Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2017/18 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 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
1	% in mechanical/physical restraints (%; All inpatients; Q4 16-17 through Q3 16-17; Hospital collected data)	948	6.10	4.90	7.40	The scope of the data-driven restraints initiative is under refinement based on a review of the evidence, readiness assessment, current state analysis, and engagement with direct service staff and patients. We continue to experience increased acuity and volumes in our Emergency Department and as a result teams have little opportunity to be proactive resulting in restraint use to manage safety. If we were to remove the patients only restrained in the ED from the indicator, the rate is reduced to 4.16%. Based on the root causes identified behind first restraints and subsequent restraint events following transition to other units, we will explore the development of focused initiative on transition and generate other options with ED teams.

Realizing that the QIP is a living document and the change ideas may fluctuate as you test and implement throughout the year, we want you to reflect on which change ideas had an impact and which ones you were able to adopt, adapt or abandon. This learning will help build capacity across the province.

Change Ideas from Last Years QIP (QIP 2017/18)	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?
1) Education focus on collaborative care planning around management of violence and aggression and/or effective coping 2) Use standardized aggression assessment tool (DASA) to daily assess patient risk for violence and when risk is identified providing patients with additional support to manage same	Yes	Yes, there was focused education on collaborative care planning and DASA assessments. Audits of our care planning work indicated multiple care planning options in our system. Subsequently we undertook a comprehensive review of the current care planning functionality and opportunities and embarking on a significant revision of the care planning functionality. As well we are enhancing support by advanced practice clinicians for clients identified to be high risk.
Data-driven focused improvement interventions on four target units with high restraint use - with a focus on improving transitions, medications, and cognitive performance. Inter-professional teams (including physicians) will be an essential part of this work	No	Review of existing initiatives – gap analysis and steady state assessment – with frontline staff led to investigation of opportunities to improve patient experience based on transfer of care between our Emergency Department/Emergency Assessment Unit to other units. We will develop a targeted initiative for this transition that includes optimizing medication as well as appropriate communication and care planning.

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2	% of high suicide risk patients with a completed Inter-professional Plan of Care (IPOC) (%; Targeted units; Most recent quarter available; Hospital collected data)	948	CB	CB	56.40	• Root cause analysis of initial baseline performance uncovered the use of a different plan of care in use for some units for high-risk patients contrary to the Suicide Risk Assessment (SRA) guideline that suggests the Suicide Risk IPOC be created for all moderate and high-risk patients. This guideline was reinforced to all inpatient units in September 2017, helping to increase current performance • All planned change ideas were implemented. The Suicide Risk Assessment (SRA) Dashboard, launched on 6 pilot units in January 2017, was rolled out to all inpatient units in September 2017 • Other change ideas, including staff education and audits to provide feedback, were implemented by leveraging the SRA Dashboard. Through the Dashboard, Managers, Nurse Educators, and Advanced Practice Clinical Leaders identified actions that had not been completed for certain patients (e.g. high-risk patients without Suicide Risk IPOCs) and followed-up with staff. Based on this, targeted education was delivered by Nurse Educators. All staff has been trained on creating IPOCs. Going forward, the SRA working group will develop a plan for identifying units that are struggling with performance and connect them with units that are doing well

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Begin spreading a series of interventions that have been piloted on two units: Dashboard to flag moderate and high-risk patients who require an Inter- professional Plan of Care (IPOC); Staff education; Audits to provide feedback	Yes	Providing real-time data to Managers, Nurse Educators, and Advanced Practice Clinical Leaders has resulted in improvements in IPOC completion rates. The Dashboard increases efficiency by providing encounter-level data so unit leadership can easily determine which clients are missing IPOCs, and follow-up with staff immediately.

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3	% of patients with completed demographic information (%; ED and all inpatients; Q4 16-17 through Q3 17-18; Hospital collected data)	948	93.00	90.00	90.40	Analysis of sociodemographic data collection across inpatient units has identified several units with areas for improvement. Root Cause Analysis is underway with targeted units to identify processes to support increased data collection. Education and training sessions for high quality data collection are planned for unit leadership and staff in the coming months.

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1) Expand to inpatient units 2) Determine approaches to increasing data collection and quality	Yes	Targeted units were identified and unit leadership consisting of managers, nurse education and APCLs as well as staff involved in data collection received education and training.

