Ontario Shores
Centre for Mental Health Sciences

Ontario Shores Centre For Mental Health Sciences
2018/19 Quality Improvement Plan

AIM		Measure								Change				
Quality Dimension	**Issue**	**Measure/Indicator**	**Type**	**Unit / Population**	**Source / Period**	**Organization Id**	**Current performance**	**Target**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Target for process measure**	**Comments**
Safe	**Safe care**	Average seclusion duration (hours)	A	Hours/All inpatients	In house data collection / April 1, 2018 - March 31, 2019	969*	14.8	13	Represents a 15% improvement from current DecYTD performance	1) Begin team debriefs on long-stay clients (24 hours+)	1) Implementation of special recovery rounds with director, manager and team from respective unit.	Number of special recovery rounds per long-stay patient.	100% for identified long-stay patients.	
										2) Optimize the clinical monitoring policy to therapeutic engagement	1) Policy update 2) Development of a comprehensive change management plan for staff.	Policy adopted; Staff are following the policy; Chart audits.	100% for staff on targeted units.	
										3)Implement alternatives to seclusion on one selected unit (PRA or FTU)	1) Pilot an alternative to seclusion approach on a designated unit. If a patient absolutely requires seclusion, a protocol will be in place to have this occur on another designated inpatient area 2) Support teams to use alternative strategies and approaches to avoid seclusion. 3) Implement a forensic treatment mall with an increase in meaningful activities and rehabilitation. We have identified an increase in seclusion incidents at the end of each month. We will increase meaningful activity during this time period.	Units see an increase in alternative strategies prior to the use of seclusion; Evaluate use of alternative strategies to seclusion.	Increase in use of seclusion alternatives.	Aligned with the Recovery Action Plan
										4) Refresh of Safewards in one program (Forensics or ARP)	1) Implement a series of education sessions to staff on Safewards to increase capacity on approaches and interventions to reduce patient aggression.	Evaluate refresh of Safewards on targeted unit.	Refresh completed; analysis of results; spread to other units if appropriate.	Aligned with workplace violence indicator for QIP
Effective	**Improve outcomes for discharged patients**	Schizophrenia Quality Standard Outcome Indicator - % of discharged patients with improved positive symptoms	A	%/Discharged patients	Monthly data / April 1, 2018 - March 31, 2019	969*	67%	74%	Represents a 10% improvement from current Dec YTD performance	1) Transition accountability for completion of the PSS to the patient's MRP.	1)Collaborate with physician leadership and medical staff to audit scores for a sample of patients recently discharged to confirm alignment with the physician's assessment. Engagement with MSA and MAC to obtain support and approval for adding the completion of this scale to the MRP role. Establish monitoring and notification approach for PSS completion by the MRP.	% of inpatient's that have their PSS completed by their MRP at admission. % of inpatient's that have their PSS completed by their MRP at discharge.	100% of inpatients will have their PSS completed by their MRP at admission and at discharge.	

										2) Continue monitoring of practice alignment with the Schizophrenia Quality Standards implementation.	1) Medical Affairs Office in collaboration with Clinical Services, Professional Practice and Decision Support will continue monthly monitoring and reporting of key process indicators identified to confirm sustainability of changes implemented.	% of programs that review and follow-up on their data regularly.	100% of programs review and follow-up on their data regularly.	
Patient-centred	**Improve inpatient satisfaction**	Improve Inpatient satisfaction Percent positive result to OPOC Survey question "I have a plan that will meet my needs after I finish my program/treatment"	P	% / All inpatients	Ontario Perception of Care (OPOC) validated survey tool / April 1, 2018 - March 31, 2019.	969*	81.60%	85%	Represents a 4.2% improvement from current Dec YTD performance	1) Ensure that patients/families are receiving the transition report.	1) Pull data from Meditech to assess number of transition reports that have been offered to patients/families.	Number of printed transition reports of the total number of patients discharged monthly.	85% by end of fiscal	
										2) Ensure that patients/families who received the transition report are satisfied with the information provided.	2) Survey patients/families to see if the information provided was: a. comprehensive b. easy to understand c. useful	% of patients and families who receive the report were satisfied.	80% by end of fiscal	
Timely	**Timely access to care/ services**	Percent of patients that achieve the target length of stay for discharged patients.	A	%/All discharged patients	In house data collection / April 1, 2018 - March 31, 2019.	969*	53%	65%	Represents a 20.8% improvement from baseline.	1) Clinical pathway implementation	1) Establishment of clinical pathway for every unit. 2) Launch critical pathway and socialize pathway to all staff, including roles and responsibilities. 3) Implement visual management system for pathway milestones.	All units will have a fully implemented clinical pathway.	100 percent by June 1, 2018.	
										2) Long stay avoidance	1) Complete a review of best practice related to deconditioning in inpatient mental health settings. 2) Based on evidence establish a program to avoid deconditioning in one general adult psychiatry setting utilizing PDSA methodology. 3) Spread the program every 2 months to another area.	Number of units with a deconditioning avoidance program in place.	3 units by March 31, 2019	
										3) Individualized care plan - focused on efficiency, improving quality and decreased length of stay.	1) Identity indicators of and monitor for at risk of not achieving pathway targets in local ALC and ALC avoidance rounds. 2) Establish individualized interventions for mitigation.	All individuals that did achieve target or became ALC completed the escalation process prior to ALC or target miss.	100%.	

