Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 27, 2023

Ontario Health

OVERVIEW

The Royal is one of Canada's foremost mental health care, teaching, and research hospitals and 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, we are guided by innovation and a passionate commitment to collaboration, honesty, integrity, and respect. We are a hospital without walls – meeting people where they are. Through partnerships with clients, families, colleagues and community partners, our mission is to transform the lives of people living with complex mental health and substance use needs – today, and tomorrow.

During these challenging times we remain committed to our desire to bring access, hope, and new possibilities to clients and families with mental health and addictions needs across the region and beyond. In fact, Access, Hope and New Possibilities is the title given to The Royal's strategic plan, which was created in 2020-2021. The strategy is a roadmap that will shape the future of The Royal and our community for many years to come and was developed in consultation with a broad group of people, including clients and families, community partners, physicians, and staff.

The following strategic priorities guide the work of the organization:

1. Innovate and shape care to client and family needs
2. Advance specialized care
3. Connect care and services for a more accessible system
4. Integrate research, education, practice, and lived expertise to improve client and family-oriented outcomes and experiences

5. Advocate and partner for systemic equity

The Quality Improvement Plan (QIP) is key document for the organization as it helps us to define and drive forward improvements in all aspects of our organization, ultimately helping us achieve our strategic goals. It is developed through consultations with our staff, leaders, clients/families, and our Board of Trustees. 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. However, indicators and quality improvement projects for The Royal and ROP are reported separately within one QIP document to ensure clear and appropriate oversight of work undertaken.

PATIENT/CLIENT/RESIDENT ENGAGEMENT AND PARTNERING

At the Royal, client and family involvement is embedded in the work that we do. The QIP is designed each year by our organizational Quality Committee before it is escalated for final approval. Both a client and a family representative are members of our Quality Committee and are thus integral members in the QIP development and refinement process. Additionally, client and family feedback and experience data is often used in the QIP indicator selection process.

Once indicators are approved by the Senior Management Team (SMT) & The Board, movement towards the target is achieved through both organizational and program specific approaches. At the program-level, quality improvement teams meet monthly to discuss their own specific QIP data. Clients and families are active members of those teams, helping programs to create action plans to address any indicators they need to improve on. At the organizational level, certain indicators are selected for their specific focus on clients. For example, the indicator focusing on the use of the Recovery Plan of Care. This multi-disciplinary tool puts clients at the center of their care and allows clients and care teams to shape care plans based on the goals of the client. Clients and their care teams continually check in on those goals to ensure that the care provided is helping the client find success in their recovery as they work towards discharge.

The Royal has been actively working to co-design many elements of care and our hospital. One element that we are particularly excited about is the Client & Family Resource Hub. The idea for the Resource Hub came directly from and was co-designed with client and family advisors at The Royal. A project manager was hired to provide an implementation plan that will be completed by March 31, 2023. The Hub will be a place for clients, families and staff of The Royal to share and receive information and resources. The physical and virtual Hub will be assisted by trained volunteers.

A multiyear project is being launched in the 2023/2024 fiscal year which aims to improve the meaningfulness and timeliness of client experience data collection & usage. For the first phase of this project, which will be carried out in 2023/2024, the aim is to provide recommendations for an improved process for capturing client experience data which will inform the future phases of this work.
This fiscal year, the project team will be:
i. Completing an environmental scan of the current state

ii. Gathering feedback from key stakeholders on existing and new methodologies for collecting client feedback
iii. Determining a set of foundational questions that can be used across the organization
iv. Determining processes (which tool, how data will be stored and analyzed, etc.)
v. Determining an area to pilot the new process

PROVIDER EXPERIENCE

The Royal launched a virtual wellness series called "Therapeutic Thursdays" over lunch-hours where we focused on different aspects of wellness and provided tools for self-development. These sessions were hosted by our Healthy Workplace Committee and held over Zoom throughout 2022, recorded and posted on our internal intranet for staff to access at their convenience if unable to attend the sessions live. We have also provided Mental Health First Aid to our staff on an on-going basis as well as Livingworks A.S.I.S.T. workshops- these trainings are available to all staff, both front-line and those in administrative/support roles. Our Peer Support team provides 1:1 support to staff as well as group support sessions in instances where there has been a critical event or loss affecting a unit. We have also provided therapy animal drop-in visits weekly for staff who benefit from interacting with animals.

