MIND FORWARD BRAIN INJURY SERVICES

Quality Improvement Plan: 2024-2025

Rationale:

As a means of accountability to the legislation, Excellent Care for All Act (2010,) the agency's 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 for 2024-2025 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 Clinical Audits. Recommendations resulting from each activity will be communicated to the appropriate staff, Service Stream Manager(s), and Senior Management team members. An audit report will also be produced for each quality activity to be presented to the Mind Forward Leadership team.

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).

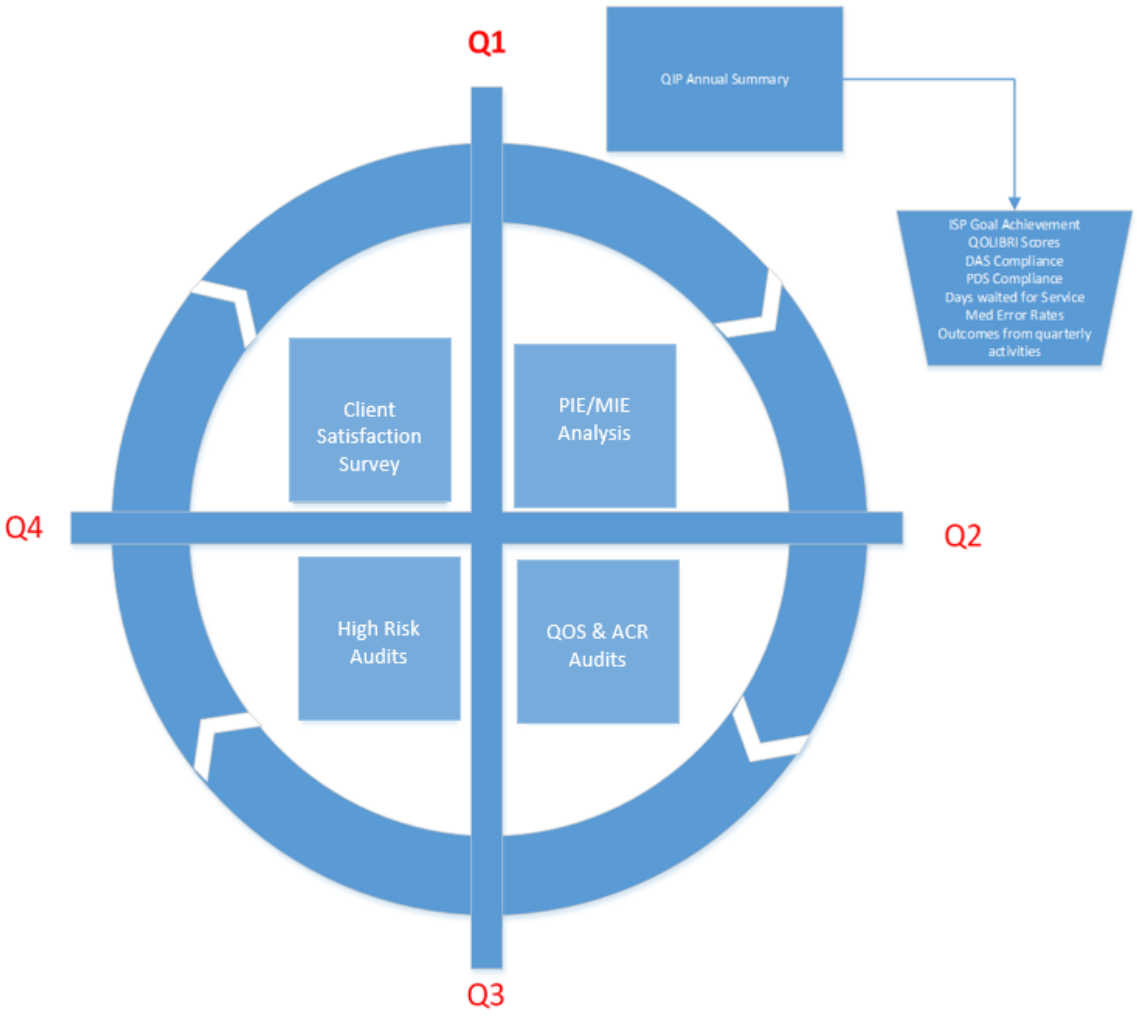
QIPs are to be developed by the organization. The Board as well as its Senior Management should ensure they are meeting the targets set out in their QIP. It is expected that the QIP will support performance improvement in the organization to achieve the targets established by the organization. The Ministry is not prescriptive about what targets are to be set within the QIP (HQO, 2022). However, province-wide priority issues within the health care system are identified and may be used to select indicators that are associated with the priority issues. These four priority issues are: Access and Flow, Equity, Experience, and Safety.

