MIND FORWARD BRAIN INJURY SERVICES

# Quality Improvement Plan: 2023-2024

## RATIONALE:

As a means of accountability to the legislation, Excellent Care for All Act (2010,) our Quality Improvement Plan (QIP) helps us document and review our current performance in a variety of areas. With this plan, we will be able to clearly see our targeted areas for improvement and chart our progress.

## PROCEDURES:

Over the course of the fiscal year, Mind Forward will engage in a continual quality improvement process that involves ongoing tracking of quality indicators as well as quarterly activities that analyze the quality of services.

The quarterly activities are carried out in accordance with processes outlined in PROG-16 Audits. Recommendations resulting from each activity will be communicated to the appropriate staff, Service Stream Managers, and Senior Management team members. An audit report will also be produced for each activity for the Mind Forward Board & Senior Management Team outlining agency areas of both strength and improvement.

An annual summary will also be produced with an overall summary of all QIP indicator data, recommendations, and action plans.

# Quality Improvement Plan 2023-2024

## PURPOSE AND SCOPE

A Quality Improvement Plan (QIP) is a documented set of quality commitments made by a health care organization to its patients, clients, residents, staff and community on an annual basis. The goal is to improve quality through focused targets and actions (Health Quality Ontario (HQO), 2022).

QIPs are to be developed by the organization. The Board as well as its Senior Management should ensure they are meeting the targets set out in their QIP. It is expected that the QIP will support performance improvement in the organization to achieve the targets established by the organization. The Ministry is not prescriptive about what targets are to be set within the QIP (HQO, 2022).

The Excellent Care for All Act 2010 and other accountability agreements require all public hospitals, most of the team-based inter-professional primary health care organizations, home and community care support services, and long-term care homes create a Quality Improvement Plan every year. Each organization develops a plan including specific targets and actions that reflect the province's health care improvement priorities, as well as the quality issues that are locally relevant (HQO, 2022).

Although Mind Forward does not fall specifically within one of these mandated organization, we are obligated through our Multi Sector Accountability Agreement (MSAA) that we participate in this annual exercise as part of our commitment to continuous quality improvement and best practice in order to embed a culture of quality in our agency.

As navigating the pandemic was a priority for all healthcare organizations throughout the 2020-2022 period, QIP submissions were put on pause. For 2022-2023, Ontario Health QIP directives continued to be voluntary, as this was seen as a period of recovery and re-evaluation. Furthermore, Ontario Health recommended to not bring previous quality indicators/ measures forward and instead to start fresh with new and relevant plans for the post-pandemic era (HQO, 2022).

Throughout the COVID-19 pandemic, Mind Forward's focus on the health and safety of our clients and staff were paramount. Emerging from the pandemic, as recommended by HQO, Mind Forward's QIP was reassessed in order to determine target indicators across quality, performance, and accountability. As part of this process baseline data was collected and analysed across all quality activities that occurred throughout 2020-2021. Areas for improvement were identified and a QIP was created to monitor these activities.

This report will compare data from 2021-2022 to 2022-2023 to assess if targets were met, areas of strengths, areas for improvement and update targets for the 2023-2024 reporting period.

The scope of the QIP includes a detailed analysis of all quality-based activities throughout the agency, as well as consideration of other data currently tracked that could provide evidence for the quality of work being provided by the agency.