We offer a strong benefits program to all employees and they have access to a comprehensive Employee and Family Assistance program through Lifeworks. This EFAP provides a multitude of online tools and tutorials as well as virtual, telephone and in-person confidential, professional support, with a 24-7 Care Access Centre.

The Royal has also partnered with a company called Workforce-Edge to review front-line patient care schedules for job satisfaction purposes and to review our scheduling processes and protocols to ensure that staff know well in advance when they will be working so they can plan their lives outside of the work environment. This work included an employee survey focused on scheduling, interviews with union leadership, focus group sessions with leaders and scheduling office staff. Workforce-Edge has made recommendations to improve employee engagement, satisfaction and retention. The Royal will be focusing, among other areas, on implementing a superior master schedule in at least one service area this year. Current master schedules vary in predictability and do not always promote work-life balance. The superior master schedule will aim to improve staff wellness and retention by promoting more consecutive days off, form more attractive FTE positions and create relief float positions to promote service area familiarity.

Our clinicians have also provided extensive feedback on our Recovery Plan of Care (RPOC) which led to the RPOC Optimization project. The project aims to optimize this tool towards a more clinically relevant document based on the improvement recommendations. Significant changes to the (RPOC) are underway with a large component of this work scheduled for 2023/2024.

WORKPLACE VIOLENCE PREVENTION

Workplace Violence Prevention (WVP) is one of the core priorities The Royal has enshrined in its strategic plan to protect staff from increased risk of injury during care provision. Given this, The Royal's organizational culture focuses on increasing incident reporting and workplace violence prevention, and to achieve this laudable objective, the SMT stands shoulder to shoulder with all applicable

stakeholders to build a strong incident reporting culture while also working to control violence and incivility in our work environment, to safeguard staff safety and to improve patient care. Providing a safe work environment for staff, patients, visitors, and clients is fundamental to the smooth operation of care services at The Royal. In view of this, our CEO leads and champions the WVP Committee's initiatives.

Corporate WVP goals, objectives, and targets are enshrined in the strategic plan to promote continuous monitoring and tracking. WVP goals and objectives are reviewed regularly every quarter by the Quality Board to ensure the organization meets and attains its targets. The Occupational Health and Safety Services (OHSS) Department and the WVP Committee continually embark on departmental risk assessments and gap analyses to effect compliance with standards and regulatory requirements. The Royal has developed and implemented standardized processes to identify manage and control situational risk factors and triggers to promote a strong safety and reporting culture within the organization. In addition to above, The Royal has implemented supplementary tools across the organization to control violence in our work environment.

Over the past several years, The Royal has improved its reporting culture while also significantly reducing WPV resulting in critical and lost time injuries. For the 2023/2024 fiscal year, OHSS has developed the following new strategies for implementation to further reduce risks, comply with provincial regulatory requirements, and to improve staff safety and reporting on our premises:
i. Evaluate and enhance critical event operational debriefing methods to avert the recurrence of the same incidents.
ii. Develop, monitor, and track new WVP indicators and targets regularly to reduce lost time incidents.
iii. Explore the feasibility of establishing The Royal Trauma Incident Support Team (TIST)to provide trauma-informed debriefing to impacted staff.
iv. Work collaboratively with the Joint Health and Safety Committee (JHSC), WVPC, and other stakeholders to develop a user-friendly navigation tool to guide injured staff as to how to access WSIB compensation and rehabilitation support.
v. Provide peer-support team members with appropriate training and education for them to be able to provide this service adequately.
vi. Implement action items on gap analysis concluded on WVP in Healthcare Leadership Table 23 Recommendations.
vii. Improve staff readiness and response to code white situations via specialized training.