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. 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.

This report compares data from 2023-2024 to assess if targets were met, improvement initiatives, and targets for 2024-2025. The scope of the QIP also 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.

Annual Schedule for Quality Assurance Activities

The infographic below shows which quarter of the previous fiscal year (2023) each quality activity occurred.



Data

Table 1 below expands on key performance indicators in bold with a description of the indicator, how the measure is calculated, data from 2022-2023, data from fiscal 2023-2024, and comments/ recommendations. For the purposes of data analysis, a score change of 5 or more is considered a significant change and benchmark is set at 85%.

Key performance indicators that were targeted for improvement in 2023-2024 will be further analyzed in Table 2.

Table 1

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.				
2022-2023	Data: -Respected: 92% -Overall Satisfaction: 91%	**2023-2024**	Data: -Respected: 98% -Overall Satisfaction: 96%	Comments/recommendations: -Significant improvement from previous year, further analysis completed in Table 2 (outcome summary).
Mayo Portland Adaptability Inventory (MPAI:4) is a standardized assessment designed to assist in the evaluation of rehabilitation programs for individuals with ABI. A decrease in score indicates an improvement in client's rehabilitation.				
Calculation: An average of the aggregate data available in CRMS software.				
2022-2023	Data: -Ability: 47.7 -Adjustment: 44.5 -Participation: 51.6 -Total:49	**2023-2024**	Data: -Ability: 48 -Adjustment: 43 -Participation: 52 Total: 49	Comments/recommendations: -Stable scores from previous year -Continue to use MPAI:4 as a standardized assessment tool
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.				
2022-2023	Data: -4.9	**2023-2024**	Data: -6	Comments/recommendations: -Stable scores from previous year -Continue to use GAD-7 as a standardized assessment tool

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.				
2022-2023	Data: -5.14	**2023-2024**	Data: -7	Comments/recommendations: -Stable scores from previous year -Continue to use PHQ-9 as a standardized assessment tool
Daily Activity Schedule (DAS) Compliance measures the accuracy of program implementation for clients within residential setting.				
Calculation: The average of March floor observational data.				
2022-2023	Data: -88%	**2023-2024**	Data: -95%	Comments/recommendations: - The compliance rate was measured at a different assisted living site for this fiscal. Compliance rate for both sites above benchmark.
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.				
2022-2023	Data: -81%	**2023-2024**	Data: -82%	Comments/recommendations: -Stable scores, further analysis completed in Table 2 (outcome summary).
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.				
2022-2023	Data: -89%	**2023-2024**	Data: -93%	Comments/recommendations: -Stable scores, further analysis completed in Table 2
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.				
2022-2023	Data: -100%	**2023-2024**	Data: -100%	Comments/recommendations: -Perfect maintenance of score

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.				
2022-2023	Data: -PSIT: 160 days -AL: 423 days	**2023-2024**	Data: -PSIT: 90 days -SIL: 216 days	Comments/recommendations: -Excellent improvement from previous year, further analysis completed in Table 2
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.				
2022-2023	Data: -PSIT: 381 days -AL: 597 days	**2023-2024**	Data: -PSIT: 172 days -AL: 586 days	Comments/recommendations: -Excellent improvement from previous year, further analysis completed in Table 2
Medication error rates- This includes medications that may have been given				
Measurement: The number of medication related incident reports average over the fiscal year.				
2022-2023	Data: -0.06%	**2023-2024**	Data: -0.07%	Comments/recommendations: -Stable and low score, no concern.
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.				
2022-2023	Data: -68%	**2023-2024**	Data: -105%	Comments/recommendations: -Excellent improvement from previous year, further analysis completed in Table 2
High Risk Audits 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.				
2022-2023	Data: -72%	**2023-2024**	Data: -86%	Comments/recommendations: - Significant improvement, the score surpasses the benchmark.