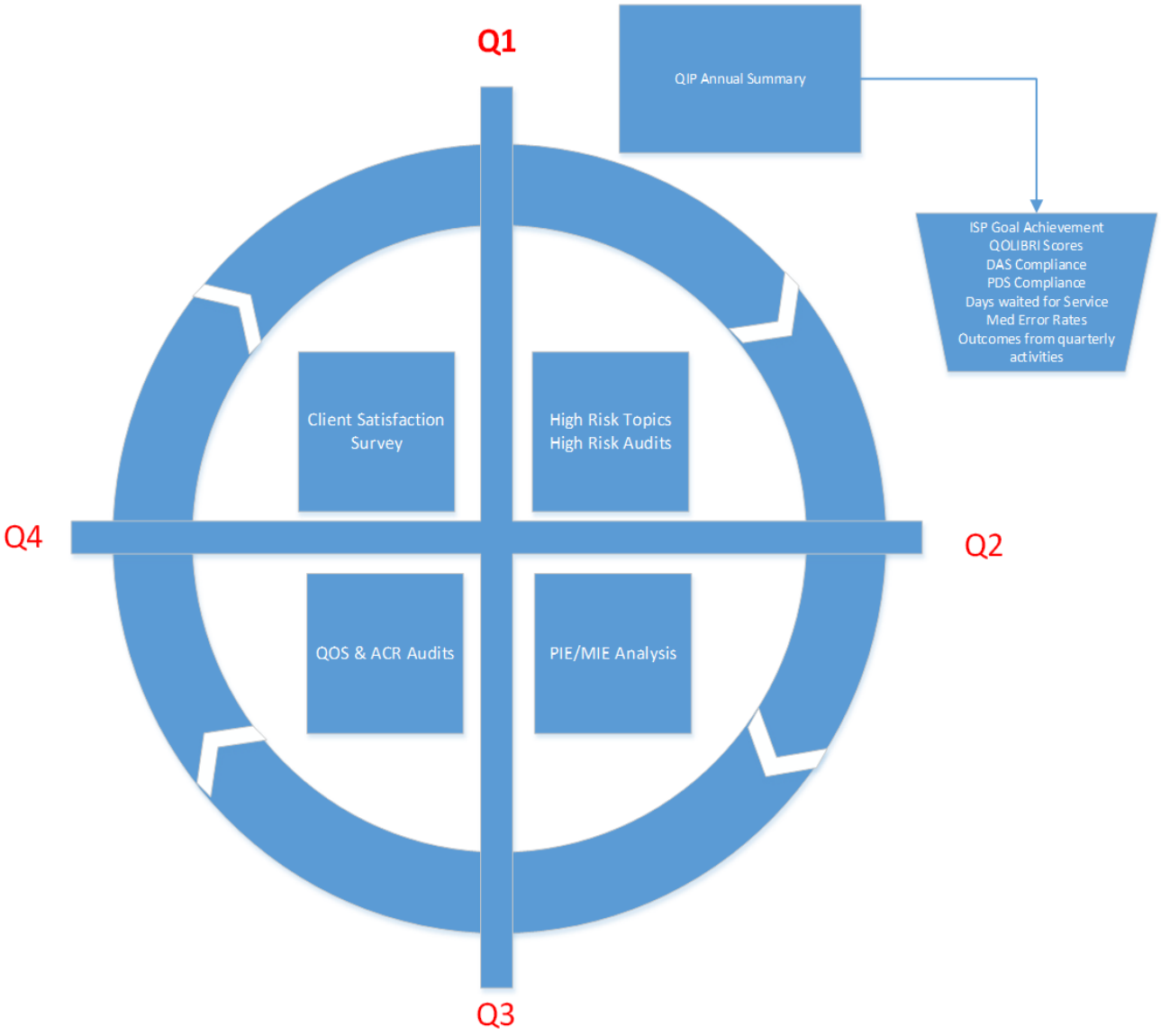
# Quality Improvement Plan 2023-2024

Utilizing the Provincial Quality Framework developed by Health Quality Ontario, Mind Forward quality assessment activities, key performance indicators, and provincial reporting numbers are listed below within the appropriate defining element of quality care. The following categories and data collection points identified are as follows (Table 1):

| Quality Overview | | |
|---|---|---|
| **Quality Element** | **Quality Improvement Focus** | **Measure** |
| **Patient Centered** | Overall Clients Satisfaction of Service and Quality of Life of clients | 1. Client Satisfaction Survey (Overall satisfaction /respect)<br>2. Mayo Portland Adaptability Inventory (MPAI)<br>3. Generalized Anxiety Disorder-7 (GAD 7)<br>4. Patient Health Questionnaire (PHQ-9) |
| **Effective** | Improve overall team performance across Agency Service Stream. | 1. Daily Activity Schedule (DAS) Compliance<br>2. Program Documentation Spreadsheet (PDS) Compliance<br>3. Program Implementation Evaluation (PIE) aggregate data scores<br>4. Individual Service Plan (ISP) Goal Achievement |
| **Timely** | Reduction in wait time from application for service to service initiation | 1. Average day from application to assessment<br>2. Average number of days from approval to service initiation |
| **Safe** | Maintain staff medication error rates at or below provincial benchmark | 1. Maintain or decrease medication error rates<br>2. Administer PIEs as outlined in audit policy<br>3. High Risk Audit Scores |
| | Ensure programming is being implemented as recommended | |
| | Ensure the safety for all clients, staff, and individuals who interact with clients | |

## Annual Schedule for Quality Assurance Activities

The infographic below shows which quarter of the previous fiscal year (2022) each quality activity occurred. It should be noted that moving into 2023-2024 the annual schedule has been changed to better align with service delivery and practices.



## Data

Table 2 below expands on the measures listed above in Table 1. Each measure is identified in bold with a description of the measure, how the measurement is calculated, baseline data from 2021-2022 with comment/ recommendation, and data for 2022-2023. Measure identified in the orange colour reference items that were targeted for improvement in the 2022-2023 QIP and will have further description in Table 3. Measure identified in red are flagged to carry forward into the 2023-2024 QIP as their outcomes are below an acceptable rate.

**Table 2**

| | Satisfactory Score | | Target of 2022-23 QIP | | Flagged for 2023-2024 QIP |
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|---|---|---|---|---|
| **Client Satisfaction Surveys** are part of our commitment to continually seek feedback toward improving our services. | | | | |
| Calculation: Total percentages of clients that either agree or strongly agree to statements about being treated with respect and being satisfied with overall service. | | | | |
| Baseline | Data:<br>-Respected:97%<br>-Overall Satisfaction: 93% | **Comments:**<br>Satisfactory scores- flagged for reliability of data and low number of respondents (n=71). Target summarized in Table3.<br>*See below Q4 data* | 2022 | Data:<br>-Respected: 92%<br>-Overall Satisfaction: 91% |
| **Mayo Portland Adaptability Inventory** is a standardized assessment designed to assist in the evaluation of rehabilitation programs for people with ABI. | | | | |
| Calculation: An average of the aggregate data available in CRMS software. | | | | |
| Baseline | Data:<br>-Ability:46.7<br>-Adjustment: 45.1<br>-Participation: 50.4<br>-Total: 49 | **Comments:**<br>Stable scores, No significant changes to note (must be a change of ≥5 to be considered significant).Continue to monitor. | 2022 | Data:<br>-Ability: 47.7<br>-Adjustment: 44.5<br>-Participation: 51.6<br>-Total:49 |
| **Generalized Anxiety Disorder -7** is useful in primary care and mental health settings as a screening tool and symptom severity measure for the four most common anxiety disorders. | | | | |
| Calculation: An average of the aggregate data available in CRMS software. | | | | |