PATIENT SAFETY

Learning from incidents occur at different instances within our organization. At a program level, we encourage incidents to be discussed at safety huddles and case conferences.

The more recurrent type of incidents are discussed within our committees and working groups, such as the Safe Handling Committee that provide oversight on fall trends. The Safe Medication Working Group has also recently implemented a high alert medication review process to standardized reviews of incidents involving high alert medication. The Workplace Violence Prevention committee provides oversight onto incidents involving violent behaviours.

All serious to critical incidents undergo a structured incident analysis process and are discussed within our Incident Review Committee, composed of Senior Leadership representatives. Patients and families are involved throughout the incident review process and can contribute to the identification of solutions to prevent incident recurrence. Their perspective is included within the incident analysis process. They are also able to report any patient safety concerns through our family relations processes.

In attempt to prevent incident recurrence and sharing lessons learned, we hold monthly incident reviews with managers to facilitate conversation with regards to incident trending and lessons learned. Exploring ways to enhance safety culture has been an on going topic during those meetings. This allows managers to provide feedback to their team and engage in discussions about patient safety. We are also currently reviewing how our incident reporting system could provide feedback to incident reporters in order to improve adherence to reporting and provide quicker responses.

Finally, a quarterly Corporate Patient Safety report is shared within the organization to reflect patient safety initiatives and learning through that quarter.

HEALTH EQUITY

Culturally safe and gender affirming care practices are critical to The Royal Ottawa Health Care Group in serving our clients and families. Both “Advocate and partner for systemic equity” and “Innovate and shape care to client and family needs” are zones in our Strategic Plan entitled, "Co-Creating Access, Hope and New Possibilities." We are also developing a client and family-oriented research framework in line with CIHR's POR strategy and in partnership with the Ontario SPOR SUPPORT Unit (OSSU); this framework belongs in our strategic zone "Integrate care, research, education and lived expertise". Our efforts to bring our strategy to life, include refining our understanding of the clients, families and communities we serve by further standardizing data entry and enhancing measurement of variables such as ethnicity and gender identities.

Work is underway to partner with stakeholders, clients and families to assess needs and recommend updates to the Electronic Health Record to better incorporate improved Equity, Diversity, Inclusion, and Indigeneity (EDII) indicators. The Royal is also partnering with AccessMHA, a referral source to The Royal, that comprehensively collects this information, to gain an improved understanding of the gender identity and ethnicity of our clients.

The Royal has also hosted a one hour webinar and panel discussion, "Under the Lens: Mental Health & Housing," to further the conversation on the need for housing equity as a foundational requirement of mental health. We are also in the midst of designing and implementing an organizational EDII Needs Analysis, which will draw upon the perspectives of client and family councils, alongside staff, to identify gaps, challenges and opportunities for training, education, awareness, processes and systems change.

EXECUTIVE COMPENSATION

The Royal has a performance-based compensation plan in place for the Senior Management Team which includes: the Chief Executive Officer; Chief of Staff and Psychiatrist-in-Chief; Chief Operating Officer and Chief Financial Officer; Vice President, Professional Practice and Chief Nursing Executive; Vice President, Patient Care Services and Community Mental Health; Vice President of Innovation and Transformation; Vice President of Research (President of the IMHR).

Accountability for the execution of both the annual QIP and the Strategic Plan are delegated to the Chief Executive Officer and Chief of Staff from the Board of Trustees. The plans are reviewed, approved and monitored by the Board of Trustees through performance evaluations of the Chief Executive Officer and Chief of Staff which is cascaded to the parties listed above. It is the sum of all objectives in these plans that determine the performance pay component of The Royal's Executives. As per Regulation 304/6 of the Broader Public Sector Executive Compensation Act, 2014 (BPSECA), The Royal developed an Executive Compensation Framework, of which 25% of the performance-based pay is allocated to the initiatives under the QIP.

