MIND FORWARD BRAIN INJURY SERVICES

Quality Improvement Plan: 2025-2026

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.

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.

Quarterly quality activities are carried out throughout the year and are overseen by the Clinical Team. Recommendations resulting from each activity are communicated to the appropriate staff and Leadership team members.

Purpose and Scope

A **Quality Improvement Plan (QIP)** is a formalized set of quality commitments established by a health care organization for its patients, clients, residents, staff, and broader community on an annual basis. The primary objective of a QIP is to enhance quality through defined targets and strategic actions (Health Quality Ontario [HQO], 2022).

Each organization is responsible for developing its own QIP. The **Board of Directors** and **Executive Team** must ensure adherence to the targets outlined within the plan, reinforcing a culture of continuous performance improvement. While the Ministry does not prescribe specific targets for inclusion in a QIP (HQO, 2022), it identifies key priority areas within the provincial health care system. Organizations may leverage these priorities to select relevant indicators aligned with broader health care objectives. The four priority areas are:

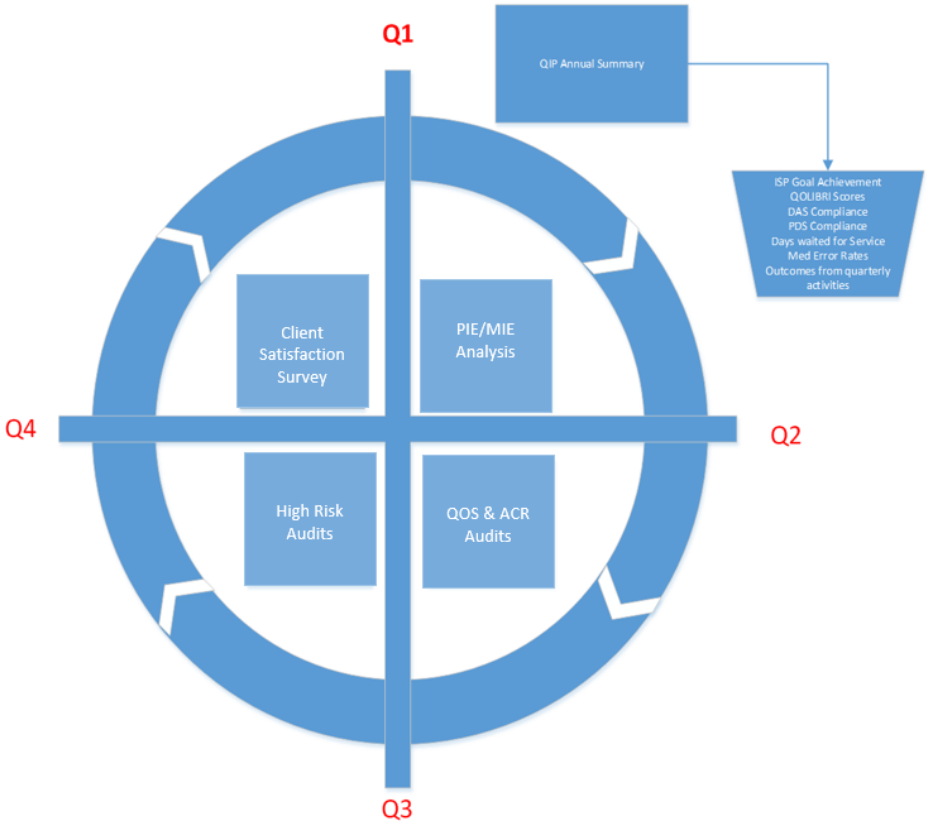
- **Access and Flow**
- **Equity**
- **Experience**
- **Safety**

Under the **Excellent Care for All Act (2010)** and various accountability agreements, all public hospitals, most inter-professional primary health care organizations, home and community care support services, and long-term care homes are required to develop and submit a QIP annually. While **Mind Forward** does not fall within the scope of these mandated entities, our obligations under the **Multi-Sector Accountability Agreement (MSAA)** necessitate the creation and implementation of a QIP. This commitment underscores our dedication to continuous quality improvement and best practices, fostering a strong culture of excellence across the organization.

This report provides a comparative analysis of data from **2024–2025**, evaluating performance outcomes, reviewing improvement initiatives, and setting targets for **2025–2026**. The scope of the QIP includes a comprehensive assessment of quality-driven activities across the agency, as well as an evaluation of existing data sources that serve as indicators of service quality.

