Ontario Shores Centre for Mental Health Sciences
2017/18 Quality Improvement Plan

AIM		Measure							Change				
Quality dimension	Issue	Measure/ Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Effective	**Effective transitions**	Improve transitions between care providers: % of discharge summaries sent to community care providers within 48 hours.	% / All patients	In house data collection / April 1, 2017 - March 31, 2018	969*	41	50.00	Target represents an 18% increase from 2016/17 baseline.	1) Improve transitions between providers to 50%.	1) In depth analysis of the data to understand where the opportunities are: are there issues with physician schedules (i.e., part time physicians who are unable to meet time requirement, vacation schedules, long weekends. 2) In depth analysis with HIM to better understand the different streams of discharge and perhaps stratify the data depending on the type of request for information to be sent. 3) In depth analysis with HIM to understand the situations in which no discharge summary is sent and gain an understanding of the stratification of circumstances in which this arises to correctly quantify the situations in which this is the case.	1) Analysis of completion time distribution by physician to provide a chance to look at root causes for long completion time cases; completion time for discharges in each of the weekdays. 2) Completion time distribution by different streams of discharge - reason for discharge, discharge disposition. 3) Number of discharge summaries not signed and sent or sent over 48 hours. 4) Percentage of auto fax number documented and receiving provider specified in discharge summary.	Improve transitions to 50% by March 31, 2018.	
Efficient	**Access to right level of care**	Reduce unnecessary time spent in hospital. ALC Rate: number of acute inpatient days designated as ALC, divided by the total number of acute inpatient days *100.	% / All acute patients	Monthly data / April 1, 2017 - March 31, 2018	969*	16.7	14.50	ALC is high priority for Ontario Shores and high impact for the mental health care system, therefore we will continue to include it in our QIP submission. The 2016/17 target is being carried over to 2017/18 as it was not met.	1) Advance early discharge planning to minimize ALC risk and decrease ALC mean wait.	1) Review and optimize the discharge planner role. 2) Establish a trigger for at risk for ALC alert that generates specific actions in care planning. 3) Require the establishment of “next best plans” when individuals are approaching ALC wherever possible. 4) Optimize the rapid round boards to highlight the path to discharge.	Decrease the mean ALC wait.	Reduce ALC to 14.5%.	

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									2) Work in collaboration with formal partners (CCAC, CCC, and Community Partners) and non-traditional partners to engage them in pulling high risk for ALC, or ALC clients into the Community.	1) Explore possibility of partnering with an LTC or CCC to transition ALC patients. 2) Work with Community partners to integrate housing waitlists in Durham Region. 3) Submit one proposal to the LHIN with community partners with the goal to reduce ALC. 4) Build upon the YATS review to establish a better means of flagging delay for discharge alerts internally and monitoring outstanding issues requiring follow-up 5) Reach out to build capacity and partner with support the non-traditional home operators including local GPs.	Decrease the mean ALC wait.	Reduce ALC to 14.5%.	
									3) Optimize Home First Processes	1) Implement all Home First Processes applicable to specialty mental health. 2) Optimize the TRAC review process and report on the themes at the quarterly steering meeting. 3) Explore options to automate TRAC reviews.	Decreased ALC Rate.	100% by March 31, 2018.	
									4) Establish corporate strategies to limit the generation of ALC .	1) Develop a communications plan for patients and families specific to ALC avoidance. 2) Explore strategies for admission avoidance for non acute/social issues.	Decreased new ALC designations.	10% from 2016/2017 new designations at year end.	
									5) Establish local approaches to ALC avoidance.	Establish a local PDSA on 3 units (1 per ARP, GNP, Forensics) to avoid ALC.	Decrease ALC % and ALC wait on the target units.	Reduce ALC to 14.5%.	