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| Baseline | Data:<br>-6.2 | Comments:<br>Noted for baseline: monitor | 2022 | Data:<br>-4.9 |
| **Patient Health Questionnaire-9** is a screening instrument that identifies depression and panic disorder amongst clients and assesses their stress and functionality | | | | |
| Calculation: An average of the aggregate data available in CRMS software. | | | | |
| Baseline | Data:<br>-6.88 | Comments:<br>Noted for baseline: monitor | 2022 | Data:<br>-5.14 |
| **Daily Activity Schedule Compliance** measures the accuracy of program implementation for clients within residential setting. | | | | |
| Calculation: The average of March floor observational data. | | | | |
| Baseline | Data:<br>-40% | Comments:<br>Below benchmark- target for QIP | 2022 | Data:<br>-88% |
| **Program Documentation Spreadsheet (PDS) Compliance** evaluates if all clients' clinical documentation and MPAI assessment is current and up-to-date. | | | | |
| Calculation: A PDS compliance score for the agency is calculated for each month to get an average score for the year. | | | | |
| Baseline | Data:<br>-83% | Comments:<br>Satisfactory score with improvement from 2020. Continue to monitor. | 2022 | Data:<br>-81% |
| **Program Implementation Evaluation (PIE)** are clinical audits that assess the consistency of program implementation across all service streams. | | | | |
| Calculation: An average is calculated for all of the aggregate data per service stream and then used to calculate an average for the agency. | | | | |
| Baseline | Data:<br>-88.5% | Comments:<br>Satisfactory Score<br>*See below Q2 data* | 2022 | Data:<br>-89% |
| **Individual Service Plan (ISP) Goal Achievement-** Each client in service has an ISP that captures their goals for the year, this measure evaluates if at least one goal was met from the year. | | | | |
| Calculation: 50 random client files are audited, checked for achievement of at least 1 goal and a percentage is calculated. | | | | |

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| Baseline | Data:<br>-98% | Comments:<br>Satisfactory Score<br>*See below Q4 data* | 2022 | Data:<br>-100% |
| **Days from application to assessment-** Number of days between when a referral is received and the intake assessment meeting is completed with the individual. | | | | |
| Calculation: The duration of days from when an application was received to when the intake assessment was completed is calculated, then divided by the number of applications for the year. | | | | |
| Baseline | Data:<br>-PSIT: 277<br>-AL: 435 | Comments:<br>Below benchmark, target for QIP | 2022 | Data:<br>-PSIT: 160 days<br>-AL: 423 days |
| **Days from approval to service initiation-** The number of days between when an individual is approved for services and when they receive the approved services. | | | | |
| Calculation: The duration of days from when an application was approved to when service started is calculated, then divided by the number of approved applications for the year. | | | | |
| Baseline | Data:<br>-PSIT: 445<br>-AL: 2280 | Comments:<br>Below benchmark- Target for QIP | 2022 | Data:<br>-PSIT: 381 days<br>-AL: 597 days |
| **Medication error rates** | | | | |
| Measurement: The number of medication related incident reports average over the fiscal year. | | | | |
| Baseline | Data:<br>-0.07% | Comments:<br>Satisfactory Score- Below Provincial Benchmark -Flagged for reliability of data/CIR data collection process | 2022 | Data:<br>-0.06% |
| **Administer PIEs as outlined in audit policy** | | | | |
| Measurement: The total number of audits completed in a year are calculated by the total number of audits that should be completed. | | | | |
| Baseline | Data:<br>-34% | Comments:<br>Below benchmark- target for QIP<br>*See below Q2 for summary of data* | 2022 | Data:<br>-68% |
| **HR Audit** evaluates staff's knowledge pertaining to agency's high risk topics and client specific high risk designation | | | | |
| Measurement: Aggregate data is used to calculate an average for each high risk topic then divided by the number of high risk topics. | | | | |

