Ontario Shores
Centre for Mental Health Sciences

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Quality Improvement Plans (QIP): Progress Report for 2016/17 QIP

The Progress Report is a tool that will help organizations make linkages between change ideas and improvement, and gain insight into how their change ideas might be refined in the future. The new Progress Report is mostly automated, so very little data entry is required, freeing up time for reflection and quality improvement activities.

Health Quality Ontario (HQO) will use the updated Progress Reports to share effective change initiatives, spread successful change ideas, and inform robust curriculum for future educational sessions.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
1	ALC Rate: number of acute inpatient days designated as ALC, divided by the total number of acute inpatient days. *100 (%; All acute patients; April 1/16 - March 30/17; Monthly data)	969	17.20	14.50	17.00	

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Change Ideas from Last Years QIP (QIP 2016/17)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Advance early discharge planning to minimize ALC risk and decrease ALC mean wait.	Yes	Method #1: Utilize LOCUS/ CALOCUS dimensional scores to identify care needs that are potential barriers to discharge. The connection between LOCUS dimensions to identify care needs and care plans were identified as purposeful and the integration of these two resources would be beneficial. Method #2: Discharge checklist optimization to reflect all aspects of discharge planning including referral management. This was accomplished later in the year and will require ongoing evaluation. We are exploring a report to support the auctioning of barriers to discharge to identify themes.
Utilize the community partners tables an advocacy tool to reduce barriers to discharge within the local community	Yes	Method: Work in collaboration with community partners to minimize/ resolve discharge barriers for those going to non LTC destinations. All appropriate clients were presented on or before November 1,

		2016. The terms of reference for this table are under review to ensure maximum effectiveness. It is acknowledged by all that resolving the current challenges we have with ALC requires a collaborative effort with our community partners.
Improve the referral, acceptance process by CCAC and LTC's through assertive advocacy and application tracking according to legislative timelines.	Yes	Method #1: Provide education for Social Workers and Clinical Managers on the LTC application process and legislative timelines for responses. Needs assessment was completed and education provided in March 2017 with a Home's First refresh. Tracking of ALC to LTC has been improved through bi-weekly meetings with internal stakeholders and CCAC. A full-time CCAC coordinator is now on site positively impacting the timeliness of referrals/applications. Method #2: Explore ongoing collaboration with CCAC in submitting successful LTC applications. CCAC assessments are now being completed collaboratively with CCAC to improve content and to use consistent language to positively impact acceptance rates without additional delays.
Home First Process Refresh	Yes	Methods: #1: Share process review data by May 15, 2016. #2: Home First refresh in collaboration with CCAC in June 2016. #3: Work with Patient Care Facilitators and Clinical Managers to establish local plans to achieve Home First philosophy. In discussion with CCAC. To include refreshed process map and focus on key elements of home first philosophy. Will be completed by end of fiscal 2016/17.
Establish local approaches to ALC avoidance.	Yes	Three PDSA's have been completed: #1. The Young Adults Transitional Unit completed a discharge focus rounds (pilot) which allowed for the team to focus on the current outstanding issues requiring action related to barrier mitigation. The ALC rate increased on the unit during this period as reasons to remain in hospital and discharge barriers were openly discussed leading to better recognition of ALC clients and mitigation plans are actively being reviewed. #2. The Geriatric and Neuropsychiatry Program developed an ALC Strategy which includes review of all clients with CCAC and timely follow-up as well as a 59 day stay approach for the Geriatric Dementia Unit (GDU). Having a defined LOS provided a driver for enhanced collaboration and partnership with stakeholders internally and externally. It assists in managing expectations and in supporting the return home (including LTC) as a goal for admission.

		#3. Our Psychiatric Rehabilitation Unit completed a PDSA on short stay admissions. They worked to have focused goals for admission and clear expectations for discharge.
Establish clear processes for escalation to support ALC avoidance.	Yes	Methods: #1: Educate clinical teams on escalation processes. #2: Support local sustainability plans for escalation. Escalation processes are fully implemented in all areas with ongoing follow up at a senior team level as required. A critical factor in success has been having utilization coordinator that supports the teams and our leaders in ensuring that escalation occurs as required and that all are comfortable with the process and follow up.