CONTACT INFORMATION

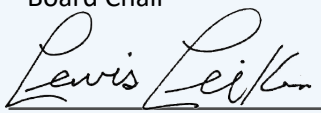
Dr. Gail Beck
Interim Psychiatrist-in-Chief & Chief of Staff
Gail.Beck@theroyal.ca

SIGN-OFF

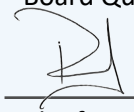
It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan on March 27, 2023

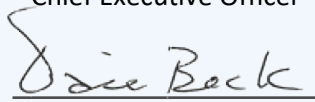
Board Chair



Board Quality Committee Chair



Chief Executive Officer



Interim Chief of Staff

Other leadership as appropriate

Theme I: Timely and Efficient Transitions

Measure

Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Improve transitions in care as measured by the % of Psycho-Social Assessments completed within 21 days of admission (applies to clients with inpatient stays greater than 21 days only)	C	% / All inpatients	In house data collection / April 1, 2023 - March 31, 2024	49.00	75.00	HIMS group indicator tracking the percentage of clients who have a psycho-social assessment completed within 21 days of an admission which helps to guide and inform the treatment plan and care provided. Benefits of this process include that client goals are identified early (best practice is for discharge planning to begin at admission so barriers to discharge are identified early in the stay this facilitates this) and that valuable information is gathered which can be disseminated early to the multi-disciplinary team. The data used to identify a baseline and determine our target at the beginning of the 2022 fiscal year was inaccurate and was fixed to reflect a more clinically relevant current state in Q3 of the 2022/23 fiscal year. Examining current workflow and documentation accountability for social workers will be a key priority over the next fiscal.	

Change Ideas

Change Idea #1	Ensure that all new social workers are oriented to the expectations for this work and to help ensure that all psycho-social assessments are completed within 21 days of an admission.		
Methods	Process measures	Target for process measure	Comments
Data will be tracked by the social work leads in both the Ottawa and Brockville sites, with support from Human Resources to ensure all new hires are accounted for.	% of new social workers who are educated on this standard within two weeks of starting their role	The target is 100%	

Change Idea #2	Examine the current workflow associated with the completion of the psycho-social assessment and address any barriers.		
Methods	Process measures	Target for process measure	Comments
TBC	TBC	TBC	

Theme II: Service Excellence

Measure

Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Improve the client experience measurement process.	C	Other / Other	Other / April 1, 2023 - Mar 31, 2024	0.00	100.00	This work has been identified as a multi-year project. This first year will involve the exploratory phase of the project with the aim of being able to define a clear process for improved capturing of client experience data in future phases.	

Change Ideas

Change Idea #1 Environmental scan of the current state.

Methods	Process measures	Target for process measure	Comments
Conduct an environmental scan of current practices.			

Change Idea #2 Gather input on existing & new methodologies for collecting client feedback.

Methods	Process measures	Target for process measure	Comments
Focus groups/surveys			

Change Idea #3 Determine a set of foundational questions that can be used across the organization.

Methods	Process measures	Target for process measure	Comments
Environmental scan, feedback gathering, comparative analysis.			

Change Idea #4 Determine processes (specific tool to be used, how data will be stored and analyzed)			
Methods	Process measures	Target for process measure	Comments

Change Idea #5 Identify a location to pilot the new process.			
Methods	Process measures	Target for process measure	Comments

Measure

Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
To improve staff wellness and retention by implementing a superior master schedule in at least one service area by March 31, 2024.	C	Other / Other	Other / April 1, 2023 - Mar 31, 2024	0.00	100.00	Implementation of a superior master schedule in at least one service area of the organization is justified. This implementation will help to inform future training requirements and the spread of this initiative across the organization.	