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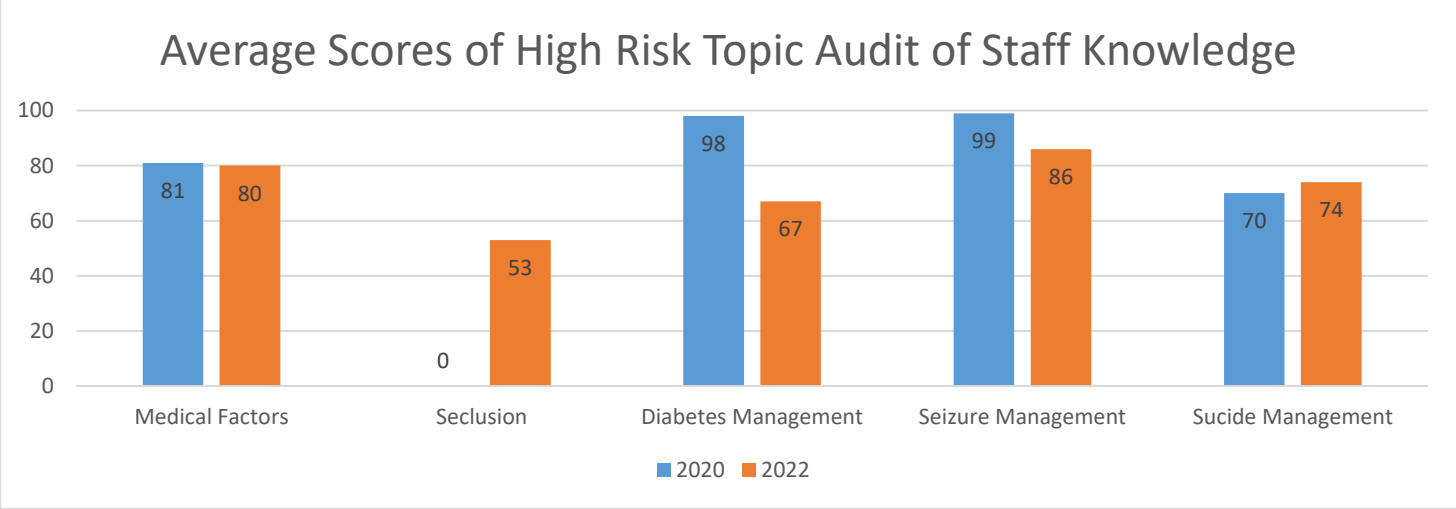
| Baseline | Data:<br>-87.8% | Comments:<br>Satisfactory benchmark-<br>*See Q1 below for summary of data* | 2022 | Data:<br>-72% |

## Summary of Quality Activities by Quarter

### Q1- High Risk Audits

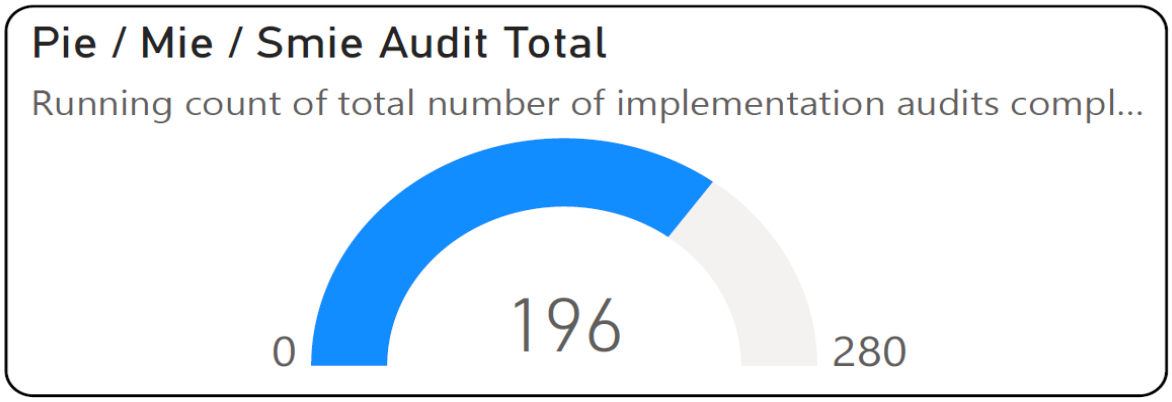


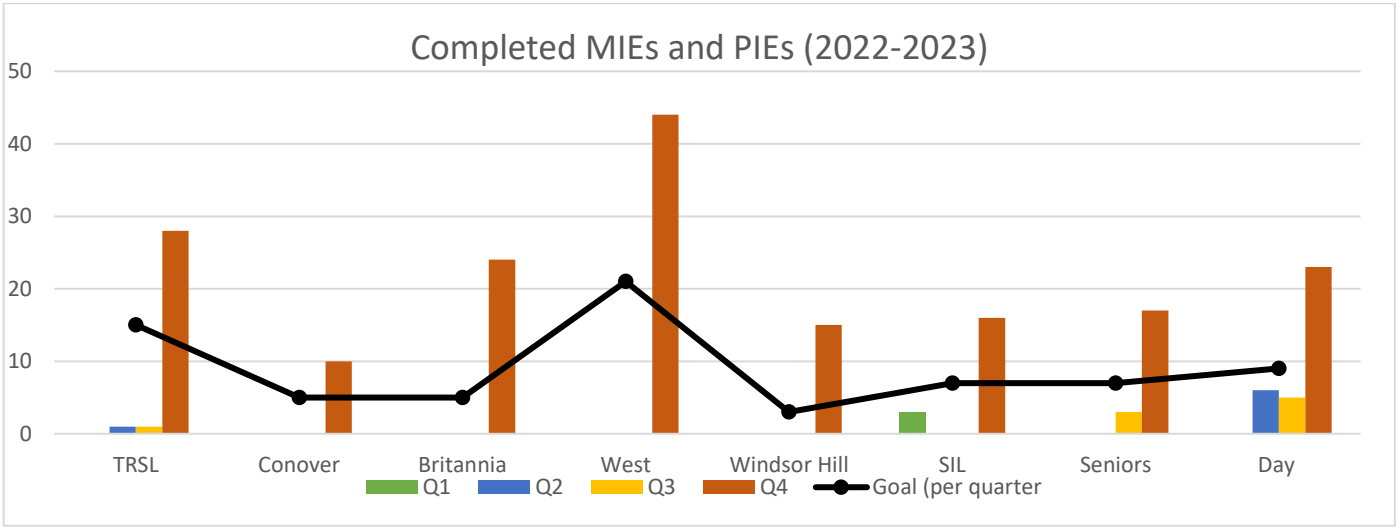

Of note, the schedule for when high risk audits were conducted during the fiscal year was changed which makes it appear that audits were not completed in calendar year 2021, however the activity did occur once per fiscal year.