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2	Average Monthly Seclusion and Mechanical Restraints Incidents (Incidents; Mental health patients; April 1, 2016 - March 31, 2017; Hospital collected data / Most recent quarter available)	969	90.00	75.60	73.40	

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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.	Yes	Method: Implementation of SafeWards model on remaining Forensics units as well as within the Assessment & Reintegration Program (ARP) program which is the highest contributor to Restraint and Seclusion incidents and duration. Very good uptake in the General Psychiatry units and has resulted in meeting target for the second half of the year. The Forensics units continue to struggle with outliers that skew the average duration. Ongoing work to address these challenges.

Implement proactive approach to Recovery Rounds that will include addressing incidents of violence and aggression.	Yes	Method: Recovery Rounds (RR) will expand to visit units who have patients identified as having 3 or more incidents of aggression/violence. During the meeting the RR team in collaboration with the inter-professional team review the plan of care and necessary recommendations to support the patient and the team in mitigating future incidents which are often the precipitators of restraints and seclusion. Recovery Rounds are an inter-professional consultation process to support staff in reducing the use of restraints and seclusion.
Improve restraint and seclusion data quality & improve data transparency	Yes	Method: 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, Admin Directors, Quality, and Medical Directors to proactively address issues and implement quality improvement ideas as they arise at the unit level. Data quality is improved and processes are in place to ensure accurate recording of data continues
On-going engagement of Recovery Advocates to support Recovery focused patient care.	Yes	Method: 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. We continue to have quarterly Recovery Advocate workshops focused on a variety of issues that impact the client/staff relationship.
CAMH, Douglas Institutes Installation, Ontario Shores, The Royal and Waypoint (five participating hospitals) are embarking on a shared clinical initiative to collectively prevent and reduce the number of episodes (incidents) and time spent in restraints and seclusions in specialized mental health environments.	Yes	Method: Participation in Restraint & Seclusion Prevention Minimization Project. Ontario Shores conducted monthly chart audits on pilot unit to measure compliance with two quality initiatives: comfort measures and patient debriefing after restraint or seclusion episode. There were no changes implemented as a result of this project, as Ontario Shores had already implemented both of the quality initiatives and had a solid practice already in place.

Focused work with front line staff to develop specific actions that will reduce the practice of restraint and seclusion. This work will include focused work patients who have been restrained and secluded to further gain specific change ideas related to reducing restraint and seclusion.	Yes	There have been numerous educational/training opportunities provided to staff to ensure that best practices are developed and incorporated into care.

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3	Average Seclusion Duration (Hours) (Hours; Mental health patients; Most recent quarter; Hospital collected data)	969	29.13	17.78	30.08	

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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.	Yes	Method: Implementation of SafeWards model on remaining Forensics units as well as within the ARP program which is the highest contributor to Restraint and Seclusion incidents and duration. Very good uptake in the General psychiatry units and has resulted in meeting target for the second half of the year. Forensics areas continue to struggle with outliers that skew the average duration.
Implement proactive approach to Recovery Rounds that will include addressing incidents of violence and aggression.	Yes	Method: Recovery Rounds (RR) will expand to visit units who have patients identified as having 3 or more incidents of aggression/violence. During the meeting the RR team in collaboration with the inter-professional team review the plan of care and necessary recommendations to support the patient and the team in mitigating future incidents which are often the precipitators of restraints and seclusion. Recovery Rounds are an inter-disciplinary consultation process to support staff in reducing the use of restraints and seclusion.
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		level. Data quality is improved and processes are in place to ensure accurate recording of data continues.
On-going engagement of Recovery Advocates to support Recovery focused patient care.	Yes	Method: 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. We continue to have quarterly Recovery Advocate workshops focused on a variety of issues that impact the client/staff relationship.
CAMH, Douglas Institutes Installation, Ontario Shores, The Royal and Waypoint (five participating hospitals) are embarking on a shared clinical initiative to collectively prevent and reduce the number of episodes (incidents) and time spent in restraints and seclusions in specialized mental health environments.	Yes	Method: Participation in Restraint & Seclusion Prevention Minimization Project. Ontario Shores conducted monthly chart audits on pilot unit to measure compliance with two quality initiatives: comfort measures and patient debriefing after restraint or seclusion episode. There were no changes implemented as a result of this project, as Ontario Shores had already implemented both of the quality initiatives and had a solid practice already in place.