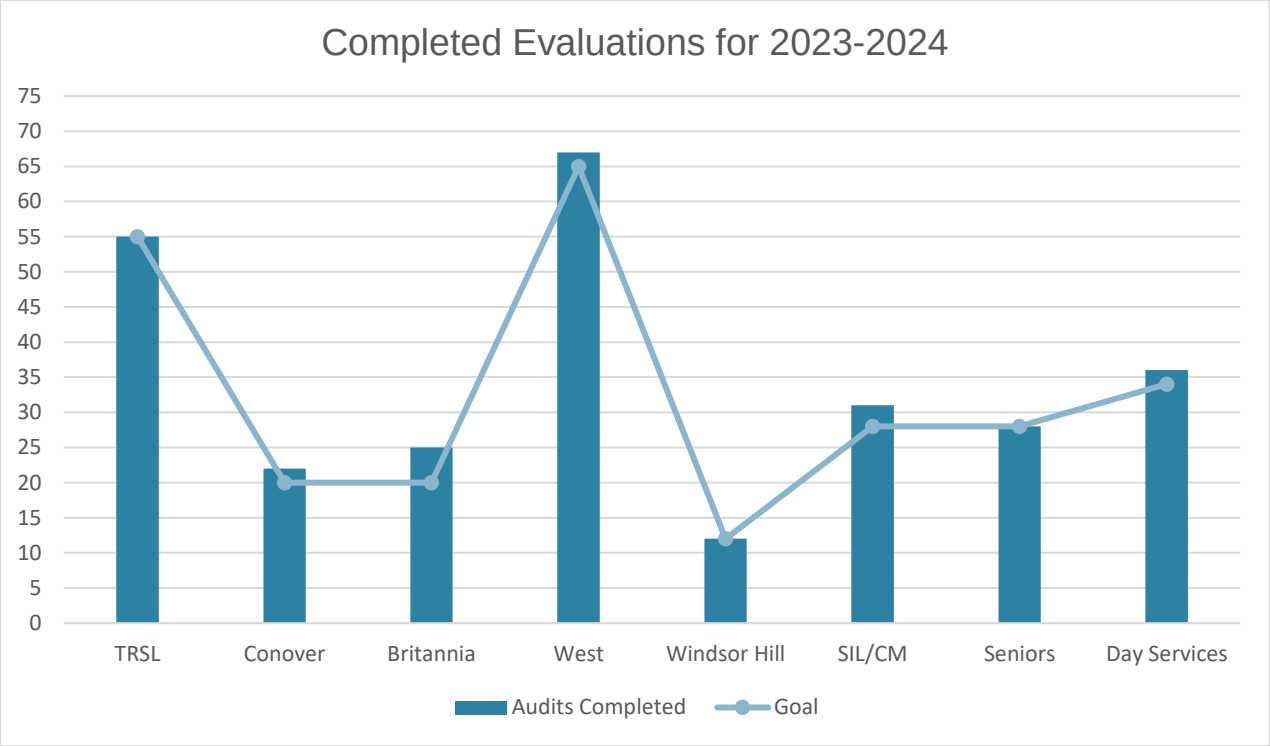
Table 2: Analysis of 2023-2024 Targets

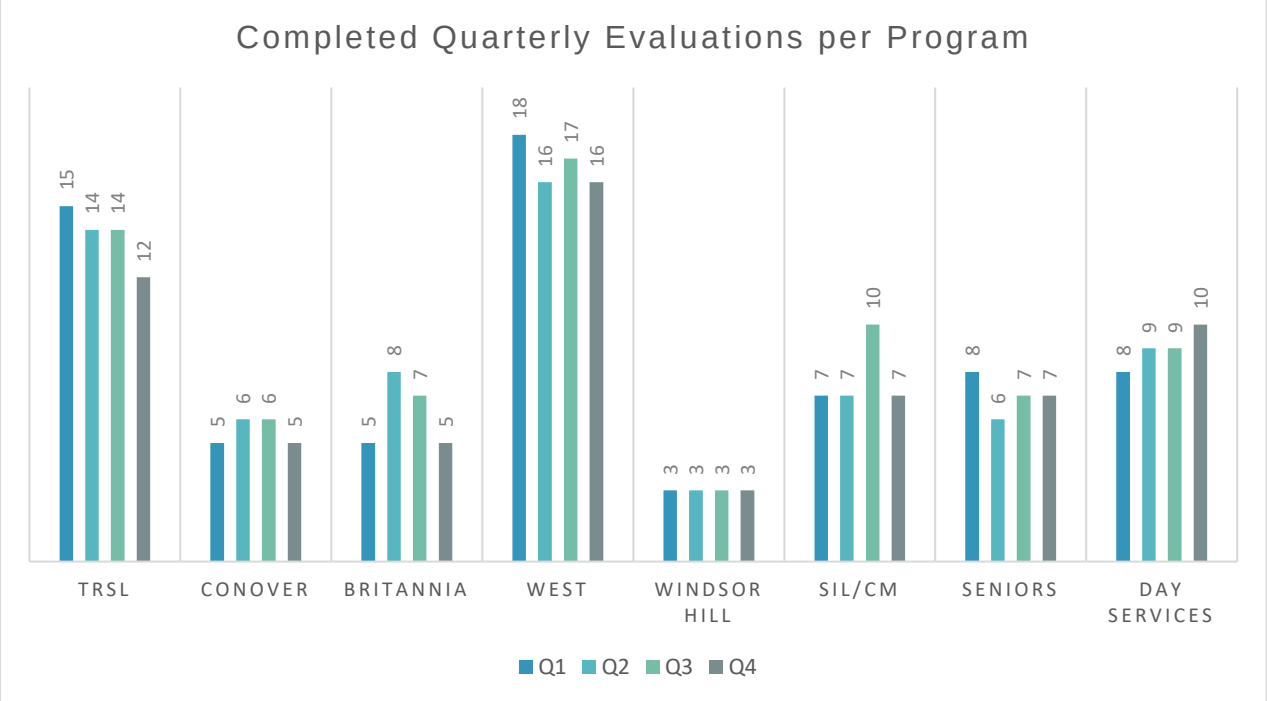
Client Satisfaction Survey					
2023 - 2024	-Complete 137 surveys	**Outcome**	- 153 surveys complete	**Improvement Initiatives**	☒ Engage the client advisory group for input and support ☐ Add survey to ISP meeting ☒ Rebuild the survey so only appropriate questions are asked to service streams
DAS Adherence					
2023 - 2024	–Move to maintenance phase -Collect Baseline TRSL –Reach Criterion TRSL –Move to maintenance TRSL	**Outcome**	-West successfully moved to maintenance -Baseline was collected at TRSL and DAS compliance average was above 85% at baseline	**Improvement Initiatives**	☒ Summary outcomes for pilot at West and determine steps moving forward ☒ Create implementation plan for TRSL that is updated with learnings from West ☒ Consult with TRSL team to develop appropriate targets for that environment
PSIT Intake Process (Days waited to assessment and for services)					
2023 - 2024	-Reduction to 2 months average wait -Increase service initiation per month to 7-8 -Client in service 488 (↑7%) Minimum 62 new clients	**Outcome**	-Time reduced to a 2.5 monthly average -Average of 6 service initiation/ month -102 new clients in service	**Improvement Initiatives**	Continue Targets: ☐ SI = 7 per Month ☐ Intake = 7 per month ☒ Monitor progress at intake committee meeting ☒ Community Managers to determine capacity analysis ☒ Track benchmarks for clients in-services
CIR/ SIR Data Entry Error					
2023 - 2024	- Decrease data entry rates by 10%	**Outcome**	- CIR and SIR digitized, measure and target no longer applicable	**Improvement Initiatives**	Improve data tracking system and accountability for quality of reportage. ☒ Drop down spreadsheet ☐ Checklist for manager re quality ☒ Digitized forms to limits errors