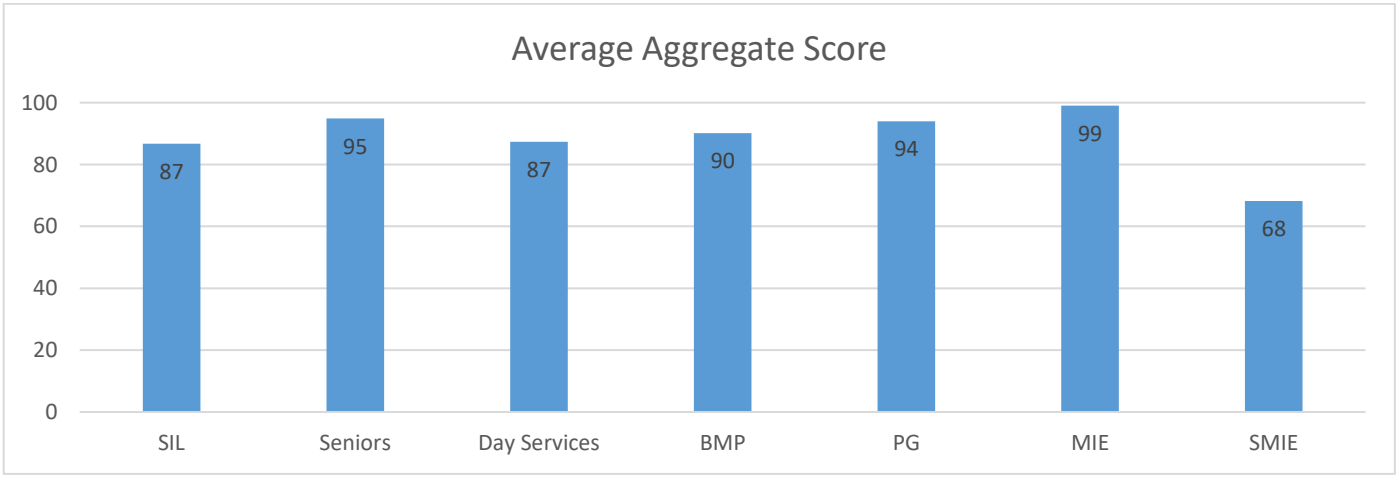
Two other changes to note include a long standing topic related to high risks audits was removed and moved to Human Resources to manage (lift and transfers) a new high risk topic was added to coincide with the addition of a new policy that was issued in 2022, PROG-25 Seclusion. Scores for this new policy knowledge was low, however upon reviewing feedback from staff and the auditors it was noted that the knowledge check was quite detailed and will be amended for next year to accentuate important take-away. Further, the learning management platform (LMS) will be utilized for the high risk topics this year to ensure more staff participation. Current practice involves clinical team members attending team meetings to provide in-service education. However as not all staff attend all team meetings, and therefore many staff miss the refresher training. Although the material is sent out to review, accountability measures are difficult to confirm and therefore the LMS system will provide the platform to ensure a greater staff participation, along with knowledge checks that can confirm comprehension.

## Q2

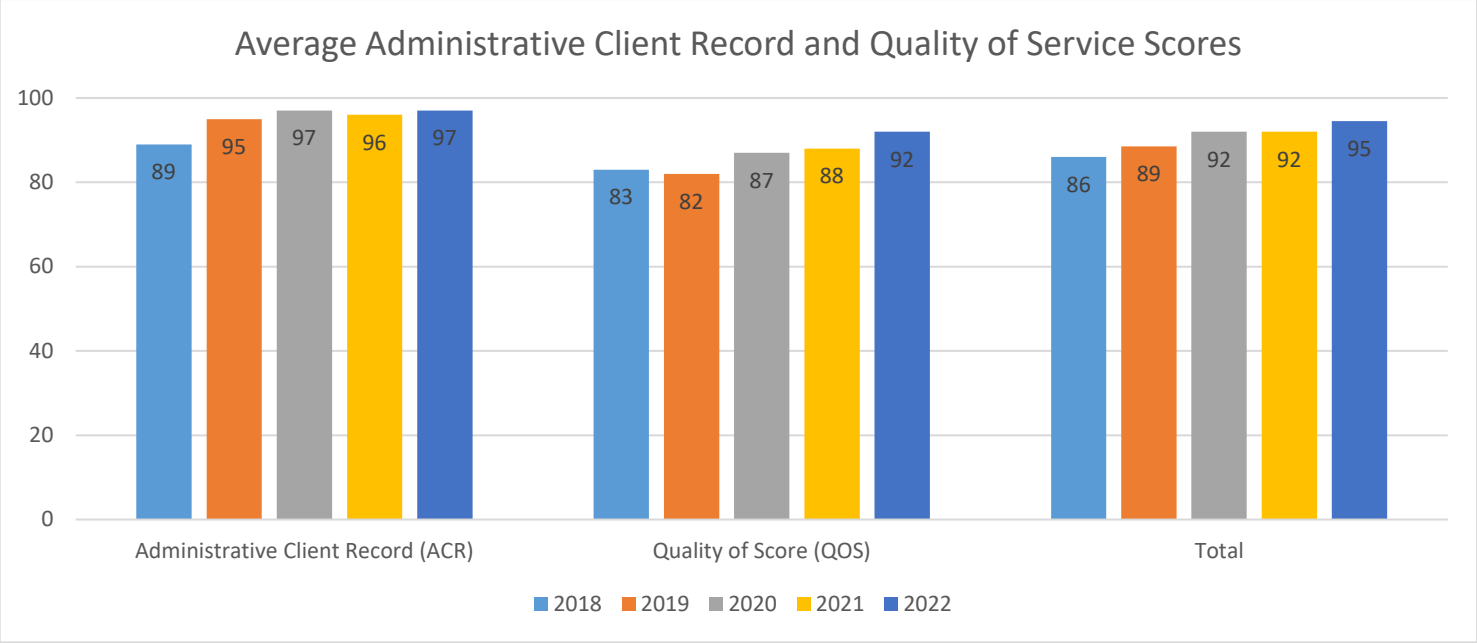
### Program/Medication Implementation Evaluations