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4	From the Ontario Perception of Care tool (OPOC) now being initiated within the organization. The question change will be: "I think the services provided here are of high quality." This question will be used consistent in all four mental health specialty hospitals that are moving forward with the OPOC survey tool. (%; Mental health patients; April 1, 2016 - March 31, 2017; OPOC survey to be distributed in November 2016)	969	CB	75.00	82.80	

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Change Ideas from Last Years QIP (QIP	Was this change	Lessons Learned: (Some Questions to

2016/17)	idea implemented as intended? (Y/N button)	Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Require each unit/ /service to have individual action plans to improve patient experience based on survey results.	Yes	Methods: Quality Improvement Advisors will monitor action plans by attending Quality & Recovery Council Meetings, updating a QI project inventory database & reporting to program directors, Integrated Programs & Services Committee (IPSC) and Senior Management Team. Ontario Shores is now utilizing the validated Ontario Perception of Care tool for mental health and addictions. This tool was rolled out in November 2016. Each of the units chose 1-2 projects to work on over the year. Target reached - 100% of units had at least one quality improvement project to work on.
Create a process to monitor positive patient experience between each annual Pt survey blitz that includes a 3-5 question rounding tool and a Mini survey to monitor / evaluate quality improvement initiatives	Yes	Method: Peer Support Specialists participated in the rounding of 3-5 questions and results were reviewed by Quality & Recovery Councils, which are supported by Quality Improvement Advisors. Piloted 3-5 questions on two units, surveying a total of 10 patients over one month. Results had positive feedback, but the process was found to be resource intensive and not sustainable. We then decided to focus on increasing the number of discharge surveys completed by the units. Each month, we sent summaries to clinical managers and directors showing Patient Experience surveys vs. the number of discharges. Overall, improving transparency of survey completion helps increase the survey response rate.
Improve communication to patients and families regarding complaint management/patient relations process by having Peer Support Specialists visiting all new patients, provide Welcome Card, with a review of the Complaints Process and revise current patient relations materials with input from patients and families	Yes	Method: Peer Support Specialist to monitor the stock of pamphlets and posters on complaint management for patients and families using an Audit tool & communicate findings to appropriate areas. Peer Support Specialists completed the unit audit for pamphlets and posters and replenished

		stock. Implemented Quality Improvement Visibility boards on every unit, with a section on "Patient & Family Feedback" which included information about the "Complaints" process. Changed the Feedback Form and Poster to highlight the word "Complaint" (formerly entitled “Feedback”) which patients and families said was not clear enough.
Formalize the process of Co-design within Ontario shores	Yes	Method: Family & Peer Support Supervisor & Patient Council Coordinator will monitor & track process measures in a database. Results will be shared with Quality & Recovery Councils and with Quality Improvement Advisors. Phase 1 of the formalized Co-Design process was launched mid-August 2016. Phase 1 focused on quality improvement initiatives as well as a review of the Quality & Recovery Councils and implementation of patient/family representation, as appropriate. Evaluation of Phase 1 completed in January 2017 and improvements will be included for Phase 2.

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5	Medication Reconciliation on discharge (%; All discharged patients; April 1, 2016 - March 31, 2017; Hospital collected data)	969	94.00	98.00	99.50	

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Focus on electronic data collection to ensure data integrity	Yes	Method: Work with Decision Support on data reports for 6.15 platform going live in November 2016. - Goal completed. Query prompt added to the intervention module in Meditech that has improved completion of medication reconciliation upon discharge.

