Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 31, 2025

The Royal
Mental Health - Care & Research
Santé mentale - Soins et recherche

Ontario Health

OVERVIEW

The Royal is one of Canada's foremost mental health care, teaching, and research hospitals. It is home to the Royal Mental Health Centre, the Brockville Mental Health Centre, the University of Ottawa Institute Of Mental Health, and the Royal Ottawa Foundation for Mental Health. With over 300 beds and serving 10,000 outpatients annually, the Royal is committed to bringing access, hope, and new possibilities to clients and families with mental health and addictions needs across the region and beyond. As an academic health sciences centre the Royal combine's specialized mental health care, advocacy, research and education to transform the lives of people living with complex treatment-resistant mental illness.

The Royal is in the process of developing a strategic plan for 2025 to 2028. The Royal currently has a 12-Month Interim Strategic Plan in place. This interim plan was developed with broad consultation with clients and families, community partners, physicians, and staff and include the following strategic priorities to guide work of the organization:

1. Leadership, Engagement and Optimal Communication
2. Develop and Strengthen and External Collaborations & Partnerships
3. Timely Access to an integrated Continuum of Excellent Care
4. Promote and Disseminate Research and Fuel our Academic Enterprise
5. Measure and Improve Clinical and Operational Outcomes

For the purposes of the QIP submissions to Ontario Health, we report for The Royal's mental health services (referred to in this

narrative as The Royal) and our long-term care facility, Royal Ottawa Place (referred to herein as ROP). A single Board of Trustees governs these two entities. Indicators and quality improvement projects for The Royal and ROP are reported separately but included within one QIP document to ensure clear and appropriate oversight of work undertaken.

ACCESS AND FLOW

Access to specialized mental health care is a key part of strengthening the regions mental health capacity. Recognizing the pressure across this system for mental health beds and outpatient programming, the Royal has selected multiple indicators to drive timely access to care. These indicators include reducing inpatient ALC length of stay and reducing wait times for outpatient program and improving general psychiatry consultation. The organization has also selected an access and flow indicator that will support emergency department capacity within the larger Ottawa area with reduction of potentially avoidable emergency department visits for long term care residents.

EQUITY AND INDIGENOUS HEALTH

The Royal is committed to embed an equity, diversity and inclusion approach in all aspects of care delivery and hospital operations. As health care providers, the organization is committed to address health inequities that exist within the communities served. As part of the equity, diversity and inclusion work, in 2024-25, the organization completed a needs assessment to roll out of EDI education across the organization. The organization will continue to include optimizing EDI training efforts and will use the 2025/26 QIP to drive meaningful staff adoption and implementation of action and behaviours supportive of EDI. The 2025/26 indicator will evaluate the % of staff who identify that they will make changes as a result of completing the EDI training.

EDI priority initiatives at the Royal launched in 2024-25 have included:

- The launch and expansion of EDI training modules, this includes an evaluation of learning impact
- The expansion of the scope and funding for the Black, African & Caribbean Peer Support Role
- The expansion of additional education sessions on diverse topics such as the Indigenous Education series, Applying an Anti-Racism Approach at Work, Equitably serving 2SLGBTQIA+ and gender diverse community members.
- The continued development of clinical and support programs that respect specialized needs, such as a Women's BIPOC Journaling group, and the Women's BIPOC wellness group.

The Royal will continue to build off these efforts in 2025-26 to strengthen the organizations EDI approach.

PATIENT/CLIENT/RESIDENT EXPERIENCE

Engagement with our patients, residents, and clients is critical to the success of The Royal. In developing this QIP, we have relied on feedback from these groups to not only help evaluate the current status of certain indicators, but also to provide suggestions and ideas for how the Royal can strengthen the quality of services. The Client Advisory Council, Family Advisory Council, Residents Council and additional committee client and family representatives have been engaged for multiple rounds of QIP co-design. Data from the client and family experience surveys spanning 5 years has been reviewed in all key stakeholder QIP development sessions to inform the indicator selection. This co-design process has led to the selection of an Experience indicator focused on driving changes to ensure patients receive adequate information about their health and their care at discharge.