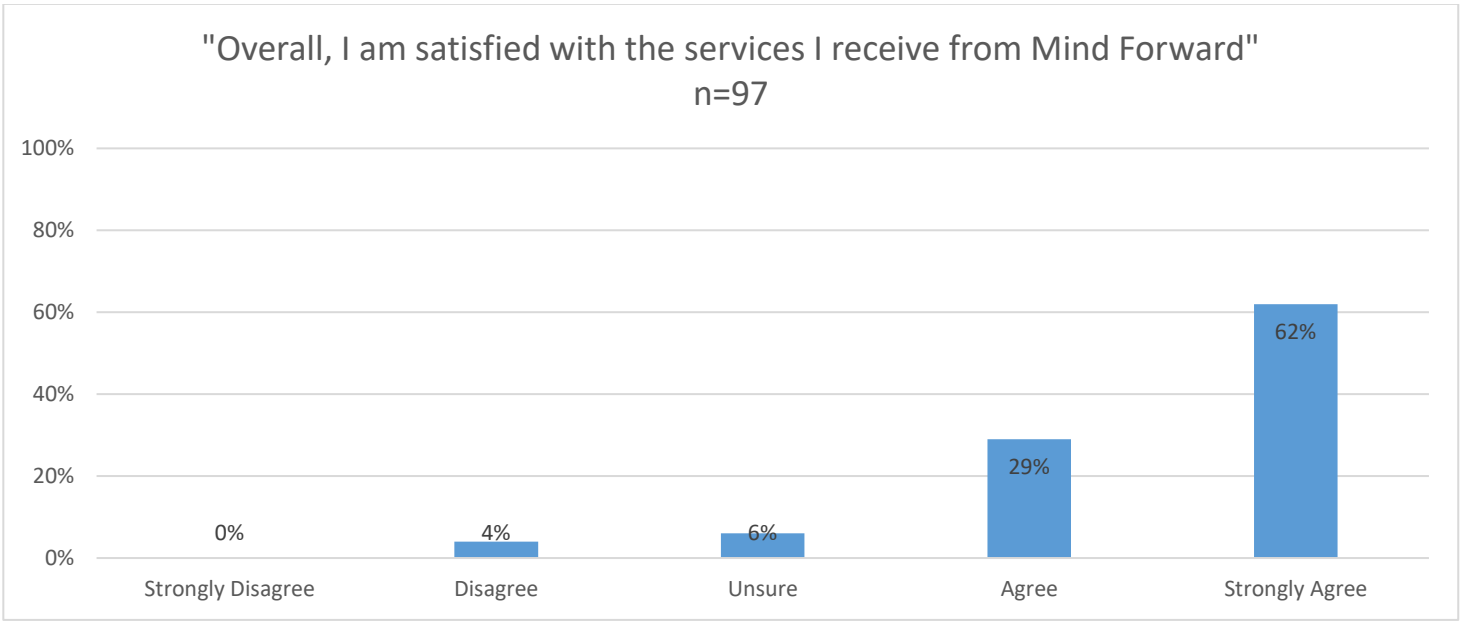



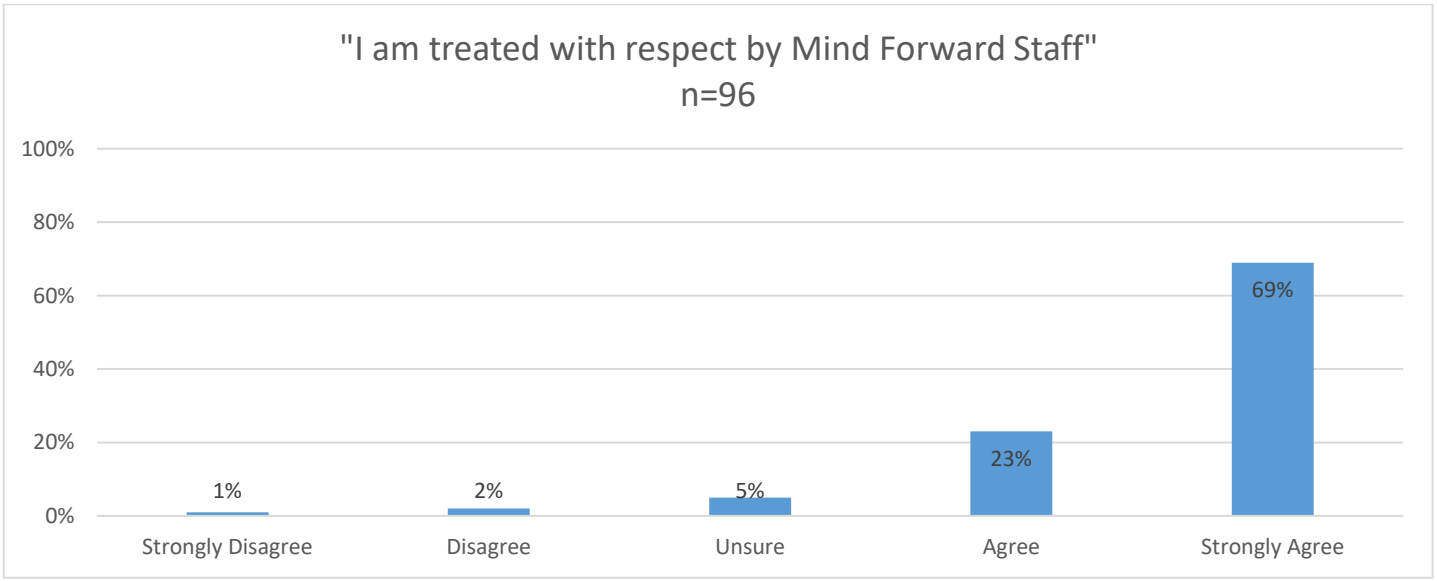
## Q3- Administrative Client Record and Quality of Services Audits




As reported in the ACR & QOS summary report, outcomes from this activity cycle were the best to date since beginning the exercise in 2012.

## Q4-Client Satisfaction Survey




Outcomes for the annual survey remained consistent with previous years. Overall response rates did improve as noted below.

## OUTCOME SUMMARY 2022-2023

| **Client Satisfaction Survey** | | | | | | |
|---|---|---|---|---|---|---|
| Baseline Performance | n= 71<br><br>total client in service 21/22- 438<br><br>16% | Target | n ≥ 100 | Outcome | 100<br><br>↑6%<br><br>19% had errors | Improvement Initiatives:<br>☐Create Quality Committee<br>☒ Develop action plan for committee to engage staff support for filling out surveys (to improve validity); consultation with client advisory committee; virtual and in-person "blitzes"<br>☒ Randomized audit of data quality |
| Target Update: 100 Client Satisfaction Surveys were complete; the target was met.<br>Each survey was looked at individually, if a client had given responses to questions that were not part of the services they receive, those answers were removed from the dataset. The Quality Committee was not created due to lack of interest and instead Day Services Team members along with Senior Staff concentrated efforts on encouraging client participation. Recommendation to continue to target increased participation in the upcoming reporting period. | | | | | | |
| **DAS Adherence at West location** | | | | | | |
| Baseline | 40% | Target | 80% | Outcome | March 88% | ☐ Implement 4 stages of DAS project as outlined in project charter entitled DAS |
| Target Update: DAS Adherence was 88%; the target was met. Criteria to move into final maintenance phase is to reach three consecutive months above 80%. Recommendation to continue to move forward with the initiative to other assisted living sites. | | | | | | |
| **Days Waited for Service: PSIT-** | | | | | | |
| Baseline Performance | -27 (9 months) from application to assessment<br>- 445 (15 months) from approval to service | Target | Reduction of 25% | Outcome | - ↓42%<br>- ↓14%<br>Average decrease of **28%** | ☒ Set Targets & Monitor at Intake Committee Meeting:<br>SI = 5 per Month<br>Intake = 7 per moth<br>☒ Monitor progress at intake committee meeting<br>☐ Formalize discussion of capacity, i.e. understand the numbers of each program<br>☒ Apply for grant funding to increase resources<br>☒ Track benchmarks for clients in-services |

