2021/22 Quality Improvement Plan
"Improvement Targets and Initiatives"

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M = Mandatory P = Priority C = custom

AIM		Measure									Change			
Issue	**Quality dimension**	**Measure/Indicator**	**Type**	**Unit / Population**	**Source / Period**	**Organization Id**	**Current performance**	**Target**	**Target justification**	**External Collaborators**	**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, 2021 - March 31, 2022	969*	179.7 (Dec ytd)	171	Incremental improvement	n/a	Improved visual management for quality and treatment milestones to reduce variation.	1. Establish a BI tool for the Forensic Program to support visual management of discrete data fields, achievement of quality and LOS milestones and overall adherence to pathways indicators. 2. Create a standard of work for Forensic Clinical Managers new to the BI tool based on feedback from other Clinical Managers.	1. % BI tool completion with new data fields, LOS milestones, and pathway indicators for the Forensic Program by end of Q3. 2. Standard of work for Forensic Clinical managers new to the BI tool by end of Q3.	1. 100% 2. Yes/No
											Establish an understanding of the unique needs of the long-stay population and strategies to address identified needs.	1. For Programs with the BI tool, work in collaboration with each program and team to determine the areas of common misses for long-stay patients and develop strategies to address these. 2. Partner with Professional Practice to leverage the bundled-care work to identify the unique needs of long-stay patients. 3. Review each long-stay miss at ALC/Bed Support Rounds and determine the root cause for the long-stays using '5 Why' methodology.	1. Common misses and associated strategies developed for each program by end of Q1. 2. Collaborate with Professional Practice to understand application of bundled-care data on the LOS indicator by end of April. 3. Root causes determined for each long-stay miss and learnings gathered on the misses.	1. 100% for each program 2. Yes/No 3. 100% for each program
											Based on Change Idea #2, establish 1 change idea unique to each program to be implemented using PDSA methodology that focuses on reducing the number of LOS days for long-stay patients.	1. Based on data and findings from root causes, finalize one change idea to be implemented using PDSA in each program. 2. Implement and monitor PDSA.	1. Change idea and PDSA finalized per program by end of Q1. 2. Implemented PDSA for each program by the end of July, with ongoing reviews.	1. 100% for each program 2. 100% for each program
Theme II: Service Excellence	**Patient-centred**	Percentage of respondents who responded positively to question #28 on OPOC: I have a plan that will meet my needs after I finish my program/treatment.	C	Percentage/ Survey Respondents	Ontario Perception of Care (OPOC) validated survey tool April 1, 2021 - March 31, 2022	969*	88.4% (Dec ytd)	89%	Continued improvement efforts	n/a	Create a process where clients would have to provide a reason for why they responded unfavorably to #28 (Strongly Disagree/Disagree)	1. Create a focused survey question for every low score for #28 that the OPOC administrator will ask. 2. Monitor, report on themes at quality councils, and develop QI initiatives as needed	1. For each unfavorable response to #28, % of qualitative responses provided by end of Q1. 2. Implement QI initiatives as identified.	1. 95% 2. Yes/No
											Create a process to measure whether the discharge discussions occurred with client.	1. Create a report to monitor whether there were conversations at the Discharge Support Meeting/other for every discharge per unit.	1. Creation of a report by end of Q2.	2. Yes/No
Theme III: Safe and Effective Care	**Safe**	Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period	MANDATORY	Count / Worker	In-house data collection April 1, 2021 - March 31, 2022	969*	296 (Dec ytd)	408	Focus on reducing number of incidents	n/a	Improve reporting culture. Ensure awareness of all staff on where to enter and how to complete employee incident reports.	1. Provide education to all non-clinical areas (EVS, Plant Services, Security, NFS, etc.) on where and how to enter employee incident reports.	1. % Units that received Employee Incident report education by end of Q2.	1. 100%
											Focus on improving the health and safety culture through data review.	1. Review employee incident reports for incident severity (cost) classification, frequency and duration to implement preventative initiatives across the organization.	1. Review of top 3 units with high numbers of workplace violence incidents focusing on lost time and health care.	1. Yes/No