Change Ideas

Change Idea #1	Create optimized master schedules that promote more consecutive days off for staff		
Methods	Process measures	Target for process measure	Comments

Change Idea #2	Consolidate 0.2 and 0.4 FTE to a minimum of 0.6 FTE positions for more attractive FTEs for recruitment and retention purposes		
Methods	Process measures	Target for process measure	Comments

Change Idea #3	Create relief float positions that are embedded in the master schedule that are dedicated to only a few service areas to promote familiarity with the services that require coverage		
Methods	Process measures	Target for process measure	Comments

Change Idea #4	Train managers to create optimized superior master schedules that can be adopted organization wide.		
Methods	Process measures	Target for process measure	Comments

Theme III: Safe and Effective Care

Measure

Dimension: Effective

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Reduce the percentage of Long Term Care (LTC) residents who experience internally acquired skin breakdown (stage 1 through 4 pressure injuries) (Royal Ottawa Place)	C	% / LTC home residents	In house data, interRAI survey / April 1, 2023-March 31, 2024	10.00	6.00	Six percent is the provincial benchmark for skin breakdowns. This is in line with the guidelines of the Registered Nurses Association of Ontario.	

Change Ideas

Change Idea #1 Unit registered and LTC float staff educated on the foundations of wound care

Methods	Process measures	Target for process measure	Comments
Training will be done in person. Training will be provided by the nurse manager. Attendance and completion data will be collected by the nurse manager at each training session.	Percentage of registered staff educated on the foundations of wound care	100% of unit registered and LTC float staff	Work on this indicator is part of The Royal's application to be a Best Practice Spotlight Organization with the RNAO. This is in response to the aging population that our LTC home is experiencing. Most, if not all, of our recent admissions have been crisis admissions who have been in hospital for sometimes years who have significant wounds.

Change Idea #2 Incorporate skin and wound care education within the incontinence program with the Personal Care Attendants (PCAs).

Methods	Process measures	Target for process measure	Comments
Data will be collected via manual audit process by the PCA incontinence champion.	Ensuring that all PCAs are using proper products for incontinence.	100%	Recently changed the incontinence products due to a vendor change, so would like to ensure that only new products are being used.

Change Idea #3 Ensure that those with skin breakdown are referred to the dietitian and provided with dietary interventions to assist.

Methods	Process measures	Target for process measure	Comments
Audit data via Point Click Care	Percentage of residents with a skin breakdown that are referred to a dietitian	100% of residents with a skin breakdown are referred to a dietitian	This is line with skin breakdown best practices to have a dietitian involved, and also a component of our LTC regulations.

Measure

Dimension: Effective

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Medication Reconciliation in Ambulatory Care: Percentage of medication reconciliation completed in ambulatory care as measured by the % of Best Possible Home Medication list confirmed by attending physician (all outpatient programs)	C	% / Mental health patients	In house data collection / April 1, 2023 - March 31, 2024	80.00	90.00	Expansion of the indicator to all OP programs at the Royal. This target is in alignment with the ongoing work and improvement that occurred in 2022/23 on medication reconciliation in ambulatory care.	

Change Ideas

Change Idea #1 Ensure that the Best Possible Medication History (BPMH) is being completed by pharmacy techs.

Methods	Process measures	Target for process measure	Comments
Dedicate pharmacy tech resources for all outpatient programs.	Percentage of BPMH completed by pharmacy techs.	90%	

Change Idea #2 Individualized physician reports be made available for all outpatient programs.

Methods	Process measures	Target for process measure	Comments
Work with Data & Analytics to expand the current dashboard to include all programs in their med. rec. dashboard so that individual physicians can see their rate of confirmation of the BPMH.	% of outpatient programs where physician reports are available.	100%	

Measure

Dimension: Effective

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Improve client centered care as measured by the percentage of inpatients with a Clinical Assessment Protocol (CAPS) from the Recovery Plan of Care (RPOC) tool	C	% / All inpatients	In house data collection / April 1, 2023 - March 31, 2024	75.00	80.00	HIMS group indicator tracking how often client's care plan are being updated. Care plans should be updated regularly throughout an inpatient stay to track & communicate progress towards recovery. The recovery plan of care tool is a multi-disciplinary tool, which can involve families/SDMs in identifying and tracking progress towards care goals. Aiming to improve on past year's work to ensure the RPOC is regularly updated. This target is in alignment with the ongoing work and improvement that occurred in 2022-2023 on CAPS. An RPOC optimization project is underway which will significantly impact the CAPS section of the RPOC. These changes are intended to support clinicians recommendations for improved documentation in the RPOC to make the section more clinically relevant and more useful.	

