2020/21 Quality Improvement Plan
"Improvement Targets and Initiatives"

Ontario Shores
Centre for Mental Health Sciences

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M = Mandatory P = Priority C = custom

AIM		Measure									Change			
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organi-zation 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, 2020 - March 31, 2021	969*	203 (Jan ytd)	180	New indicator	n/a	Improved visual management for quality and treatment milestones to reduce variation	1) Ensure discreet data fields associated with clinical pathways and ALC leading practices are built into the EMR for priority processes and indicators by June 1, 2020. 2) Establish BI tools by June 30, 2020 for every program that support visual management of discrete data fields, achievement of quality and LOS milestones and overall adherence to pathways indicators. 3) Upon implementation of the Bi tool work in collaboration with each program to establish an improvement target for reduced variation August 30, 2020. 4) Utilize the ALC and long stay avoidance rounds for oversight and support for reduced variation starting July 1, 2020.	1) % of data fields built into EMR by June 1, 2020 2) % BI tool completion with new data fields, LOS milestones, and pathway indicators for each Program by June 30, 2020 3) % of IP Units that established an improvement initiative to reduce variation by Aug 30, 2020	1) 100% by June 1, 2020 2) 100% by June 30, 2020 3) 100%
											Establish an understanding of the unique needs of the long stay population	1) Profile development by program of who our long stay non-ALC patients are by end of Q1. 2) Identify themes by program for the needs of non-ALC long stay patients by June 15, 2020.	1) % Profile completion rate for each program for long -stay non-ALC clients (by end of Q1) 2) % Programs that have completed the themes of their "needs for their non-ALC long stay" by June 15, 2020	1) 100% by end of Q1 2) 100% by June 15, 2020
											Establish 1 change idea unique to each program to be implemented using PDSA methodology with oversight at program Quality Councils and the corporate LOS QIP working group	1) Establish a LOS QIP working group by April, 2020. 2) Finalize one change idea to be implemented using PDSA in each program by June 26, 2020. 3) Complete any required pre-work to support the change idea and implement the PDSA no later than September 8, 2020.	1) LOS Working Group established by April 2020 2) % of 1 change idea identified per program identified by June 26, 2020 3) % Implemented PDSA's by Sept 8, 2020	1) 100% by April 2020 2) 100% June 26, 2020 3) 100% by Sept 8, 2020
	Timely	Percentage of patients with schizophrenia that have initiated evidence-based psychotherapies. (CBT and/or FIT - inpatients)	C	Percentage/ inpatients	In-house data collection April 1, 2020 - March 31, 2021	969*	63.8% (Jan ytd)	85%	Incremental improvement	n/a	Develop and communicate a sustainability plan for CBTp on discharge	1. Patients are supported in completing their therapy 2. Clinicians are motivated to initiate therapy, knowing there is a clear and supported path for completion, even post-discharge.	1. % Completion of a sustainability plan in place for each program. 2. % of clients who are discharged prior to their completion of CBTp, who continue the therapy as an outpatient.	90-100% for all measures

											Development of a standardized approach to motivational interviewing at Ontario Shores	1. Review of existing MI practices 2. Development of a best practice guide 3. Education to elevate skills among front-line clinicians providing CBTp and FIT	1. Completed review of existing MI practices 2. Best practice guidance collected and shared 3. % of CBTp- and FIT-trained clinicians who have completed education in MI best practices	90-100% for all measures
											Ensure that patients who screen appropriate and agree to CBTp and/or FIT initiate psychotherapy in a timely manner	Implement a 30-day maximum to waitlists for CBTp and FIT.	1. % of patients who are waiting ≤30 days for CBTp 2. % of patients who are waiting less than ≤30 days for FIT	90-100% for all measures
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, 2020 - March 31, 2021	969*	85.5% (Jan ytd)	89%	New approach to survey administration	n/a	Create a process where clients would have to provide a reason for why they responded unfavorably (Strongly Disagree + Disagree)	1. OPOC Administrator reviews survey and compiles themes of responses 2. Add extra qualifiers to the survey by adding a space to provide reasons behind their responses to #28.	1. % of qualitative responses to every low scoring survey response received (Disagree + Strongly disagree)	95-100%
											Develop a robust notification process to track impending inpatient discharges that provides the Quality team enough notice to administer the OPOC survey	1. Weekly monitoring of discharges (based on BI tool) vs % surveys offered by the Quality Team 2. Track the reasons for missed notifications on a monthly basis . Discuss any themes with Programs & develop mitigation strategies	1. % Pts offered Patient Experience survey by month 2. % of tracked reasons for "missed" survey offered	1. 95% - 100% 2. 95-100%
											Create a mechanism for Units to work on QI initiatives based on themes for low scoring responses (Disagree + Strongly disagree)	1. Measuring the themes on a monthly basis 2. Reporting themes to Quality & Recovery Council (monthly) and reporting on PDSA's based on QI initiative 3. Create a BI report for OPOC (or equivalent reporting system)	1. % of units that have identified at least 1 QI initiative (by March 2020) 2. % PDSA's initiated by IP Units & OP Services by June 1, 2020 3. Completion of a BI report for OPOC by May 1, 2020	1. 100% 2. 100% 3. 100%
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.	MANDATO	Count / Worker	In-house data collection April 1, 2020 - March 31, 2021	969*	390 (Jan ytd)	540	Continue to increase reporting culture	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 departments on where and how to enter employee incident reports.	1. % Units that received Employee Incident report education 2. % increase in the number of workplace violence related incident reports entered into Meditech	1. 100 % 2. 20% increase in incident reports