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4	7 day readmission - the number of stays with at least one subsequent hospital stay within 7 days divided by the total number of hospital stays in a given quarter (%; All inpatients; Q4 16-17 through Q3 17-18; Hospital collected data)	948	5.00	4.80	5.70	• Following a successful pilot on 2 inpatient units, the Discharge Optimization Project is being rolled out to the other inpatient units in 4 cycles. Patient-Oriented Discharge Summaries (PODS) replaced the previous discharge instructions document for patients and their supports. PODS were rolled out to all inpatient units (with one exception) in November of 2017 and the implementation was supported by the Advanced Practice Clinical Leaders and Nurse Educators to ensure optimal support for the clinical teams. All inpatient Social Workers and Nurses were cross-trained on PODS in order to meet the demands of planned, as well as after-hours, discharges • The Discharge Optimization project approach focuses on people, process, technology and evaluation, while specific interventions include feedback reporting of rates for key indicators, communication, training as needed, and optimization of the discharge workflow. Additional planned activities include further utilization of quality improvement methodology to identify and resolve unit-specific barriers and additional changes to I-CARE to ensure technology is supporting the optimized discharge workflow

- Based on the lessons learned from the pilot phase, the 7-day readmissions rates can fluctuate substantially based on the unit-specific patient population and discharge volumes. The Health Record Completion policy was revised allowing for 48 instead of 72 hours for discharge summary completion to further improve the rates of timely discharge summary completion across all inpatient units

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Pilot, evaluate and begin expansion of a new evidence-based discharge project	Yes	Timely discharge summary completion rates can be impacted by the staffing structure on the unit resulting in a greater likelihood of delay if the summary is completed by a resident and requires review, and co-signature, by the attending physician. Based on the optimized discharge workflow, the inpatient pharmacists are now more involved in the discharge process providing an enhanced interdisciplinary approach to care. During the pilot phase, significant improvements in the rates of follow-up booking have been observed on one of the two pilot units. Pre-booking follow-up appointments can be particularly challenging due to the limited access to follow-up resources in the community especially for patients who are homeless, do not have a primary care provider or an outpatient psychiatrist.

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5	90th percentile ED LOS (Hours; ED patients; Q4 16-17 through Q3 17-18 (YTD); Hospital NACRS)	948	11.40	11.40	14.20	<u>Root causes</u>: • Continued year-over-year increase in ED visit volumes (projecting over 12,000 visits for 2017/18), additional RN and MD complements required, challenges of ED admit no inpatient bed, need for ED diversion for low-acuity patients required, and the ED Triage Assessment documentation/process requires review/modification. Increases in MD and RN complement have resulted in improvements in quality, safety and duration of ED visits. • Planning underway: o Streamline triage, and redevelop the ED Multidisciplinary Assessment. We are working with ED Alliance Partners and the Project Management Office (EPMO), and a subcommittee has been established o Streaming of patients into two ED zones, which is expected to ensure orderliness to the flow based on the acuity and needs of the client and workload of staff at the same time. A subcommittee is being established o Development of a Discharge Summary tool (similar to the Patient-Oriented Discharge Summary (PODS) for patients, and leaning of the process to send ED assessment information to – General Practitioners and community psychiatrists o To plan and open a new 23 bed general psychiatry/

psychiatric intensive care unit (GPU2/PICU) in 2018

- We have established a Drop-in Bridging Clinic to support reduction of ED LOS; however, data is not yet available. Significant gains have been evident with patient flow, both in terms of positive collaboration between clinical programs and CAMH's ability to mobilize during admission surges
- It is expected that both continued efforts with implementation of the recommendations of the ED Process Improvement Initiative and opening the new 23 bed unit will result in further improvements in reducing ED LOS

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Increase acute care capacity	Yes	CAMH underwent an ED Process Improvement Assessment by Consultants (Completed June 2017). ED process improvement recommendations have been reviewed and some have been implemented (see below). Planning is underway to implement recommendations with expected completion in fall 2018. We do not yet have data to assess impact. More specifically we: • Increased the RN complement to those recommended areas in the ED Process Improvement Project (October 2017) • Increased the MD complement to include 1 FTE (5 PM to 12 PM shift Monday to Fridays, in January 2017) • Implemented a Drop-in Bridging Clinic to support diversion of Canadian Triage and Acuity Scale(CTAS) 5 patients, improved follow-up post-discharge to support (October 23, 2017) • Developed a Patient Flow Protocol and efforts are underway to modify and evaluate this protocol and convert to CAMH Policy

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6	Average length of stay (ALOS) for inpatients admitted to the EAU through the ED (Hours; All inpatients admitted through ED and subsequently transferred to another inpatient unit; Q4 16-17 through Q3 17-18 (YTD); Hospital collected data)	948	17.60	17.60	19.90	Root causes: • Continued year-over-year increases in ED visit volumes and patients requiring admission, as well the need for additional general psychiatry and a psychiatric intensive care unit/beds and Dual Diagnosis beds