| | | | | | | |
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| Target Update: The wait time from application to assessment was reduced by approximately 42% and the wait time from approval to service initiation was improved by approximately 14%, the target was not met. Capacity continues to be a barrier to service initiation and will continue to be a target for improvement in the upcoming reporting period. | | | | | | |
| **Medication Error Rates Data Entry/Tracking** | | | | | | |
| Baseline Performance | 15 /136 = 11% error rate (Data entry, categorized incorrectly) | Target | 50% reduction in errors in data entry and categorization of data.<br><br>Target of 6% or less.<br><br>-Subjective observation of improvement in efficiency of data analysis and data collection process. | Outcome | 30/144 with errors =20.8%<br>An ↑ 9.8% | ☐ Improve data tracking system and accountability for quality of reportage.<br>☒ Update policy and forms to better define categories. |
| Target Update: A total of 144 recorded client incident reports were analyzed for 2022 fiscal; 30 data entries had errors (categorized incorrectly or missing, SIR instead of CIR, missing detail of incident, etc.). Unfortunately, the error rate increased to 20.8%, up 10% from the previous reporting period. The data tracking spreadsheet was improved subjectively and modified following the analysis. This will continue to be a target for the upcoming period. | | | | | | |
| **PIEs** | | | | | | |
| Baseline Performance | 30% | Target Q1 2023 | Increase to 80% | Outcome | 196/288<br>68% | ☒ Engage leadership team to assess barriers<br>☒ Engage with external consultant to assess and establish process, benchmarks, expectations<br>☒ Start the SMIEs<br>☐ Monitor data more closely over the course of the year and share data with team quarterly<br>☒ Clinical Team to complete set number for each quarter |
| Target Update: Clinical team set numbers for each quarter per service stream; a total of 288 audits were to be completed in one year. A total of 196 audits were completed, the performance improved to 68%, however, the goal was not met. Due to changes in leadership the progress of PIE completion throughout the year was not monitored as planned and therefore this will be moved forward to continue for improvement in the upcoming reporting period. | | | | | | |