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									6) Executive leadership, support, and engagement around ALC avoidance.	Optimization of escalation processes and tracking in advance of ALC designation.	Decrease new ALC designations.	Reduce ALC to 14.5%.	
Patient-centred	**Person experience**	Improve Inpatient satisfaction Percent positive result to OPOC Survey question "I think the services provided here are of high quality."	% / All inpatients	Ontario Perception of Care (OPOC) validated survey tool / April 1, 2017 - March 31, 2018	969*	82.8	83.00	2017/18 target represents a 8% increase over current target. 2017/18 target represents a 1% increase over performance in November baseline when OPOC tool was implemented at Ontario Shores.	1) Complete corporate quality improvement initiatives over the Fiscal year will be completed.	Improvement initiatives relate to: 1. Food 2. Care planning participation 3. Improving transitions 4. Inpatient engagement in activities Each project will utilize QI methodology. Patient experience advisors will support these projects.	% of Projects completed by end of March 2018	100% of projects completed by March 2018	
									2) Improve knowledge of the complaints process (from Patient Experience Survey results)	1) Include the new brochure and Feedback Form into all Admission Packages , and provide refresh education to leadership on the Patient Relations Process. 2) Review and approve the Patient Relation Policy . 3) Conduct an Audit of Forms, Posters, Brochures on In-patient units and Out-patient Services. 4) Update Patient Relations Brochure.	After initial implementation of the New Admission Packages, conduct sample audit of how many admission packages contain Patient Relations information. Deliver all new brochures, forms, and posters as appropriate.	100% of Admission Packages containing Complaint Brochures (Sample Audits) by June 2017	

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									3) Improve and expand the Co-Design Framework	1) Evaluate and improve the Co-Design Framework. 2) Develop materials and pamphlets for staff to share with patients and families in order to increase volume and diversify the list of volunteers in the "participant/contact list."	1) Utilize PDSA methodology to evaluate Phase 1, & begin Phase 2. 2) All patients and families will receive information about Co-Design Process in the Welcome package. 100% of units have materials & pamphlets by May 2017.	100% of units receiving Co-Design Information by conducting Sample Audits to be completed by June 2017	
Safe	**Safe care**	Reduce the use of seclusion: Average duration of seclusion per incident	Hours / All inpatients	In house data collection / April 1, 2017 - March 31, 2018	969*	29.9	25.00	2017/18 target represents a 17% decrease from 2016/17 current performance.	1) Utilize the 10 interventions in the SafeWards model to develop positive relationships between patients and staff, and focus time on engagement as opposed to containment.	Implementation of Safewards within the Geriatric Neuropsychiatry Program (GNP) and Adolescent Program for 2017/18	% of patient care units using the concept of SafeWards.	100% of inpatient units will be using the concepts of SafeWards by March 31, 2018	
									2) Implement a regular notification to an identified recipient group outlining patients that are currently in seclusion or restraint including the MRP and duration of the incident.	Decision Support to push out this report and notification on a predetermined interval via an e-mail.	The report will be distributed daily at 0900 and 2100 hours.	To occur 100 % of the time	

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									3) Organize a focus group consisting of front line clinical staff across the Assessment & Reintegration Program (ARP) and Forensic Program to share strategies, actions and approaches to restraints and seclusion reductions.	Appreciative inquiry and solution focused problem solving approach to examine restraints and seclusion reduction actions.	Sharing of ideas that can be leveraged to reduce restraints and seclusion duration. Specifically, spreading actions from units that have successfully implemented restraints and seclusion reductions actions to other units that have higher restraints and seclusion duration.	To commence by May 1, 2017	
									4) Implement and evaluate the weekly aggression rounds on inpatient units to proactively address concerns regarding patient aggression.	Weekly aggression rounds are triggered by incidents of 3 or more documented incidents of patient aggression on an inpatient unit. Rounds are pre-scheduled and attended by a member of Senior Management Team, Professional Practice, Advanced Practice Psychologist, and Professional Practice Leader for Behavioural Therapy.	Process measures in place to ensure that rounding occurs for each patient that meets the threshold identified. Impact of Rounds on reducing patient aggression over a week to week period.	Rounds will be completed for 100% of identified patients.	
									5) Improve restraint and seclusion data quality	Continue to complete monthly restraint and seclusion data validation as well as monitor daily restraint and seclusion report to ensure orders are cancelled appropriately and there are not multiple active orders. Implementation of restraint and seclusion steering committee to include Clinical Managers, Administrative Directors, Quality, and Medical Directors to proactively address issues and implement quality improvement ideas as they arise at the unit level.	% of programs with improved data quality for seclusion data.	100% by March 31, 2018	