PROVIDER EXPERIENCE

The Royal has experienced significant changes in leadership over the last couple of years, and workplace culture can be affected by a period of uncertainty. The Royal's Culture Club was established in 2024, as part of the REVEL engagement method to support engagement and positive workplace culture at the Royal. REVEL was created through the Public Health Agency of Canada (PHAC) to support health care workers experiencing burnout post-COVID. Members of the Culture Club come to the table each month with open hearts and minds to solve problems, address tough issues and work towards building a place of deep meaning and connection for those that work here. The goal of our Culture Club is to foster engagement, earn trust and collaborate in a new way forward to strengthen and improve employee experience so organization can meet it's brilliant potential.

The Royal has committed to implement dedicated staff co-designed wellness spaces at both the Ottawa and Brockville site locations. These areas are designed to be spaces for staff relaxation, restoration and connection.

SAFETY

The Royal continues to nurture a strong patient safety culture across the organization where everyone has a role to play in the delivery of safe and quality care. A robust patient safety program is in place at the Royal, encompassing prospective analysis, near miss and incident reporting and review, recommendations tracking, and education sessions. Incidents are reviewed based on a severity rating, including a Quality of Care review for critical and severe incidents. Events learning as shared with team using a just culture lens and staff are routine celebrated and recognized for their

contribution to patient safety though both informal and formal programs like the “Good Catch” Awards.

The Royal has invested in electronic positive patient identification technology (ePPID) to support patient safety and the reduction of harm to patients resulting from patient misidentification. ePPID uses barcode scanning technology, the scanning of a 2D or 3D barcode on the patient armband in combination with verbal confirmation of a patient’s unique identifiers, name and hospital file number to positive identify at patient prior to providing care. The Royal’s ePPID solution has been implemented with a focus on reducing the patient risk of misidentification during medication administration. This safety solution has not been fully optimized as the workflow is not aligned with best practice which include the scanning of barcoded armbands affixed to the patient receiving care. Currently the clients of the Royal do not wear armbands. The Safety indicator for 2025/26 includes implementing patient, client and resident armbands to strengthen positive patient identification. This change will be significant for the organization, clients and family members will be heavily embedded within all aspects of this change as key stakeholders.

The Royal believes that a safe and healthy workplace has strong workplace violence prevention measures in place. Workplace violence prevention will remain an indicator on the 2025-26 QIP. The organization believes there are still significant opportunities to improve workplace safety. The Royal will continued to implement changes targeting reductions in the rates of workplace violence incidents resulting in lost time as the Provider Indicator for 2025/26. Changes to drive this indicator will enhancing the current Code White Taskforce and expanding access to seclusion rooms for select inpatient units.

EXECUTIVE COMPENSATION

The Royal maintains its commitment to the Excellent Care for All legislation; as such, The Royal’s executive compensation framework, including the percentage of salary at risk and targets for which the executive team is accountable, are linked to executive performance from a quality perspective as follows:

All members of the Royal’s Executive Leadership Team will have 5% of their annual base salary directly linked to achieving 100% of the selected QIP targets. The following roles participate in the Executive Performance Incentive Program. Incentives are awarded based on the degree of achievement of the below performance targets:

- Chief Executive Office
- Chief Operating Officer
- Chief of Staff
- Senior Medical Officer
- Vice President People & Culture
- Senior Vice President Patient Care Service
- Vice President Finance