## QUALITY IMPROVEMENT PLAN 2023-2024

| Target Indicators | Performance 2022-2023 | Target Q1 2024 | Improvement Initiatives |
|---|---|---|---|
| Client Satisfaction Survey | n= 100<br><br>Closed Fiscal 2022-2023 at 455 client in service = 22% of clients.<br><br>Error rate= 19% | n> 136.5 (↑30%) | ☐ Engage the client advisory group for input and support<br>☐ Add survey to ISP meeting<br>☐ Rebuild the survey so only appropriate questions are asked to service streams |
| DAS Adherence: Activities completed per day West location | ≥80% for 2 consecutive months at West | –Move to maintenance phase at West once 3rd month achieved (continue data probes to assess maintenance)<br>Collect Baseline TRSL<br>–Reach Criterion TRSL<br>–Move to maintenance TRSL | ☐ summary outcomes for pilot at West and determine steps moving forward<br>☐ Create implementation plan for TRSL that is updated with learnings from West<br>☐ Consult with TRSL team to develop appropriate targets for that environment |
| Intake Process: PSIT<br>-Days waited to assessment<br>-Days waited service (SI) | -160 ( 5.3 months)<br>-381 (12.7 months)<br><br>Current client in service= 455<br><br>Number of closed last year 29 | Reduction to 2 months average wait<br>Increase SI per month to 7-8<br><br>Client in service 488 (↑7%)<br>Minimum 62 new clients | Continue Targets:<br>☐ SI = 7 per Month<br>☐ Intake = 7 per month<br>☐ Monitor progress at intake committee meeting<br>☐ Community Managers to determine capacity analysis<br>☐ Track benchmarks for clients in-services |
| CIR/SIR Data Entry Error | 30/144 with errors =20.8%<br>(Data entry, categorized incorrectly) | ≥10% decrease in error rate targeting 5-10% | Improve data tracking system and accountability for quality of reportage.<br>☐ Drop down spreadsheet<br>☐ Checklist for manager re quality<br>☐ Digitized forms to limits errors |
| PIEs | 68%<br>(196/288) | 80% | ☐ Monitor data more closely over the course of the year and share data with team quarterly |

| | | | |
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| -Adhering to policy for number to complete<br>-Improving SMIE scores | Aggregate SMIE score 68% | | ☐ Metrics reviewed in supervisions by Senior Managers to quickly identify barriers and support needs<br>☐ SMIE- more of them; more frequent SM training |
| PDS- Assisted Living | 74% | 85% | ☐ BSM to complete BMPs<br>☐ Clinical Team to complete Assessment Plans and Summaries<br>☐ Quarterly TL Meetings to encourage connection, support and provide opportunity for group mentorship<br>☐ RBT training for professional development of TLs<br>☐ Managers to monitor PDS in individual supervision and create support plans for anything that is out of date longer than 3 months.<br>☐ Senior Managers to monitor PDS for Manager supervision as performance measure<br>☐ Site specific PDS compliance rate |
| Client Data Entry | Baseline TBD | | ☐ Use master data to determine missed data rate (how often not completed by staff)<br>☐ Assess baseline of missed data rates with Teams pilot<br>☐ Create formal process for follow up re missing data<br>☐ Update data taking training for front line staff<br>☐ Continue initiative moving to digital data collection<br>☐ Audit data completion at shift changes |

## SUMMARY

Three of the five targets set in 2022-2023 were achieved, increased number of client survey participation, decrease in numbers of days waitlisted, and DAS adherence. Although improvement was noted for the PIE frequency (38% increase), the

target of 80% was not reached. Finally the rate of errors in data entry for CIR and SIRs increased by almost 10% from the last reporting period. All 5 targets will be brought forward into the new reporting period to continue improvement objectives.

Furthermore the 2023-2024 QIP will add three new targets that have been identified from this past year's ongoing measures that fell below acceptable rates. These are the Assisted Living PDS compliance, staff knowledge scores for high risk topics, and aggregate SMIE outcome scores.

Additionally, a new quality metric will be added to target data collection by front line staff. This measure was identified through by the senior management team as an area for improvement across the agency.

**REPORT COMPLETED BY: Anna Cook, Director of Quality and Clinical Services**

_____ **Date:** May 17, 2023

SIGNATURE

**Approved By: Andrea Paszti, CEO**

Andrea Paszti _____ **Date:** June 16, 2023

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References:

Health Quality Ontario (HQO). February 18, 2022. *Quality Improvement Plans*. https://www.hqontario.ca/Quality-Improvement/Quality-Improvement-Plans.