										Utilize Safe Workplace Champions to support prevention of Workplace Violence.	1. Staff engagement and support, using the Safe Workplace Champion as a proactive approach to reducing potential workplace violence incidents.	1. Monthly meetings with the Champions to review themes and issues that arise.	1. Yes/No
	Safe	Total Seclusion Duration Hours	C	Total hours/all inpatients	In-house data collection April 1, 2021 - March 31, 2022	969*	318 (Dec ytd)	370	New indicator	n/a	Improve the therapeutic environment in the PICA.	1. Implementation of the sensory support assessment for patients in a PICA. 2. Staff communication and education on tool completion. 3. Evaluate the implementation of the sensory support assessment for patients in the PICA.	1. Sensory support assessment tool built into MediTech by the end of April. 2. % of staff educated on tool completion by beginning Q2. 3. Evaluation plan developed and implemented by end of Q4.	1. Yes/No 2. 100% 3. Yes/No
											Provide additional consultation for patients with high levels (duration or frequency) of restraint or seclusion utilization. Continuation from 20/21 where recommendations were developed, this year will be finalization of policy revision.	1. If the patient has been in mechanical restraints or seclusion for a continuous period of 48 hours, and/or has had 3 incidents of mechanical restraints or seclusion in the previous 30 days, Professional Practice will, in consultation with the Medical Director, arrange to have another physician perform an in-person consultation during recovery rounds. If the Most Responsible Physician (MRP) is a Medical Director, it will be arranged for another physician to perform an in-person consultation.	1. % of consultations provided for patients within specified parameters in the revised policy.	1. 90%
											Each program to establish local restraint and seclusion working groups.	1. Select unit(s) to establish local working group. 2. Each working group to review data, debrief incidents, discuss reflective practices and implement a PDSA.	1. Working groups established on select units by end of Q1. 2. % Implemented PDSA by beginning of Q2.	1. 100% 2. 100%
	Safe	Percentage of patients that screen moderate or high on a suicide risk assessment and have an associated care plan goal	C	Percentage /inpatients and outpatients	In-house data collection April 1, 2021 - March 31, 2022	969*	70% (Dec ytd)	95%	New indicator	n/a	Force function in the electronic medical record to make mandatory completion of the care plan goal.	1. Build a rule in Meditech to populate and make mandatory to document the care plan goal when indicated as moderate or high suicide risk. 2. Educate clinicians on care planning and developing/identifying interventions.	1. Rule built into Meditech by end of Q1. 2. % of clinicians provided education on care planning.	1. Yes/No 2. 90% of those clinics/areas in scope
	Effective	Patient positive recovery indicator - % of patients with meaningful improvement in RAS (inpatients)	C	Percentage of improvement/inpatients	In-house data collection April 1, 2021 - March 31, 2022	969*	55.8% (Dec ytd)	65%	Continued improvement efforts	n/a	Use IMROC's Team Recovery Implementation Plan to support Recovery-oriented practice on the IP units. Develop micro-learning opportunities to support the new practices identified.	1. Use the Quality and Recovery Councils to guide the completion of the tool for each in scope unit 2. Using the tool, there will be 3 priority areas identified with corresponding action plans. 3. Develop micro learning opportunities to support the implementation of the priority actions. 4. Review action plans at Quality and Recovery Councils to monitor progress. Action plans will also be monitored through the RAS QIP Working Group	1. % of in scope units that complete the tool by the end of May. 2. Develop plans with specific actions for three priority areas identified within the IP unit by the end of June. 3. Development of three micro learning opportunities associated with priority areas by the end of July. 4. Action plans reviewed and monitored for progress through the QIP RAS working group	1. 100% of IP units 2. 100% completion rate of Action Plans 3. three micro learning modules 4. Yes/No
											Continue to customize and refine the Recovery curriculum for patients.	1. Continue to monitor and customize recovery college programming and population specific needs for all in-scope units. 2. Evaluate feedback from staff and patients and implement suggested improvements.	1. Recovery College programming customized based on needs. 2. Suggested improvements from evaluations are reviewed are implemented after each RC session.	1. Yes/No 2. Yes/No