Quality Dimension	Indicator	Target	Target Justification	Weight
Access and Flow	Reducing inpatient ALC length of stay by 5% from 2024-25.	5% from 2024-25.	Improve current performance by a 5 % reduction.	14.285%
Access and Flow	Reduce wait time by 20% for outpatient Mood and Anxiety program and General Psychiatry consultations.	20% reduction as compared to 2024/25 wait times	Improve current performance by a 20 % reduction.	14.285%
Access and Flow	Reduce rates of potentially avoidable emergency department (ED) for long term care residents displaying symptoms of delirium	5% reduction as compared to 2024-25 ED visit rates for LTC residents displaying symptoms of delirium.	Improve current performance by a 5% reduction.	14.285%
Equity	% of all staff who have completed EDI training and respond yes to "I will make changes to support EDI at the Royal as a result of this training – yes or no".	Target 80% confirming yes "I will make changes to support EDI at the Royal as a result of this training"	Achieving a 80% target This will help Improve EDI capacity & knowledge and & integration at the Royal	14.285%
Experience	Inpatient report of receiving adequate information about their health and their care at discharge,	Target 79%	79% is a 5% increase from 2024-25 OPOC question 29)	14.285%
Safety	Reducing the rate of workplace violence incidents resulting in lost time injury	Target 0.82	0.82 is a 5% reduction from the 2024/25 average rate	14.285%
Safety	Implementation of patient, client and resident armbands to strengthen positive patient identification.	Target: 95%	A 95% rate will support patient safety and is an achievable target.	14.285%

CONTACT INFORMATION/DESIGNATED LEAD

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SIGN-OFF

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan on **March 31, 2025**

SIGNED ORIGINAL ON FILE

Sharon Squire, Board Chair

SIGNED ORIGINAL ON FILE

Lewis Leikin, Board Quality Committee Chair

SIGNED ORIGINAL ON FILE

Cara Vaccarino, Chief Executive Officer

EDRVQP lead, if applicable

Access and Flow

Measure - Dimension: Timely

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Reducing inpatient ALC length of stay by 5% from 2024-25.	C	% / All inpatients	In house data collection / Monthly	CB	CB	Improve current performance by a 5 % reduction. This will improve access to acute inpatient services. It is an achievable target for us as Patients who require acute inpatient admission and mental health treatment at the Royal will be admitted in a more timely way as inpatient beds will be more readily available due to timely planned patient transitions to alternate care environments.	

Change Ideas

Change Idea #1 Implement “At Risk” ALC rounds

Methods	Process measures	Target for process measure	Comments
Identification of "At Risk" ALC evidence based practice and respective standardized rounding tools will occur in Q1 2025/26. Implementation of evidence based best practice ALC rounding will be planned and go live in Q2 2025/26	% uptake and execution "At Risk" ALC rounding all inpatient units except those in the Forensic programs.	85% adoption of " At Risk" ALC rounding a respective tools and workflow.	

Change Idea #2 Implementation of long stay rounding			
Methods	Process measures	Target for process measure	Comments
Identification of long stay evidence based rounding tools and best practices will occur in Q1 2025/26. Implementation of evidence based long stay rounding processes will be planned and go live in Q2 2025/26	% uptake and execution long stay rounding all inpatient units excluding forensics.	85% adoption of long stay rounding a respective tools and workflow.	

Change Idea #3 Implementation of an escalation pathway to remove ALC discharge barriers			
Methods	Process measures	Target for process measure	Comments
Identification of ALC escalation pathway best practices and processes will occur in Q1 2025/26. Implementation of a evidence informed ALS escalation pathway to SLT , q2-Q4 2025/26/	% uptake escalation pathway processes across all inpatient units excluding forensics.	85% adoption of the established ACL escalation pathway.	

Measure - Dimension: Timely

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Reduce wait time by 20% for outpatient Mood and Anxiety program and General Psychiatry consultations .	C	% / Other	In house data collection / Monthly	CB	CB	Improve current performance by a 20 % reduction. This will improve wait times for patients to access to care, reducing gaps in service delivery for Mood and Anxiety Program and General Psychiatry Program Patients.	

Change Ideas

Change Idea #1	Streamline the referral management process to increase the capacity of the Mood and Anxiety outpatient services to receive and handle consultations effectively		
Methods	Process measures	Target for process measure	Comments
Methods will be established in Q1 2025/26, Indicator leads will provide an update to the work plan. Implement will occur Q2 - Q4 2025/26.	% uptake and execution of identified methods. Indicator leads will provide and update to the work plan in Q1	100% uptake and execution of identified methods.	