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									6) On-going engagement of Recovery Advocates to support Recovery focused patient care.	Participation in Recovery workshops which will focus on shared recovery commitments, mutual expectations and on-going review of unit based guidelines to ensure alignment with recovery principles.	Sustainability of number of Recovery Advocates attending workshops.	100% by March 31, 2018	
Timely	**Timely access to care/services**	Improve transitions and wait times for specialized mental health: % of inpatient discharges with an outpatient appointment at Ontario Shores outpatient clinic within 7 days	% / All patients	Hospital collected data / 2017-2018	969*	63	79.00	2017/18 target represents a 25% increase above current performance.	1) Inpatient process optimization to support seeing people within 7 days.	1) Explore EDD auto notifications to all providers in Ontario Shores circle of care 7 days prior to discharge. 2) Add a field to the discharge checklist that requires date and time of outpatient appointment that is mandatory. 3) Enhance the patient experience process by bringing them to the OP area in the weeks before discharge have introductions (Secretary, Clinician and doctor if the DSM hasn't occurred). Consider an OTN if an off sire service. 4) Have follow up details pull to the EVMB to ensure appointments are in place. 5) Explore having upcoming CSW appointments pull to the discharge summary.	Upon audit, 100% of all inpatients will have an appointment booked prior to discharge that will be documented in the inpatient chart.	79%	

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									2) Outpatient optimization	1) Review best practice to support flexibility to meet demands that are at times short notice and implement PDSA's where needed, which are tracked at Quality Councils. 2) For individuals on service that are admitted to an inpatient unit the Primary Clinician will have weekly contact with the unit Social Worker to plan for discharge. 3) Wherever possible attend the DSM by phone or in person to support he plan for discharge and follow up. 4) Provide appointment cards with appointment dates and key contact information to inpatient units to be included in their discharge package. 5) Explore having the inpatient EDD pull to the outpatient status board if a person is currently on service.	Explore reasons behind high number of appointments no show or cancelled units including patient diagnosis, age and etc. to find the most effective approach.	79%	
									3) Root causes any individuals not seen within 7 days.	1) Create PDSA's at locally when trends are identified. To be monitored through the Quality Council.	Root causes completed and reviewed at Program Quality Councils.	100%	

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Timely	**Timely access to care/services**	Reduce wait time for specialized mental health: Median wait for outpatient service at Ontario Shores from referral.	Days / All patients	In house data collection / April 1, 2017 - March 31, 2018	969*	28	22.00	2017/18 target represents a 21% increase above current performance.	1) Remove identified bottle necks at each stage of waiting (Complete referral, Intake, Service Start).	1) Explore each wait for opportunities to remove barriers to the referral flowing quickly. 2) Develop plan for mitigation where bottlenecks are identified. 3) Optimize Share Point to improve time to account creation. 4) Review ACTT and HSC intake process for value add of face to face assessment. 5) Review policy related to calls to offer appointments. 6) Seek innovative approaches to scheduling.	Wait time from referral to first appointment.	10% by September 2017.	
									2) Identify innovative approaches to service delivery that support increases in individuals seen.	1) Explore group service delivery where outcomes are equal for individual and group. 2) Explore the use of Same Day assessments to enhance the patient experience.	Unique registrations	Increase by 10% by January 2018	
									3) Expand the use of predictive models for wait times in collaboration with Decision Support in 4 services.	1) Identify 4 services with highly standardized models of care to understand supply and demand. 2) Develop PDSA's for each service and track at local Quality Councils.	Wait time from referral to first appointment.	10% reduction within 3 months of reviewing the predictive model	

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									4) Support local approaches for change ideas.	Identify 3 local approaches to decrease wait time, that will be documented on PDSA's and monitored through Quality Councils.	Decrease wait time in 3 target services.	10% reduction	