Change Ideas

Change Idea #1 Ensure that all inpatients have a Recovery Plan of Care initiated within 72 hours of an admission.			
Methods	Process measures	Target for process measure	Comments
Working with an interdisciplinary working group as well as with program-level quality improvement teams to implement this change idea.	% of inpatients who have a RPOC initiated within 72 hours of an admissions	95%	This indicator will help ensure that the CAPS are updated at least once during each 28 day period. Current rate for this indicator is 85%.

Change Idea #2 Transition the current 19 individual CAPS into 5 domains of care for a more streamlined approach to clinical care plans.			
Methods	Process measures	Target for process measure	Comments
The RPOC Optimization working group along with the HIMS partnership with support from clinical informatics will work on reconfiguring the current RPOC CAPS section build in order to consolidate it into 5 domains of care.	% completion rate for the transition to 5 domains of care for CAPS	100%	This change idea supports clinician feedback on the need for a more streamlined and concise care planning document. Ideally, this will support the improvement of the overall goal of % of CAPS updated every 28 days.

Measure **Dimension:** Effective

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of adults admitted to hospital with a primary diagnosis of schizophrenia who did not respond adequately to treatment with at least two antipsychotic medications, and who then receive clozapine	C	% / Other	In house data collection / April 1, 2023 - March 31, 2024	67.00	75.00	Support for physicians to utilize the Health Quality Ontario (HQO) Schizophrenia Treatment Plan should improve this indicator.	

Change Ideas

Change Idea #1 Ensure clients with a primary diagnosis of Schizophrenia have a documented HQO Schizophrenia treatment plan

Methods	Process measures	Target for process measure	Comments
Support physicians by providing them their own client's data on how many have been placed on a treatment plan	Percentage of inpatients with a primary diagnosis of Schizophrenia that have a documented HQO Schizophrenia treatment plan	32%	Current baseline for this measure is 22%

Measure **Dimension:** Safe

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.	P	Count / Worker	Local data collection / Jan 2022–Dec 2022	795.00	794.00	Increasing the target by 20 this year. CSIF completion and incident reporting are going to be part of this year's mandatory training requirement and we hope that will create awareness and the importance of reporting.	

Change Ideas

Change Idea #1 To ensure that code whites are documented in the Client Staff Incident and Feedback (CSIF) system			
Methods	Process measures	Target for process measure	Comments
In house code white stat data	Percent of code whites that have an associated CSIF report completed	60%	FTE=1118 This indicator measures the number of reported workplace violence incidents by hospital workers (as by defined by OHSA) within a 12 month period. While there is no denominator for this indicator, organizations are asked to include the total number of hospital employee full-time equivalents (FTE) in the measures section of the QIP Workplan.

Change Idea #2 Improve documenting follow-ups and corrective action plans of Threats, Assaults, Aggression (TAA) incidents within the CSIF system.			
Methods	Process measures	Target for process measure	Comments
Audits of CSIF reports	Percent of TAA incidents that have documented follow up and corrective action plan completed by the program manager	60%	Minimum standard for follow up documentation is categorized as: At least one Contributing Factor and one item in the Actions Taken section have been completed with a description of what was done as well as the completion of the mini risk assessment.