Change Idea #2	Centralize referral management for all outpatient services.		
Methods	Process measures	Target for process measure	Comments
Methods will be established in Q1 2025/26, Indicator leads will provide an update to the work plan. Implement will occur Q2 - Q4 2025/26.	% Uptake and execution of identified methods. Indicator leads will provide and update to the work plan in Q1	100% uptake and execution of identified methods.	

Change Idea #3	Increase the capacity to facilitate general psychiatry consultations and brief treatment.		
Methods	Process measures	Target for process measure	Comments
Methods will be established in Q1 2025/26, Indicator leads will provide an update to the work plan. Implement will occur Q2 - Q4 2025/26.	% uptake and execution of identified methods. Indicator leads will provide and update to the work plan in Q1	100% uptake and execution of identified methods.	

Measure - Dimension: Timely

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Reduce rates of potentially avoidable emergency department (ED) visits by 5% for long term care residents displaying symptoms of delirium: (Royal Ottawa Place)	C	% / LTC home residents	In house data collection / Quaterly	CB	CB	5% reduction as compared to 2024-25 ED visit rates for LTC residents displaying symptoms of delirium. This will support ED capacity and hospitals bed availability and access for patients within the larger Ottawa area.	Nurse Led outreach team (NLOT),, Behavioural Supports Ontario (BSO)

Change Ideas

Change Idea #1 Increase utilization of Nurse practitioner from NLOT			
Methods	Process measures	Target for process measure	Comments
1. Develop and algorithm for a nursing referral pathway to involving the NP 2. Monthly meeting with NP and LTC team to review all ED transfers in the previous month and evaluate for appropriateness and make corrective action plans if necessary	1. Number of referrals to NP for in the month 2. Meeting will occur each month.	100% of nurses will contact the NP for assessment of a resident prior to sending out a resident for a symptom of delirium – (during NP working hours) on a monthly basis.	

Change Idea #2 Increase early interventions to prevent delirium			
Methods	Process measures	Target for process measure	Comments
1. Provide training to nursing staff on early interventions and warning signs 2. increase utilization of resident rounding to target early interventions ie: anticipating resident needs, offering fluid, adherence of toileting schedules 3. Add to unit shift to shift report and discuss in unit huddles any resident changes from baseline for immediate follow up	1.% of nursing staff to complete training by end of Q1 2. % of staff to document on rounding by end of Q1 3. % of resident who are sent to ER for delirium in that month will have been identified in unit huddles prior.	1. 80% of nursing staff to complete training by end of Q1 2. 80% of staff to document on rounding by end of Q1 3. 100% of resident who are sent to ER for delirium in that month will have been identified in unit huddles prior.	

Change Idea #3 Investigate Best Practice tools for early intervention to prevent delirium			
Methods	Process measures	Target for process measure	Comments
Research early intervention tools including but not limited to the Preview ED tool and the CAM (confusion assessment method for delirium)	Tools will be investigated by end of Q2 to determine if feasible for our setting.	Tools will be investigated by end of Q2 to determine if feasible for our setting.	

Equity

Measure - Dimension: Equitable

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% of all staff who have completed EDI training and respond yes to “I will make changes to support EDI at the Royal as a result of this training – yes or no”. Target 80%.	C	% / Staff	In house data collection / Quaterly	CB	CB	Achieving a 80% target This will help Improve EDI capacity & knowledge and & integration at the Royal. This will also help strengthen and support a culturally safe care and work environment.	

Change Ideas

Change Idea #1 Optimize EDI training material uptake through the evaluation of staff identified adoption of EDI supportive actions and behaviours post training.