Annual Schedule for Quality Assurance Activities

The infographic below shows which quarter of the previous fiscal year (2023-2024) each quality activity occurred.



For the current fiscal year (2025–2026), the focus of quality exercises has been adjusted as follows:

Quarter 1: Program Implementation Evaluations (PIE), Medication Implementation Evaluations (MIE), and Safe Management Implementation Evaluations (SMIE) analysis
Quarter 2: High Risk Audits
Quarter 3: Quality of Services (QOS) and Administrative Client Records (ACR) audits
Quarter 4: Client Satisfaction Surveys

Data

Table 1 below expands on key performance indicators, how the results are calculated, performance from 2023-2024, performance from fiscal 2024-2025, and comments/ recommendations. For the purposes of data analysis, a score changes of 5 or more is considered a significant change and benchmark is set at 85%.

Key performance indicators that were targeted for improvement in 2025-2026 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.				
2024-2025	-Feel Respected: 98% -Overall Satisfaction: 96%	**2025-2026**	-Feel Respected: 92% -Overall Satisfaction: 98%	Comments/recommendations: - Significant decline in the percentage of clients that agree with statements about respect. Recommendation to follow up with clients who disagree with this statement to better understand their concerns.
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.				
2024-2025	-Ability: 48 -Adjustment: 43 -Participation: 52 Total: 49	**2025-2026**	-Ability: 48 -Adjustment: 44 -Participation: 53 Total: 49	Comments/recommendations: -Fairly 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.				
2024-2025	-6	**2025-2026**	-5	Comments/recommendations: -Fairly stable score 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.				

2024-2025	-7	2025-2026	-6	Comments/recommendations: -Fairly stable score from previous year -Continue to use PHQ-9 as a standardized assessment tool
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.				
2024-2025	-82%	2025-2026	-86%	Comments/recommendations: -Improvement and now above benchmark of 85%
Implementation Evaluations are clinical audits (i.e. PIEs, MIEs, SMIEs) 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.				
2024-2025	-93%	2025-2026	-94%	Comments/recommendations: -Stable scores, data overview provided below under Summary of Quality Activities
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.				
2024-2025	-100%	2025-2026	-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.				
2024-2025	-PSIT: 90 days -AL: 216 days	2025-2026	-PSIT:17 days -AL: No longer applicable as the assessment for AL now only occurs when a bed becomes available	Comments/recommendations: - Continue to touch base with clients every 6 months that are on the wait list for assisted living
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.				

2024-2025	-PSIT: 172 days -AL: 586 days	2025-2026	-PSIT: 113 days -AL: Not applicable as 4 of the 5 AL beds were fully occupied. Note: 1 client transitioned to West, however, that program differs in intake process.	Comments/recommendations: -Excellent improvement from previous year
Medication error rates- This includes medications that may have been given				
Measurement: The number of medication related incident reports average over the fiscal year.				
2024-2025	-0.07%	2025-2026	- 0.1%	Comments/recommendations: - Fairly stable, continue to monitor
Administer PIEs as outlined in audit policy				
Measurement: The total number of audits completed in a year is divided by the total number of audits that should be completed.				
2024-2025	-105%	2025-2026	-96%	Comments/recommendations: -Significant decrease -Recommendation to complete and submit audits on a monthly basis. Also, for Senior Managers and Managers to share the task of completing audits.
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.				
2024-2025	-86%	2025-2026	-80%	Comments/recommendations: - Significant decrease - Recommendation for Senior Managers to complete High Risk training with Clinical Support as needed. Also, for audits to be completed in Q3 and suicide management audit tool to be re-evaluated.