Indicators for the Quality Improvement Plan 2023/24

Strat. Plan Algn.	Indicator	Rationale	Target	Current Prf.	Accreditation Std. Definition
		IMPROVING CLIENT & FAMILY EXPERIENCE			
	Improve client centered care as measured by the percentage of inpatients with a Clinical Assessment Protocol (CAPS) from the Recovery Plan of Care tool updated within 28 days	HIMS group indicator tracking how often client's care plan are being updated. Care plans should be updated regularly throughout an inpatient stay to track & communicate progress towards recovery. The recovery plan of care tool is a multi-disciplinary tool, which can involve families/SDMs in identifying and tracking progress towards care goals.	80%	75%	**Mental Health Services Standard 3.3:** Care plans are developed in partnership with the client and family based on a comprehensive assessment. **Mental Health Services Standard 3.4.9:** Client progress toward achieving goals and expected results is monitored in partnership with the client, and the information is used to adjust the care plan as necessary.
	Improve the client experience measurement process.	The client experience is at the centre of what drives the Royal's work. Amplifying the client voice and experience features prominently in all aspects of our strategy and receiving regular feedback from clients is one way that we can do that. Over the past few years, there has been a growing recognition that The Royal needs to collect client experience data more frequently than is done with the current OPOC. This indicator is a process measure which would see the organization implement a new survey methodology for client experience over the course of the year. By ensuring that The Royal is able to regularly collect client experience feedback, the organization will then be better positioned to react and respond to feedback.	0%	100%	Client experience and input is a key tenet of Accreditation across all 11 standards that apply to the Royal.

Indicators for the Quality Improvement Plan 2023/24

Strat. Plan Algn.	Indicator	Rationale	Target	Current Prf.	Accreditation Std. Definition
SUPPORTING INNOVATIVE CLINICAL BEST PRACTICES TO ACHIEVE THE BEST POSSIBLE HEALTH OUTCOMES					
	Percentage of medication reconciliation completed in ambulatory care as measured by the % of Best Possible Home Medication list confirmed by attending physician (all outpatient programs).	This measurement focuses on the physician confirming the medication in the E.H.R. BPHM = Best Possible Home Medication list. This formal process aims to ensure accurate and comprehensive medication information is communicated consistently across transitions of care & enables prescribers to make the most appropriate prescribing decisions.	90%	80%	**Ambulatory Care Standard 1.3.5:** Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information at ambulatory care visits when medication management is a major component of care. (REQUIRED ORGANIZATIONAL PRACTICE)
	Improve transitions in care as measured by the percentage of Psycho-Social Assessments completed within 21 days of admission (applies to clients with inpatient stays greater than 21 days only)	HIMS group indicator tracking the percentage of clients who have a psycho-social assessment completed within 21 days of an admission which helps to guide and inform the treatment plan and care provided. Benefits of this process include that client goals are identified early (best practice is for discharge planning to begin at admission so barriers to discharge are identified early in the stay this facilitates this) and that valuable information is gathered which can be disseminated early to the multi-disciplinary team.	75%	49%	**Mental Health Standard 3.3.1:** Each client's physical and psychosocial health is assessed and documented using a holistic approach, in partnership with the client and family. **Mental Health Standard 3.3.3:** The client's physical and psychosocial needs, choices and preferences as identified in the client assessment are used to develop service goals.
	Percentage of adults admitted to hospital with a primary diagnosis of schizophrenia who did not respond adequately to treatment with at least two antipsychotic medications, and who then receive clozapine	Health Quality Ontario (HQO) standards outline for clinicians and patients what quality care looks like. They focus on conditions or topics where there are large variations in how care is delivered, or where there are gaps between the care provided in Ontario and the care patients should receive. The Royal is currently in the process of rolling out the HQO Standards for Schizophrenia which contain 11 quality statements for the care of schizophrenia. The indicator selected for the QIP surrounds the use of clozapine which has been shown to reduce suicidality in patients with schizophrenia. The HQO standards roll out is a priority project for the organization as health care funding models of the future will depend on organizations being able to showcase their achievements in meeting these targets.	75%	67%	**Mental Health Standard 3.4.7:** Treatment protocols are consistently followed to provide the same standard of care in all settings to all clients. **Mental Health Standard 3.4.14:** The impact of each client's medication regime on the client's outcomes and satisfaction is regularly evaluated in partnership with the client and family, and adjustments are made as necessary.