Methods	Process measures	Target for process measure	Comments
Enhance the mandatory PALMS EDI training material to include an evaluation component targeting staff impact and adoption. This will include the question “I will make changes to support EDI at the Royal as a result of this training – yes or no”. If staff respond "No" and additional open test question will b provided for staff to provide specific feedback on how to enhance the training and/or to share barriers to optimizing EDI approaches to care and collaboration at the Royal.	1.Integrate EDI training evaluation questions within all required training material 2.Integrate EDI training evaluation feedback to improve training materials by Q3 2025/26.	1. 100% completion Q1 2025/26 2. 95% completion Q4 2025/26	

Experience

Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Inpatient report of receiving adequate information about their health and their care at discharge, target: 79% (5% increase from 2024-25 OPOC question 29)	C	% / All inpatients	In house data collection / Monthly	74.00	79.00	79% is a 5% increase from 2024-25 OPOC question 29 results, this will improve patient and family experience.	meditech cluster

Change Ideas

Change Idea #1 Implement a standardized and evidence based tool to optimize patient and family member discharge teaching and information exchanged.

Methods	Process measures	Target for process measure	Comments
Implementation of a Patient Orientated Discharge Summary	1. Completed all required meditech enhancement and workflow mapping, 2. Complete all required staff education and subsequent go live of the PODS in all inpatient units. PODs will be implemented using a rolling method and will Go Live first in the Schizophrenia Inpatient unit. 3. Evaluate and refine the tool based on patient and staff feedback and performance	1. 100% completion Q2 2025/26 2. 100% completion by Q3 2024 3. 100% completion by Q4 2025/26	

Change Idea #2	Optimizing post discharge outreach to patients to provide additional opportunities to discuss are review discharge teaching and to answer patient and/or family member questions.		
Methods	Process measures	Target for process measure	Comments
The process and workflow to support the outreach and completion of team phone calls to patients within 72 hours of discharge will be identified in Q1 2025/26 by the indicator leads.	To be completed and ready for go live Q2 2025/26	80% completion Q4 2025/26, this include staff training and supporting materials and resources. This is a reasonable year 1 process measure target. An evaluation question will be added to the patient experience survey shared post discharge to capture the % of patient who received a phone call.	

Safety

Measure - Dimension: Safe

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of workplace violence incidents resulting in lost time injury	O	% / Staff	Local data collection / Most recent consecutive 12-month period	0.86	0.82	0.82 is a 5% reduction from the 2024/25 average rate This rate reflects a commitment to continue to advance patient and staff safety.	

Change Ideas

Change Idea #1 Develop and Implement a Code White taskforce enhancements

Methods	Process measures	Target for process measure	Comments
Enhancements to be identified in Q1 2025/26. Details of enhancements to be added to the work plan once identified by the taskforce and co-chairs.	Identification and adoption of Code White Taskforce enhancements	95% adoption of all Code White Taskforce enhancements by Q4 2025-26.	

Change Idea #2 Expansion of access to seclusion rooms – select inpatient units

Methods	Process measures	Target for process measure	Comments
Procure funding & construction resources to advance the construction of seclusions rooms at the Royal Ottawa Mental Health Centre (ROMHC). Construction plans and a comprehensive proposal for construction of seclusion rooms at this site have been submitted to the Senior Leadership team in 2024/25.	Release of the funding required to execute the construction of seclusion rooms at the ROMHC site, securement of a construction contract to complete the build.	100% release of required funds, securement of a construction contract for all build components.	

Measure - Dimension: Safe

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Implementation of patient, client and resident armbands to strengthen positive patient identification, target: 95%	C	% / All inpatients	Local data collection / Quarterly	CB	CB	A 95% rate will support patient safety and is an achievable target. in year one of this imitative. This will strengthen patient safety.	

Change Ideas

Change Idea #1 Implementation of patient, client and resident armbands

Methods	Process measures	Target for process measure	Comments
1. Procure & execute required hardware and software / Meditec enhancements to generate armbands 2. Establish an armband application process & oversight model 3. Establish & implement sustainability audits and interventions as indicated	1. To be completed and ready for go live Q2 2025/26 2. To be completed and ready for go live Q2 2025/26 3. To go live in parallel to the armband application process & oversight model launch in Q2 2025/26	1. 100% completion Q2 2025/26 2. 100% completion Q2 2025/26 3. 100% All inpatient units armband audits completed by Q3 2025, target rate 75% armbands in place. 100% all in scope clinical treatment areas (inpatient and outpatient) audited, target rate 95% armbands in place.	