										4) Local audit processes and accountabilities will be in place discharge, ALC avoidance ad ALC	Specific foci for audits will be: i. The identification of patients at high risk for being designated ALC and compliance with the practices implemented to mitigate this risk. ii. Compliance and effectiveness of these admission policies and procedures. iii. Compliance and effectiveness of the organization's escalation processes. iv. compliance and effectiveness of policies and practices related to early discharge planning. v. compliance and effectiveness of the practices for proactively managing ALC. vi. Compliance and effectiveness of the communication of patients and SDM roles and responsibilities. vii. Compliance and effectiveness of physician engagement. viii. Compliance and effectiveness of senior team visibility. ix. Compliance with ALC practices and the effectiveness of CQI related to ALC x. Establish audit process for pathway adherence and improvement opportunities.	Audit results.	Min 70% on all audits	
Safe	**Workplace Violence Prevention**	Number of incidents of workplace violence.	M	# workplace violence incidents/worker	In house data collection / April 1, 2018 - March 31, 2019.	969*	314	314	Developmental work will be undertaken to capture incidents from all defined workers. Please note that the 314 reported incidents currently does not align to the OHSA definition of worker. This number is based on our current tracking and reporting mechanisms.	Establish a process/ procedure to capture all workplace violence incidents into one system from all workers as defined by Occupational Health & Safety Act.	1) Review the parameters in Meditech and Parklane to be able to expand those who can enter information to capture Workplace Violence incidents for non-employee defined workers.	Number of incidents reported by those workers not previously captured in Meditech.	All workers to have access and be trained in Meditech to report Workplace Violence incidents. Establishes a true baseline in order to set goals for 2019/20.	
										2. Audit current employee workplace violence incidents to determine how many no injury claims are incidents of workplace violence as defined by HQO.	1) Pull existing employee related data from Parklane for the 2017/2018 and manually review to determine the number of reported incidents and the number of reported incidents that don't meet the definition of workplace violence. Review of incidents on a quarterly basis in 2018/2019.	Percentage of reported incidents that are applicable for reporting as workplace violence.	2017/18 audit to be completed no later than May 30, 2018. Quarterly audits completed no later than 30 days after conclusion of the quarter.	
Timely	**Timely access to care/ services**	Average number of days patients waited for outpatient services.	A	# /outpatients	In house data collection / April 1, 2018 - March 31, 2019.	969*	69.6	50	Represents a 28% improvement from current Dec YTD performance.	1. Implement stepped care in Anxiety and mood services.	1. Complete an evidence review for stepped care best practices and innovations. 2. Using a guiding team determine levels within a stepped care program. 3. Determine enablers of model and implement actions to support. 4. Implement in all Anxiety and mood services ambulatory services utilizing PDSA cycles.	Implementation of stepped care model.	December 15 2018.	

										2. Central Scheduling optimization	1. Establish standard work for all roles within the scheduling team. 2. Identify outliers to booking principles and root cause for opportunities to support. 3. Reduce clinician incidence of self-scheduling where feasible.	Full implementation of central scheduling in all ambulatory areas.	Jun-18	
										3. Optimize data quality processes.	1. Review and optimize available BI tools related to wait lists 2. Establish data quality monitoring processes with clear ownership. 3. Create push notification when there are data quality opportunities in real time.	Data quality audit.	Demonstrate a 20% improvement from baseline by October 2018.	
										4. Enhance processes to support right care, right place, right time.	1. Explore options for formal shared care. 2. Establish one innovative approach to primary care that supports access to Psychiatry. 3. Optimize our access services to implement a new model for patient engagement in the referral, intake and crisis process.	New model implementation.	Mar 31, 2019.	
										5. Implement strategies to address long wait services.	1. Initial stages of stepped model (group and individual) to be implemented in Traumatic Stress Clinic as standard model of care. 2. Complete a Value Stream Analysis for wait 0-3 for long wait and highest volume services (Traumatic Stress Clinic, Prompt AMD, Memory Clinic and Prompt care Clinic). 3. Explore options to enhance resources for long wait and high volume services (Traumatic Stress Clinic, Prompt AMD, Memory Clinic and Prompt care Clinic).	1. Regular new group offering available by July 2018. 2. Reduce average wait 1.	1. Monthly 2. 3 days	