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LEAN process review to improve efficiency and flow	Yes	It is expected that both continued efforts with implementation of the recommendations of the ED Process Improvement Initiative and the opening of the new 23 bed inpatient unit in 2018 will result in further improvements in reducing average length of stay for inpatients admitted to the EAU through the ED. Change ideas completed to date: • We implemented a Drop-in Bridging Clinic to support the ability for inpatient units to discharge with support • We implemented a Patient Flow Protocol and efforts underway to modify and evaluate this protocol and convert to CAMH Policy

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7	Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged. (Rate per total number of discharged patients; Discharged patients ; Most recent quarter available; Hospital collected data)	948	61.00	73.00	77.00	• Root causes: o Anecdotally, we learned that some of the physicians are not familiar with the discharge medication reconciliation functionality in the electronic health record (I-CARE), especially if they are primarily practicing in an outpatient setting and only provide occasional coverage on inpatient units o Aspects of the discharge medication reconciliation process are not intuitive and therefore require training, reinforcement and support • Discharge medication reconciliation completion rates were around 76 -77% in the first three quarters of 2017/18, however, we are seeing improvements in Dec (83%) Key lessons learned: o Involving pharmacists in the discharge process is beneficial in supporting clinical teams and patients • Planned activities: o Continue to engage with inpatient units to review rates for the discharge medication reconciliation process and coordinate improvement as part of the Discharge Optimization Project roll-out

- Planned activities (cont.):
  - Introduce I-CARE changes to ensure technology supports the discharge medication reconciliation process in a sustainable way
  - Create education materials to support physicians

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Examine and optimize functional components of discharge medication reconciliation process in I-CARE to improve ease of use and quality of outputs	Yes	The review identified several features of medication reconciliation process in I-CARE that were not amenable to change. Therefore, functional changes focused on improving medication information outputs to help clinicians see the value of conducting medication reconciliation, as well as facilitating pharmacist notifications of discharges (i.e., adding the Estimated Discharge Date information to the unit patients' lists in I-CARE) to improve the process flow. Training supports also became a focus. This work aligned with the broader Discharge Optimization Project.
Change activities were incorporated into the broader Discharge Optimization Project	Yes	High-level work performed as part of the Discharge Optimization Project: • Discharge medication reconciliation rates provided monthly to the two pilot units initially and subsequently spread across other inpatient units. Education for physicians on the pilot units on completing discharge medication reconciliation (April 2017) • Pharmacist support and greater involvement in the discharge process • Linking discharge medication reconciliation to discharge order in I-CARE to ensure technology supports this process • Patient-Oriented Discharge Summaries (PODS) were launched initially on pilot units and spread across all other inpatient units. PODS provide patients with a set of clear and easy-to-understand instructions upon discharge including the medications they need to

take. The key benefits of PODS as compared to the previous version of the discharge summary are:

- The medication details are more patient-friendly
- The medications are not displayed until discharge medication reconciliation has been properly completed
- The medication section contents can be enhanced by pharmacist-driven intervention o Additional activities related to the PODS launch focused on enhanced communication with physicians

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8	Number of Lost Time Claims related to a workplace violence event expressed as Workplace Violence Incidents per 100 Full Time Employees (FTEs) (Days lost; 100 FTE; Q4 16-17 through Q3 17-18; Hospital collected data)	948	CB	CB	0.36	• This was a new indicator being measured in 2017/18 so root cause analysis was not completed as previous data was not available prior to the 2017/18 fiscal year • As a new indicator, we will continue to monitor the impact of the change ideas • CAMH has an organizational commitment to reduce workplace violence. There is commitment and collaboration between CAMH senior leadership and union leadership to work together on this issue o The implementation of a Workplace Violence Prevention Committee in May 2017 has been a key outcome of this commitment • A key lesson learned was to ensure management and unions work together, and have joint messaging, to staff on initiatives around reducing workplace violence

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Implement risk flagging protocols and tools including DASA and aggression risk assessment tools	Yes	The Dynamic Appraisal of Situational Aggression (DASA) was implemented as the standardized aggression /violence risk assessment tool in mid- 2016, and is now completed on the majority of our inpatient units once every 24 hours, for all patients, at 5:30 AM. Risk flagging was implemented on 3 pilot units in November 2016 and subsequently implemented on all remaining units in early 2017. Risk flagging allows for a visual means of identifying risk on the units and leads to team discussions about patients who have been flagged for a risk of violence. All staff, including support staff, can see and are therefore made aware of the risk flag, which can lead to improved safety and precautions when working with the patients flagged. We encourage other organizations to ensure the following: • When developing a risk-flagging process that you engage all stakeholders from direct service staff in varying roles, including physicians, as well as union leadership and administrative leadership • Establishment of clear guidelines and processes for risk flagging and that the process is based around inter-professional discussion and evidence (assessment based results) prior to flagging patients • Establishment of rigorous processes for proposal, approval, and timely review of risk flags

