Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for the 2015/16 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 2015/16	Org Id	Current Performance as stated on QIP2015/16	Target as stated on QIP 2015/16	Current Performance 2016	Comments
1	# of CAMH patients currently on or have completed an integrated care pathway (ICP) either in an inpatient setting or ambulatory care. (# of CAMH patients; CAMH patients; Q4 2014-15, Q1-Q3 2015-16 (rolling four quarters); Integrated Care Pathways spread-sheets: all data related to ICP is currently captured manually)	948	185.00	500.00	851.00	CAMH has exceeded the target with 4 Integrated Care Pathways being added to the existing 7.

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Change Ideas from Last Years QIP (QIP 2015/16)	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?
Continue to focus on the sustainability and growth of the established ICP 1b. This year we area also focusing on the evaluation of ICPs across the organization.	Yes	Regular monitoring of all ICP's is helpful in ensuring that all eligible patients are admitted to the pathway. We are aligning I-CARE documentation standards to improve workflow and simplify documentation. Evaluation strategies include surveying patient experience as well as tracking percentage improvement in overall functioning.
Design and implementation of new pathways	Yes	Four new ICP's were developed and implemented.

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2	# of events of absconding by involuntary non-forensic patients (# of events; all inpatients; Q4-2014/15 - Q3 2015/16 (rolling four quarters); From electronic incident reporting system)	948	67.00	64.00	59.00	We have exceeded this target through our implementation of change ideas and we are committed to continuing our work on early and consistent identification of risk for absconding.

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Early and consistent identification of risk for absconding.	Yes	This change idea is currently under implementation. We have implemented a standardized risk assessment tool for our forensic population and are now reviewing how to adapt the tool for the non-forensic population.
Conduct AWOL analysis, establish trends/ contributory factors and mitigation strategies.	Yes	Review of incidents identified failure in environmental controls due to human error (e.g. Not verifying locked door; letting people exit unintentionally etc.) and issues related to passes including classification of patients as involuntary or voluntary.
Develop local-level mitigation strategies for at risk patients.	Yes	Rapid Rounds and team reviews being conducted routinely on inpatient units.
Staff training.	Yes	Policy review and best practices techniques discussion is being embedded in monthly meetings.
Ensure consistent debriefing following event.	Yes	AWOL events are reviewed by manager and immediate debrief after events are occurring in most instances (76%). Staff feel supported by these debriefs and are goal is to have the debriefs occur for 100% of events.

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3	% in mechanical restraints (%; All inpatients; Q4 2014 – 2015 to Q3 2015 2016 (rolling four quarters); Hospital collected data)	948	3.60	3.40	4.30	We continue to experience high volumes through our ED and increased acuity in our inpatient areas. We are analysing restraint use at the unit level to better understand needs for each unit and the patient population it serves. We are also working with our Peer Hospitals on a joint project to share best practices across organizations and pilot a common set of bundled interventions. We have identified that some point-of-care staff were recording restraint events in a manner which may be artificially inflating # of restraint events e.g. in some instances continuation of an event is incorrectly documented as a new restraint event. This led to review of our processes for documentation and subsequent staff education.

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Build staff capacity in prevention and management of aggressive behaviour and promoting comfort and well-being.	Yes	100% physicians in ED have had PMAB training and plans are in place for new trainees and staff. • A revised curriculum and approach is being piloted with selected teams. This approach focuses on prevention and has built “action planning” into the education. Formal evaluation is planned for summer 2016, however feedback to date is very positive from the participants and the “action planning” is

		generating ideas for subsequent development of more formal QI initiatives. •Audits of key units over a 3 month period identified that Team Reviews are consistently practiced and there is regular discussion of comfort and wellness strategies. •We are now focusing on ensuring that these discussions are translating into care plans.
Leadership oversight.	Yes	•Audit conducted to verify that 100% of inpatient units are engaged in team reviews on a weekly basis and rapid rounds /huddles on a daily basis. Now focusing on quality of the discussions and follow through •Daily restraint data is now sent to the leadership teams, there is increased ability to support oversight regarding team processes and documentation.
Learning from debriefs.	Yes	•We have seen an increase in the % of patients that are engaging in a post event debrief. •Having someone external to the unit is a helpful alternative to support both staff and clients • If needed, Staff can access the Patient Experience Officer to facilitate the debrief. •Patient Event Debrief Form electronic version launched in I-CARE Jan 2016. We expect regular reports and review of data will lead to further increases.

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4	Total Margin (consolidated): % by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expense, excluding the impact of facility amortization, in a given year. (%; N/a; Q3 FY 2014/15 (cumulative from April 1, 2014 to December 31, 2014); OHRS, MOH)	948	0.90	0.00	0.00	Strong leadership oversight and mitigation strategies including a review of all vacancies continue to inform CAMH's commitment to meeting this target.

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Efficiency through more effective utilization of staffing resources.	Yes	•An area of focus has been the review of constant observation practices. •Discussions leading to the development and implementation of standard protocol have already led to a modulating effect •CAMH Continuous Observation guidelines are informing constant care guidelines for seniors across the Toronto Academic Teaching Hospitals.
Quarterly review of performance by Executive Leadership.	Yes	•Strong leadership oversight and mitigation strategies included review of all vacancies

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5	Average Length of Stay (LOS) for clients discharged within 4-90 days (Days; Discharged inpatients; Q4 14-15 through Q3 15-16 (rolling four quarters); Hospital collected data)	948	25.00	24.50	24.50	Target was met and we will now be reviewing the impact of Integrated Care Pathway, on Length of Stay.