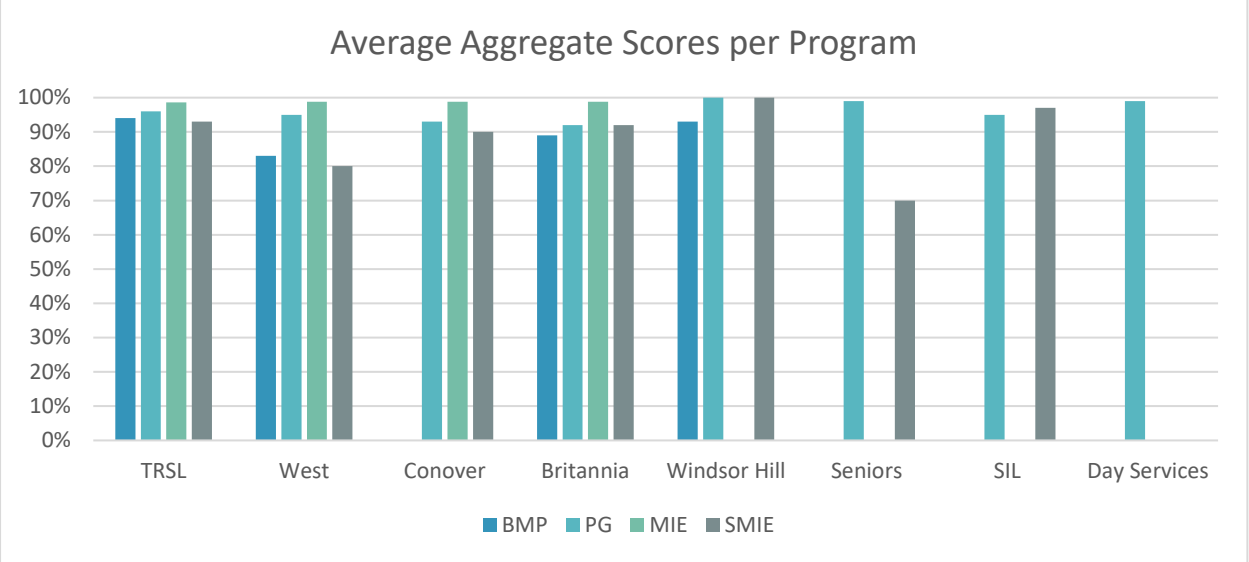
PIEs					
2023 - 2024	-Complete a minimum of 80% of number of PIEs/MIEs for fiscal	**Outcome**	-Programs met and exceeded the number of PIEs/MIEs for the fiscal, compliance rate was 105%	**Improvement Initiatives**	☒ Monitor data more closely over the course of the year and share data with team quarterly ☒ Metrics reviewed in supervisions by Senior Managers to quickly identify barriers and support needs ☒ SMIE- more of them; more frequent SM training
Client Data Entry					
2023 - 2024	-Determine Baseline	**Outcome**	-83 data points missing from site 1 and 203 missing from site 2. -A further analysis is needed for missing data as masterdata entries are combined/ streamlined in comparison to data that is collected by staff. - 40% of data was missing following Teams Pilot	**Improvement Initiatives**	☒ Use master data to determine missed data rate (how often not completed by staff) ☒ Assess baseline of