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9	Percent positive result to the OPOC question: "I think the services provided here are of high quality" (%; All inpatients who completed the survey; Q4 16-17 through Q3 17-18; Validated Ontario Perception of Care (OPOC) survey tool)	948	79.40	80.20	82.90	• Understanding the perspectives and experiences of our patients is crucial to the quality improvement process at CAMH; and the administration of our annual patient survey (the Ontario Perception of Care tool) is one of the primary and arguably most ambitious means by which we gather these insights and information • Following the 2016 administration of the OPOC, we explored opportunities to conduct the survey more frequently (and/or at staggered times) across the organization, which we accomplished in 2017, and to conduct a focused pilot project with patients at discharge • The pilot project was implemented in Q4 2016/17, in order to validate the results of the 2016 OPOC survey • The top 5 inpatient questions with the lowest positive responses were selected and the pilot survey was administered by Client Experience Assistants on two inpatient units with high-turnover (Medical Withdrawal Services and a Schizophrenia High-Risk unit) • Both units developed targeted interventions based on the results of the first two months of data collection (May-June 2017) • This pilot allowed for ongoing collection of patient feedback and timely follow-up action

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1) Investigate and assess additional surveying methodologies and tools to increase capture of patient experience data 2) 2) Examine results and develop action plans to address gaps	Yes	1) Administered over a two-month period, the pilot survey allowed patients to give real-time feedback just prior to their discharge. The ability to make targeted changes in areas specific to the unit, and in partnership with patients, ensured meaningful quality improvement. The positive outcomes in 5 of the 6 areas that were targeted are an indication that this change idea was effective. It also reflects the importance of small continuous improvement efforts as part of overall efforts to improve patient experience outcomes. 2) The interventions were implemented in partnership with patients in the form of focus groups. There was continued surveying to elicit patient feedback until October 31, 2017. An analysis of the data post interventions saw a positive correlation between the areas targeted for improvement and positive patient responses in the pilot survey. This intervention is resource intensive; we are therefore exploring an efficient way of continuing to expand this across more units.
Pilot, evaluate and begin expansion of new-developed evidence-based discharge project	Yes	Following a successful pilot on 2 inpatient units, the Discharge Optimization Project is being rolled out to the other inpatient units in 4 cycles. Patient-Oriented Discharge Summaries (PODS) replaced the previous discharge instructions document for patients and their supports. The Discharge Optimization project approach focuses on people, process, technology and evaluation, while specific interventions include feedback reporting of rates for key indicators, communication, training as needed, and optimization of the discharge workflow. Additional planned activities include further utilization of quality improvement methodology to identify and resolve unit-specific barriers and additional changes to I-CARE to ensure technology is supporting the optimized discharge workflow.

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10	Percent positive result to the OPOC question: "I think the services provided here are of high quality" (%; All outpatients who completed the survey; Q4 16-17 through Q3 17-18; Validated Ontario Perception of Care (OPOC) survey tool)	948	94.20	94.70	90.50	• Understanding the perspectives and experiences of our patients/clients is crucial to the quality improvement process at CAMH; and the administration of our annual patient survey (the Ontario Perception of Care tool) is one of the primary and arguably most ambitious means by which we gather these insights and information • Response rates in outpatient services allowed CAMH to do correlational analysis of the OPOC results. Overall satisfaction results were correlated with other survey questions. Results showed client confidence in staff drove positive quality responses, while negative scores on discharge planning questions drove poorer quality ratings. We are considering discharge planning support initiatives for next year

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Reduce wait times and improve operations effectiveness for targeted clinics	Yes	In 2017/18, several strategies were put in place to reduce clinic wait times and improve operational effectiveness: 1) Mood and Anxiety Ambulatory – initiated a process to streamline referrals for Cognitive Behavioural Therapy (CBT) directly to a new sub-clinic which provides faster access to psychotherapy than what was historically provided 2) Addiction Outpatient Services – a rapid access clinic was initiated. Referrals directly from CAMH ED and high risk referrals to Access CAMH are streamed to a clinic with minimal wait time (1-2 days). This has been critical in the service's response to the opioid crisis. Additional pharmacy support has also been added to these services, to increase staff and patient education on overdose prevention 3) Service Optimization – recommendations from the Ambulatory Review were implemented. This included realignment of service leadership to allow for integration of services and standardization of care. Further steps to reduce wait times and improve operations in Q4 and into Q1 2018/19 will include: 1) Additional physician recruitment in the Mood and Anxiety Service 2) Streamlined intake functions in all addiction services. This will improve access to addiction medicine for clients and standardize intake functions. Implementation will occur in February 2018 3) Medication review process will be rolled out to addiction and concurrent disorder outpatient areas starting in Q4. The initial focus of this work will be to conduct medication reviews with clients and/or providers