		Dashboard developed by Decision Support to track data from Data Repository in real-time. Accessible by all pharmacists to determine status of discharge medication reconciliation completion for each patient. Dashboard was a new change idea suggested and developed by Decision Support. It is instrumental to maintaining results. Would highly recommend to other sites to pursue.
Improve communication of discharges to Pharmacy	Yes	Method: Working with inpatient teams, determine strategies to ensure Pharmacy is notified in advance of discharges. In particular when the decision to discharge is made quickly so all steps of med rec on discharge may be completed and documented. Goal achieved. Pharmacy rep attends bed management meetings thrice weekly and communicates info to Pharmacy staff. Query added to Discharge Checklist in Meditech for Social Workers, specifically "Pharmacy made aware of discharge Y/N". Addition of query to the checklist was a new change idea. Improved communication made an impact in achieving results. Ensuring different ways to communicate info decreases likelihood of missed discharge med rec.
Involve patient and families in med rec on discharge.	Yes	Method: Develop strategies for sharing the updated BPMH (Home Med List) with client and/or family and determine medication information needs at this transition. Goal is now linked with Accreditation work on a discharge package for patients. With increased CI resources 100% completion achievable by fiscal year end 2016/17. Template for info to provide at discharge developed and piloted on Young Adults Transitional Unit. - New idea to combine the QIP work with discharge package for patient's initiative through Accreditation. Use EMR to provide data as much as possible to streamline process.
Review exclusion data for med rec on discharge e.g. patient expired or AMA and determine consistent process for data collection between	Yes	Method: Collaboration with other Mental Health (MH) facilities. Goal on track-four MH facilities in MHAQI group have determined agreed upon exclusions for when med rec on

MH facilities.		discharge is not necessary e.g. patient expires or leaves AMA to ensure data comparisons are accurate. Waiting for final approval from larger MHAQI group-on track for year end. When a discharge med rec has been missed because for example a patient was transferred to acute care and didn't return, have been able to support exclusion of this data=sustained data improvements. No new ideas-continuation of discussions amongst the four sites. Awareness that one site is auditing a department process rather than #med rec done/#patients discharged. Key learnings-ensure that if data is compared to other facilities that each facility is using the same process and measures.
Analysis of incomplete discharge med recs to identify trends.	Yes	Method: Review incomplete Med Recs to determine contributing causes. Each missed discharge med rec was thoroughly reviewed with unit pharmacist (3 missed to date). 3/3 were investigated and overall theme was lack of communication of discharge to pharmacy. Strategies to improve communication discussed and implemented-see above. Important to analyze why med rec was missed to determine gaps and process improvements required.

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6	Wait times: The median number of days from referral to admission. (median days from referral to admission; Assessment and Reintegration Program, Dual Diagnosis, Geriatric Neuropsychiatry) (Days; Mental health patients; Monthly data; Hospital collected data)	969	19.00	13.00	12.00	

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	as intended? (Y/N button)	learnings? Did the change ideas make an impact? What advice would you give to others?
Ensure crisis admission and Partial Hospitalization Program admissions are appropriate	Yes	Method: Review crisis admissions with a focus on role of outpatient staff, crisis nurse, MRP and Partial Hospitalization Program (PHP). LOCUS scores are documented within standard time frames prior to a crisis admission with required frequency for update to support unnecessary admissions of crisis patients. We learned about the importance of engaging outpatient teams in the process of diverting outpatient admissions. Utilizing a standard tool to guide need for admission, we created standard language. The importance of understanding root cause for mismatches on admission has been emphasized.
Identification of individuals, on admission, requiring short stay and establish plans to support discharge	Yes	Methods: #1. Create visual management system to identify short stay patients. #2. PDSA on 3 target units by year end. PDSA was completed on one General Psychiatric unit and then spread to the Forensic program. It was determined that PDSA to be used in forensics would be aligned across all units to target LOS-ALC. Ongoing work to reduce waste by integrating with the EMR is important.
Establish local ownership for key flow performance indicators.	Yes	Method: Create a utilization team (Patient Flow) with a focus on key flow indicators with Clinical Manager ownership for key performance indicators (Wait Time, LOS, admissions). Table created and Key Performance Indicators (KPI) monitored monthly. At mid-year, managers were asked to choose 1 KPI to work on, most chose Average LOS minus ALC and plans are evolving locally. It was important to create an accountability structure that also supports learning and sharing.
Review Partial Hospitalization Program (PHP) admissions from external sources and establish PDSA utilizing LOCUS assessment.	Yes	Methods: #1. PHP admission review. #2. Review of diversion to PHP from Central Intake. #3. Establish a PDSA. Review completed. 89.7% of current PHP clients matched LOCUS 4 care needs on admission. This statistic does not separate internal and external referrals. Sought partner referring source and trained them on LOCUS, with plan to receive LOCUS with PHP referrals by year end. We are continuing to work in collaboration with referring partners to support right person, right place, right time the first time.