		R Y								Focus on decreasing the severity of workplace violence incidents reported	1. Review WSIB approved claims data 2. Review by HR of employee incident reports for appropriate incident severity classification	1. % decrease of WSIB approved Lost Time and Health Care Incidents 2. % increase of "no injury/near miss" incident reporting classifications and decrease in moderate and serious harm	1. % decrease in WSIB aproved Lost Time claims 2.10-15% increase in no injury/near miss incident reporting
										Utilize Safe Workplace Champions to support prevention of Workplace Violence	Staff engagement and support, using the Safe Workplace Champion as a proactive approach to reducing potential workplace violence incidents.	1. % Units / services with an identified Workplace Champion	100%
Safe	Average Seclusion Duration (hours)	C	Hours/all inpatients	In-house data collection April 1, 2020 - March 31, 2021	969*	10 (Jan ytd)	9.5	Incremental improvement	n/a	Improve the therapeutic environment in the PICA.	1. Implement a sensory support assessment for every patient in the PICA to ensure that individualized therapeutic resources are available for each patient. 2. Standardization of PICA guidelines/practices/resources through the creation of a PICA working group to create the optimal therapeutic environment for patients that will contribute to a reduction and/or prevention of the use of seclusion or restraint.	1. % of patients who receive a sensory support assessment. 2. % of PICA guidelines/practices/resources standardized.	1. 90% 2. 100%
										Utilization of a standardized question template to guide clinicians and teams in the process of de-seclusion or de-restraint.	1. Development of a question template that can be built into Meditech.	1. % of patients who have a documented question template for de-seclusion/restraint	1. 90%
										Provide additional consultation for patients with high levels (duration or frequency) of restraint or seclusion utilization.	1. If a patient is placed in restraint or seclusion for more than 48-hours (a reduction from current threshold of 72-hours) or 3 times or more over the course of a 30-day period during an admission, then decision support flags this to the Manager and Professional Practice.	1. % of second-opinion consultations provided for patients with 48 hour or "3-episode" thresholds attended by medical director, PIC or VPMA.	1. 90%
Safe	Percentage completion of suicide risk assessments for those deemed at risk (inpatients and outpatients)	C	Percentage completion/inpatients and outpatients	In-house data collection April 1, 2020 - March 31, 2021	969*	29% (Jan ytd)	80%	New indicator	n/a	Force function screener completion in Mental Status Assessment	When either risk of suicidal ideation or self harm is identified in the MSA, a mandatory field for completion will appear.	1. Complete/Not Complete	100% complete
										Educate clinicians	Provide education on the new screener and workflow to all impacted clinicians.	1. % of IP clinicians educated on new screener	90-100%
										Develop a new suicide risk algorithm for outpatients	Collaborate with stakeholders and update the outpatient suicide risk algorithm, post to Policy and provide education within education strategy	1. Complete/Not Complete	100%

	Effective	Patient positive recovery indicator - % of patients with meaningful improvement in RAS (inpatients)	C	Percentage of improvement/inpatients	In-house data collection April 1, 2020 - March 31, 2021	969*	61.9% (Jan ytd)	70%	Focus on self-reported patient recovery	n/a	Revamp our RAS and Recovery education to focus on each clinical portfolio with a strategic approach to ensure more "current staff" receive the training	Develop a "blitz" like approach utilizing both Peer support/patient experience and each program's APN/CNS to deliver the training	1. % of units that have received RAS training and education 2. Improved RAS scores. 3. % of new staff to receive the Recovery training at orientation.	90% of all unit staff to receive the training. 100% of new staff to receive the recovery training
											Evaluate the RAS integration into practice via the Recovery Plan of Care	1. Conduct RAS tracers in each unit to determine the extent to which the RAS is used in collaborative goal setting with patients. Conduct fidelity audits on sample of units (patient charts) 2. Identify areas of opportunity to integrate RAS into care planning 3. Create a plan to communicate the creation of customized co-designed RAS resources for clinicians/patients.	1. % Units that have had RAS tracers completed 2. Complete/not complete 3. % of units with communication plan	1. 100% Tracers complete (at least one per unit - in scope) 2. 90-100% 3. 100%
											To better understand patient experience factors that influence recovery	1. Quarterly review of RAS domain performance at Quality and Recovery Councils. 2. Development of actions to address areas of poor performance.	1. Documented review of data quarterly at the RAS domain level. 2. For units not meeting target, % of units with an action plan that's been implemented	1. 100% - quarterly review completed 2. 100% actions developed and implemented.