montessori room at minimum 2x/week<br><br>Each patient will spend at minimum 15 minutes in the Montessori room during each visit. |

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| | | | | | | | | | | | 6. Re-establish Safeward practices on high seclusion units [ FORENSICS] | 6a) Establish Safeward working groups on FAU, WASU, CGP-D, GTU and ADOL | WGs established | WGs established: yes |
| | | | | | | | | | | | | 6b) All staff review Safeward education modules | % staff knowledgeable in Safewards practices | 100% staff knowledgeable in Safewards practices |
| | | | | | | | | | | | | 6c) Specific focus on a couple of safewards interventions to enhance recovery oriented practices. Safewards interventions used as a means of preventing seclusion | # of Safewards interventions documented in patient's EMR | At minimum, 2 SafeWards interventions documented for 100% of appropriate patients in their EMR |
| | Safe | Percentage of patients with an identified suicide risk who receive at least one brief intervention in an ambulatory setting | C | Percentage / outpatients | In-house data collection April 1, 2023- March 31, 2024 | 969* | 7.9% | 60% | Incremental improvement | n/a | 1. Meditech Optimization | 1a) Adding prompts to support workflow | % Completion of Prompts | 100% Completion of prompts |
| | | | | | | | | | | | | 1b) Make necessary edits to the template.<br>Add logic & mandatory fields to promote adherence to best practices where possible | % Completion of the changes to the template | 100% Completion of template changes |
| | | | | | | | | | | | 2. Continue education support for clinicians | 2a) Updating resources<br><br>2b) Further brief intervention specific training bursts throughout the year | Resources updated on Shoreline<br><br>Each team identifies 1-2 training modules to complete. | All additional resources completed & uploaded<br><br>100% completion of training modules identified. |
| | Effective | Percentage of outpatients with PHQ-9 scores that improved by at least 6 | C | Percentage of improvement/outpatients | In-house data collection April 1, 2023- March 31, 2024 | 969* | 54.8% | 57% | Incremental improvement | n/a | 1.Utilize PHQ-9 score at central intake to determine appropriate treatment modality. | 1a) Dedicate intake clinicians to use this tool | % CI clinicians using this tool | 100% CI clinicians using this tool |
| | | | | | | | | | | | | 1b) Encourage the score to be part of referral form package | % of referral forms with PHQ9 score prepopulated by referring office | 90% of referral forms with PHQ9 score prepopulated by referring office |

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| | | points at discharge. | | | | | | | | | 2. Increase in PHQ-9 completion rate within patient portal by clients | 2a) Identify a dedicated patient portal expert to help support patient navigation (to increase registration) | % of clients who complete PHQ9 in Patient Portal | 75% of clients who complete PHQ9 in Patient Portal |
| | | | | | | | | | | | | 2b) Follow up with clients who missed initial Portal registration | % of clients who missed first registration who receive a follow up eg. call/email | 90% of clients who missed first registration who receive a follow up eg. call/email. |
| | | | | | | | | | | | | 2c) Improve external promotion of Patient Portal | % Increase in Portal registrations | 20% increase in Portal registrations from last year |
| | **Effective** | Percentage of patients with a primary diagnosis of Schizophrenia or Schizoaffective disorder have improvement in their BPRS-6 from admission to discharge | C | Percentage / outpatients | In-house data collection April 1, 2023- March 31, 2024 | 969* | 84.8% | 87% | Incremental improvement | n/a | 1.Addition of anchor definitions to the scale in Meditech.<br><br>These are definitions for each score in each category of the BPRS-6. This is done to guide completion of the scale and improve inter-rater reliability in scoring. | 1a) Submission of change request | Anchor definitions added to Meditech | 100% of anchor definitions added to Meditech |
| | | | | | | | | | | | | 1b) Presentation at required committees/working groups at Ontario Shores for adoption | % Adoption of definitions at Ontario Shores | Audit of Committee/working group minutes at Ontario Shores |
| | | | | | | | | | | | | 1c) Presentation at required committees with Cluster for adoption | % Adoption of definitions from Cluster | Audit of Committee/working group minutes at Cluster |