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Improve discharge planning.	Yes	•Audits have been helpful in identifying opportunities for further improvement., • In the future we expect to leverage electronic health record so that the Estimated date of discharge is activated in the record to highlight discharge planning. • Having staff focused on utilization management is helpful in promoting collaboration across teams and early identification and mitigation of that may impede discharge.
Increased utilization of Integrated Care Pathways.	Yes	•The first step was to encourage consistent use of pathways and we have achieved adherence > 90%. We will now shift our focus on evaluating the impact of pathway on Length of Stay

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6	ED Wait times: 90th percentile ED length of stay for admitted patients. (Hours; All patient admitted through the ED; Q4 14-15 through Q3 15-16 (rolling quarters); NACRS)	948	CB	8.00	10.40	As per our submission, the stated target of 8 hours was a placeholder and reflected the provincial target. The data for ED length of stay prior to the new clinical information system was not accurate due to system limitations. 2015-16 was a year of collecting baseline information. This target will be readjusted now that we have been able to establish a base line

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Improve patient flow across CAMH.	Yes	Active collaboration of Program leads, daily bed call/huddles and regular bed flow meetings with After Hours Managers are helpful. We continue to be faced with increased volumes in our ED and challenges in discharging patients due to a lack of appropriate discharge destinations
LEAN bed flow initiative.	No	This change idea was halted for a period; we have now reinstituted the monthly bed flow trouble shooting meetings with representation from bed flow, the emergency, medical affairs, after hours managers and the CMI bed manager

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7	From in-house Client Experience Survey: "Overall, how would you rate the care you are receiving? (add together % of those who responded "Very Good and Good"). (% of positive responses; All inpatients who completed the survey; annual survey; In-house survey)	948	68.70	69.40	69.70	CAMH has met this target through implementation of a variety of change ideas including: patient engagement at different levels of the organization; enhanced team capacity for engagement and increased therapeutic programming during "off-hours". Work on medication safety education and discharge planning continues to require innovative staff engagement as highlighted by the audits.

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Enhance team capacity for patient-centered engagement.	Yes	•We have identified, factors that correlate highly with overall satisfaction as being treated with respect and involvement in discharge planning.. •Individual programs are engaging in quality improvement initiatives that seek out and integrate client feedback in service planning.
Increase therapeutic programming for patients on weekends.	Yes	•ENCORE programming is the result of patient, family and staff collaboration. • Encore offers on average 43 hours of programming per week and is open 7 days per week, including evenings.
Engagement in discharge planning.	Yes	•Results of audits in 5 units indicate that 64% of patients/SDM involved in discharge planning •We will look to expand audits across organization and develop focused QI initiatives at the unit level
Medication Safety Education.	Yes	Patient health-teaching included in new medication protocols
Engagement in program and service delivery	Yes	•Patient/Peer engagement has been very positive. Quality councils for each program developed strategies for client engagement in service planning. Some examples include:

planning.	•Engaging youth as peer mentors ; •Empowerment Council representative on program Quality council; Patient involvement in planning of new facilities; Peer workers engaged in the development of Integrated care pathways; and new role for Patient Experience Officer to conduct patient debriefs and provide comfort and wellness education developed and implemented successfully

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8	Medication reconciliation at admission: The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital (%; All patients; most recent quarter available; Hospital collected data)	948	CB	90.00	88.00	We have consistently met the 90% target in Q4 and Q1 and achieved 91% in Q2, leading to one year average of 90%.

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Examining and optimizing the role of Pharmacy in medication reconciliation.	Yes	•Medication Reconciliation is an interprofessional activity. Ongoing pharmacy support is required to ensure medication reconciliation is completed in a timely manner. •Regular review of adherence to expectations is helpful. Consider having this information on program dashboards for partnership in monitoring adherence.
Physician Education via dedicated training.	Yes	•Training for inpatient staff physicians and new residents ongoing due to turnover. •Helpful to have training materials (“How To”) available in I-CARE Help.
Process and functional improvement.	Yes	Functional improvements implemented, nearing targets. Need to continue to monitor to ensure consistency.

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9	Total number of inpatient days where a physician (or designated other) has indicated that a patient occupying an acute care hospital bed has finished the acute care phase of his or her treatment, divided by the total number of inpatient days in a given period x 100. (%; All acute patients; October 2014 – September 2015; DAD, CIHI)	948	X	20.00	0.00	The stated target for this indicator was a placeholder only. For the majority (94%) of our Alternate Level of Care (ALC) clients discharge is hindered by lack of appropriate housing destination. As noted in our submission, ALC remains a high priority for CAMH, however it is not an indicator that can be further influenced by our efforts. Increased capacity and coordination are needed at a system level to achieve this aim. We continue to work with partners with respect to housing solutions and advocate at a systems level.

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Implement Toronto Central (TC) LHIN-funded high-supportive housing initiative and explore further opportunities	Yes	•All fifteen funded high support units have been filled. The addition of new units resulted in a drop in ALC numbers in July 2015, however, CAMH ALC rate has once again increased to 19%. Because the majority of our ALC patients require high support housing, without new investment in high support housing, it is expected that ALC numbers will remain high.

Develop ALC Avoidance Strategy	Yes	ALC avoidance work continues with very active involvement of CCAC on inpatient units.
In partnership with Toronto Central (TC) Community Care Access Centre (CCAC) access need for CCAC support in CAMH ED, and develop implementation strategy	Yes	CCAC worked with CAMH to review potential need for CCAC support in the ED, review indicated that there were very few potential CCAC referrals; we jointly concluded that CCAC staffing in CAMH ED is not warranted and that ED will continue to liaise with CAMH CCAC coordinator as needed.