missed data rates with Teams pilot ☒ Create formal process for follow up missing data ☐ Update data taking training for front line staff ☒ Continue initiative moving to digital data collection ☐ Audit data completion at shift changes
Program Documentation Assisted Living					
2023 - 2024	85%	**Outcome**	**84%**	**Improvement Initiatives**	☒ BSM to complete BMPs ☒ Clinical Team to complete Assessment Plans and Summaries ☒ Quarterly TL Meetings to encourage connection, support and provide opportunity for group mentorship ☐ RBT training for professional development of TLs ☒ Managers to monitor PDS in individual supervision and create support plans for anything that is out of date longer than 3 months. ☒ Senior Managers to monitor PDS for Manager supervision as performance measure ☒ Site specific PDS compliance rate

Summary of Quality Activities by Quarter

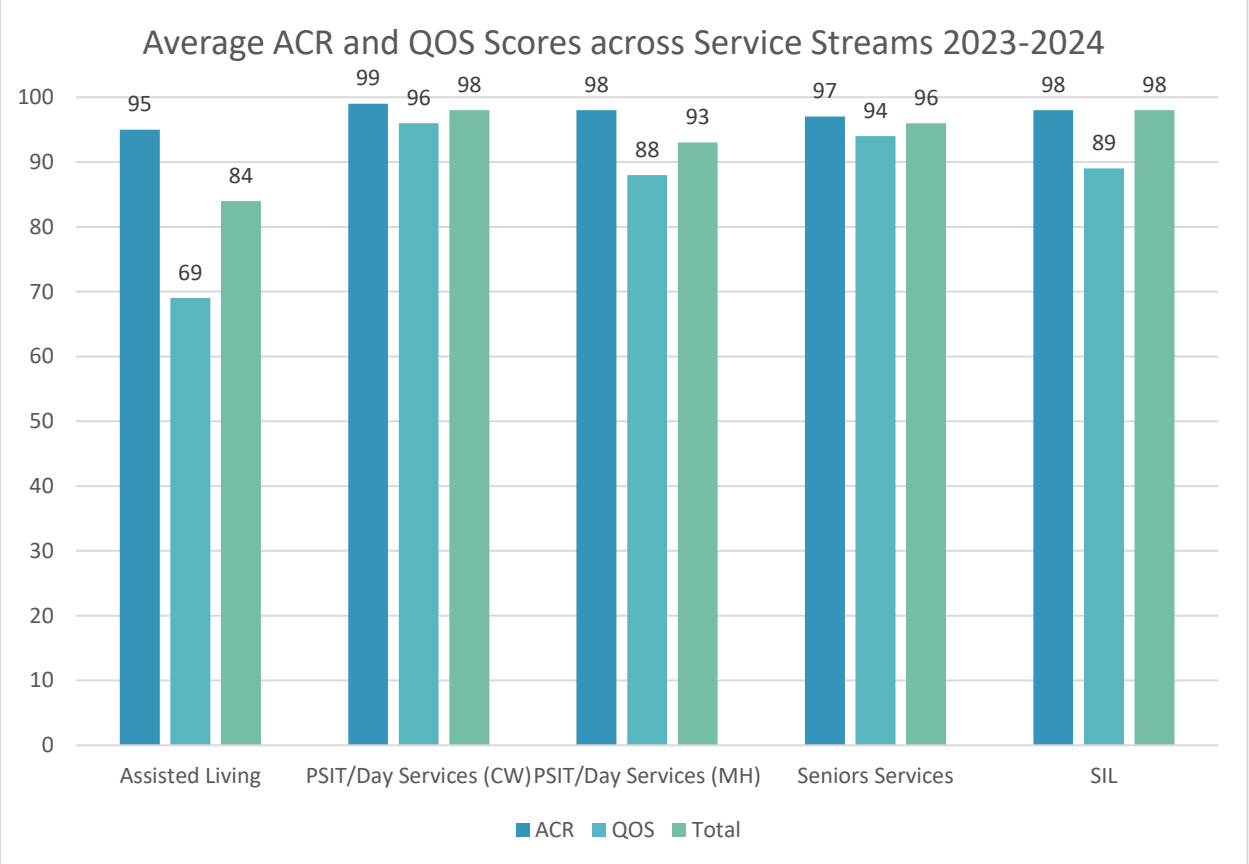
Q1 Program/Medication Implementation Evaluations