Indicators for the Quality Improvement Plan 2023/24

Strat. Plan Algn.	Indicator	Rationale	Target	Current Prf.	Accreditation Std. Definition
SUPPORTING INNOVATIVE CLINICAL BEST PRACTICES TO ACHIEVE THE BEST POSSIBLE HEALTH OUTCOMES					
	Reduce the percentage of Long Term Care (LTC) residents who experience internally aquired skin breakdown (stage 1 through 4 pressure injuries) (Royal Ottawa Place).	Becoming a Registered Nurses' Association of Ontario (RNAO) Best Practice organization is a goal for Royal Ottawa Place Long Term Care. The program supports LTC homes in adopting evidence-based practices that support systemic and consistent approaches to providing quality care for residents. It ties directly into our strategic pillar of 'innovate and shape care to client and family needs' to help us achieve our five year aim of 'The Royal will achieve top quartile performance in accreditation results and meet or exceed quality targets.' One of the best practice guidelines for being a spotlight organization is ensuring the organization has a strong skin and wound care program in place. Ensuring that our residents do not experience skin breakdown or pressure ulcers is a sign of good clinical care, as these wounds can often develop in to more severe clinical conditions. The target is alignment with the provincial target for this work.	6%	10%	**Long-Term Care Services Standard 2.5.3:** An interprofessional and collaborative approach is used to assess clients who need skin and wound care and provide evidence-informed care that promotes healing and reduces morbidity and mortality. (REQUIRED ORGANIZATIONAL PRACTICE)

Indicators for the Quality Improvement Plan 2023/24

Strat. Plan Algn.	Indicator	Rationale	Target	Current Prf.	Accreditation Std. Definition
		IMPROVING CARE TEAM WELL-BEING			
	Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period	Workplace violence is a known risk when working in health care, particularly in the mental health setting. Increasing workplace violence reporting has been a priority across the province. Although no longer a mandatory indicator from Ontario Health, The Royal is committed to action in supporting our staff when they see violence in the workplace. This work aligns with our strategic pillar of 'innovate and shape care to client and family needs' within objective 2 – 'develop and empower our people as change leaders, collaborators, advocates and strong teams within a mutually supportive respectful environment.'	66/mo	66/mo	**Leadership Standard 4.1.5:** A documented and coordinated approach to prevent workplace violence is implemented. (REQUIRED ORGANIZATIONAL PRACTICE)
	To improve staff wellness and retention by implementing a superior master schedule in at least one service area by March 31, 2024.	Health care organizations globally are experiencing a health human resource challenge. The pandemic has seen health workers retire early, exit the profession, and experience high levels of burn out. Strong health human resources appear in every aspect of our strategy as they are the engine that will help us achieve our strategic aims. Current master schedules vary in predictability as each unit has different cycles for master schedules. Some master schedules do not promote work life balance as employees work several shifts in a row, have one shift off and are back at work the following day. This does not provide for an adequate rest period. In addition due to lack of relief predictability, relief shifts are often staff at overtime. Relief float positions are assigned to all units that require relief with no consistency to one or two units. This can affect client care, relief engagement and productivity due to lack of knowledge and training and orientation on unit protocols, procedures etc.	0%	100%	**Service Excellence Standard 2.3:** Well-being and worklife balance are promoted within the team. **Service Excellence Standard 2.3.1**: The team leadership assigns and reviews the workload of each staff member in a manner that ensures client and staff safety and well-being. **Leadership Standard 3.4:** The organization invests in the recruitment, development, and retention of its human resources. **Leadership Standard 3.4.15:** The organization implements staff retention strategies and regularly evaluates the strategies to improve effectiveness.
		EFFECTIVELY USING RESOURCES			

Contact Information
Alison Middlebro'
Director of Quality and Patient Safety (interim)
alison.middlebro@theroyal.ca