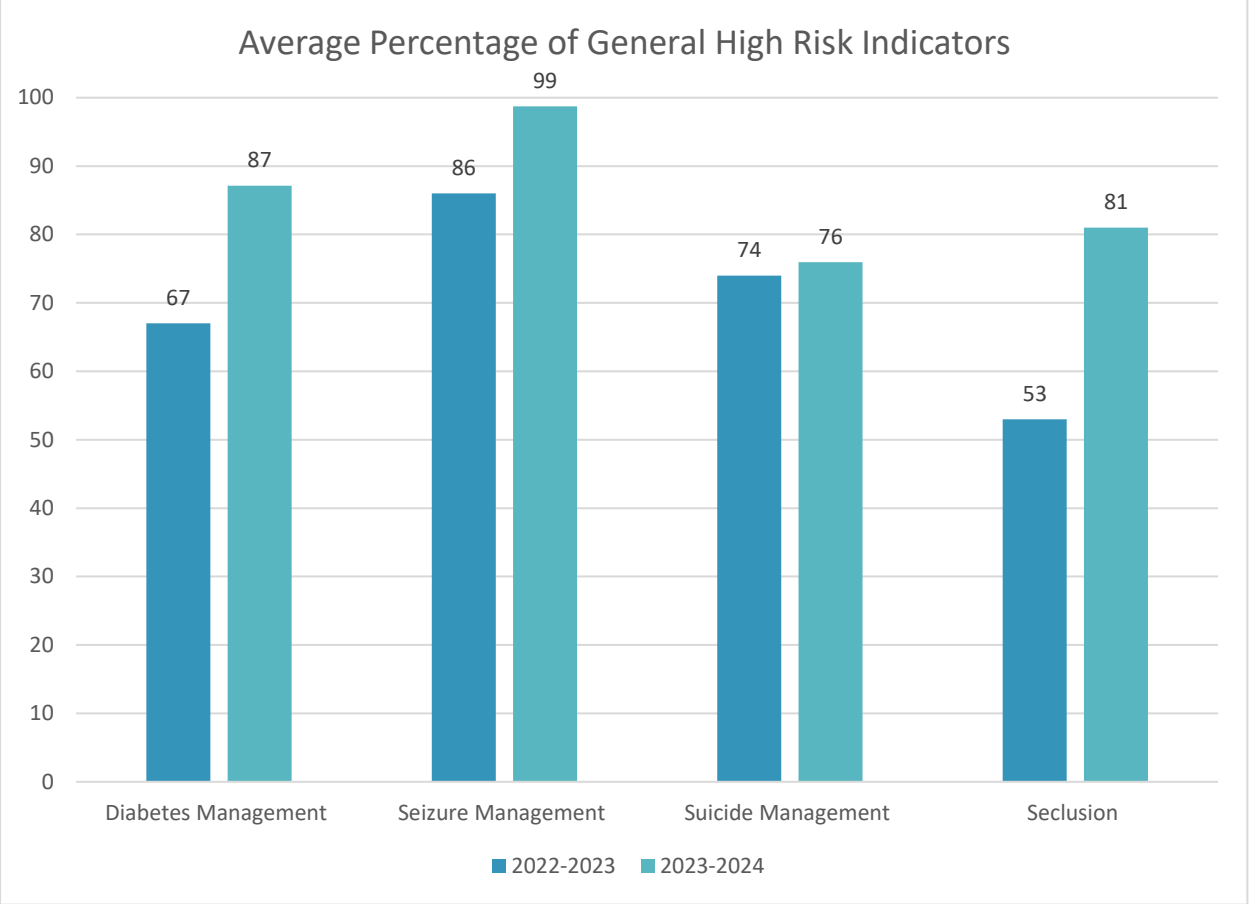




Q2- Administrative Client Record and Quality of Services Audits

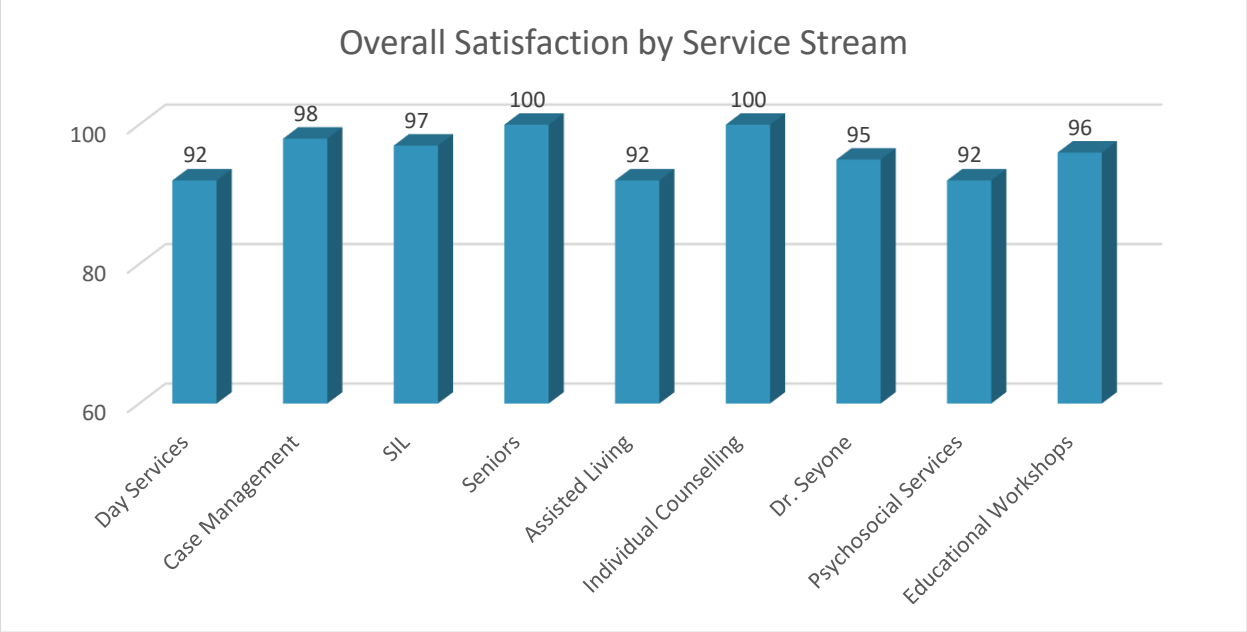


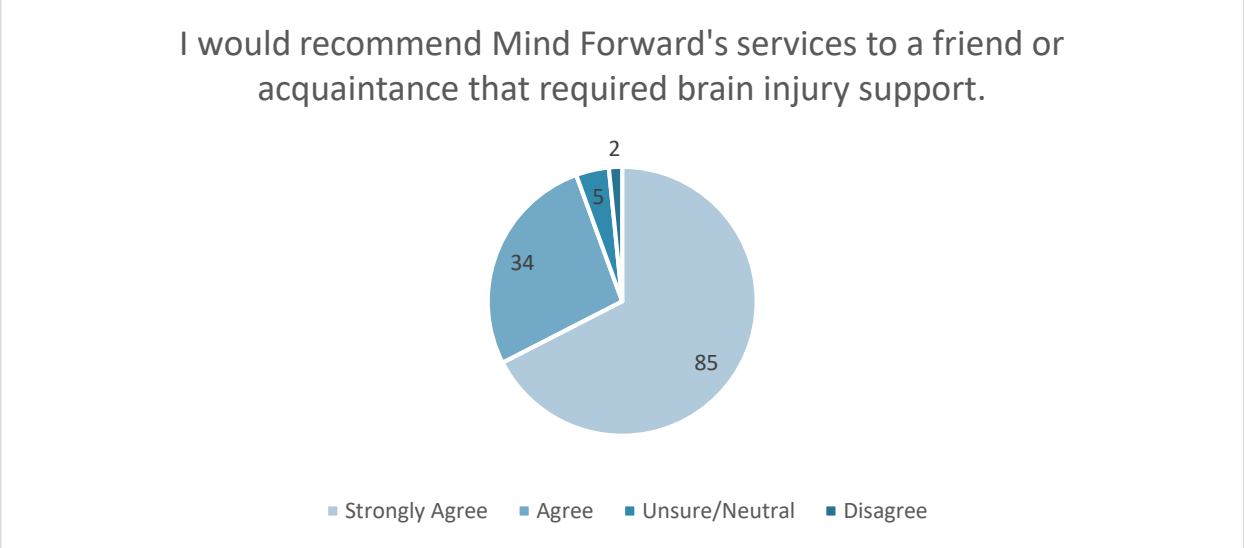
Q3- High Risk Audits



A significant increase in scores was observed for Diabetes Management, Seizure Management and Seclusion. PROG-25 Seclusion Policy was a newly implemented policy in 2022-2023. In the last year, educational efforts were made to familizarise staff with policy as well modifying the assessment tool which would would have contributed to the signficant increase.

Q4 – Client Satisfaction Survey





Quality Improvement Plan 2024-2025

Target Indicators with addressing healthcare issues	Target	Rationale	Improvement Initiatives
Client Satisfaction Survey Addresses: Experience	The number of completed satisfaction survey to reflect 85% of clients served.	Improve the reliability of the survey results.	☐ Complete Surveys throughout the fiscal ☐ Coordinate Survey completion with ISPR completion
Daily Activity Schedules (DAS) Addresses: Experience and Safety	85% DAS adherence	DAS framework aligns with the three pillars of clinical services and has proven to reduce clients' maladaptive behaviours.	☐ Improve TRSL DAS based on learnings from previous fiscal ☐ Obtain DAS adherence baseline for remaining 3 sites ☐ Implement strategies as needed to improve DAS adherence to 85%
Intake Process: PSIT -Days waited to assessment -Days waited service (SI) Addresses: Access and Flow	Reduce days waited for assessment to 2 months and increase monthly service initiation to 7/ month	Reducing wait times and increasing service initiations directly affects individuals affected by ABI	☐ Examine current intake process to create capacity
PDS- Assisted Living Addresses: Experience and Safety	85%	Current client documentation ensures clients are receiving individualized rehabilitation programming	☐Continuation of quarterly TL meetings ☐Continuation of Program Manager to review PDS ongoingly with senior staff ☐Continuation of Directors monitoring PDS compliance rates for Manager Supervision ☐ Continuation of site specific PDS rates
Digitization Addresses: Experience	Baseline TBD	Converting current practices to a digital format will improve efficiencies and productivity	☐ Continue initiative of gathering AL client data on teams ☐ Collect digital data on when injury or client concern is reported and when medical care is obtained ☐ Compare performance with benchmark for internal processes
Training Addresses: Experience, Equity, and Safety	Baseline TBD	Continuous Training contributes to skill development and improved operations across the agency.	☐ 85% of leadership team to receive EDI training through HR/ EDI ☐ Improve communication between HR and Clinical about staff performance on audits to identify training needs

			☐ In-depth clinical training during onboarding ☐ Develop inter-rater reliability for PIEs/MIEs Increased safe management review and practise throughout the year ☐ More high-risk topic refreshers during the year
Quality Assurance Measures (QAM) Addresses: Experience, Equity, and Safety	Baseline TBD	Quality Assurance Measures Help agencies provide high quality services and support	☐ An overview of the QAM and its' guidelines ☐ Complete training on QAM ☐ Identify services and procedures for QAM implementation

SUMMARY

Four of the seven 2023-2024 targets were achieved, with one target being no longer applicable. The four achieved target indicators were: Client Satisfaction Survey, DAS adherence, PIEs/ MIEs, and Client Data Entry. CIR/SIR data entry was no longer applicable as the internal process for completing incident reports was digitized, thereby eliminating the data entry errors. Four of the targets are being brought forward as two were not achieved and two have new recommendations. Finally, two new indicators are being added as they address the priority issues within the healthcare system and align with other agency initiatives.