Table 2: Analysis of 2024-2025 Targets

Client Satisfaction Survey					
Goal	-Complete satisfaction survey for 85% of clients served	Outcome	-40% completion rate. It is important to note that between 2023-2024 and current fiscal, there was a 65% increase in respondent rate. In other words, there were 126 respondents in 2023-2024 and 208 respondents in current fiscal.	Improvement Initiatives	☐ Complete Surveys throughout the fiscal ☒ Coordinate Survey completion with ISPR completion
Daily Activity Schedules (DAS)					
Goal	-85% DAS adherence	Outcome	-A program drift from DAS adherence observed at the two sites assessed, as a result, unable to obtain baseline compliance rate.	Improvement Initiatives	☐ Improve TRSL DAS based on learnings from previous fiscal ☒ Obtain DAS adherence baseline for remaining 2 sites ☐ Implement strategies as needed to improve DAS adherence to 85%
Intake Process					
Goal	-Average of 2 months wait time for days waited from application to assessment -Complete 7 service initiations per month	Outcome	-Average of 17 days waited from application to assessment -Complete 3 service initiations per month	Improvement Initiatives	☒ Examine current intake process to create capacity
PDS- Assisted Living					
Goal	-85% compliance rate	Outcome	-84% compliance rate	Improvement Initiatives	☒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					
Goal	-Baseline TBD	Outcome	-Teams forms drafted for AL clients -No data recorded for when client concern is reported -PDS compliance and supervision metrics identified as areas of improvement for internal processes	Improvement Initiatives	☒ 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					

Goal	-Baseline TBD	Outcome	- 87% of leadership completed EDI training - A full day of clinical training provided during on-boarding - Collaboration between HR and Clinical revealed a need for standardized procedures for auditing - 146 SMIEs completed during fiscal -1:1 training provided as clients with high risk designation transitioned to AL	Improvement Initiatives	☒ 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					
Goal	Baseline TBD	Outcome	-Training and Review of QAM completed - Recommendations made for various departments to consider implementation	Improvement Initiatives	☒ An overview of the QAM and its' guidelines ☒ Complete training on QAM ☒ Identify services and procedures for QAM implementation

Summary

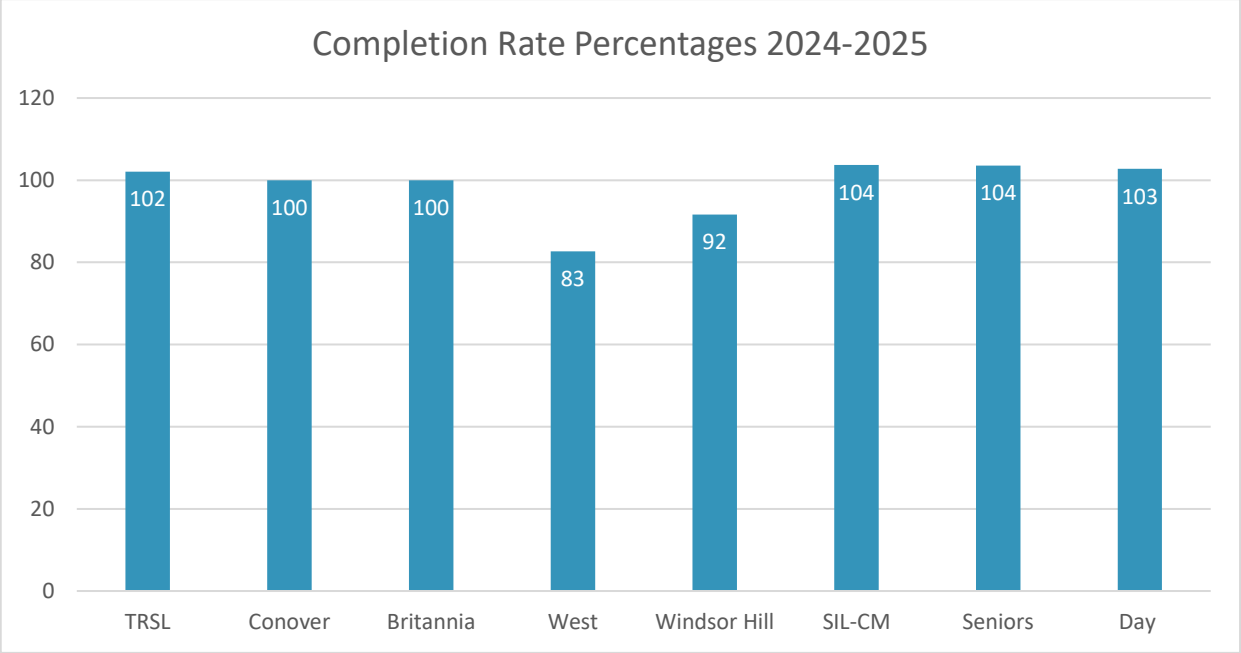
Overall, three of the seven goals were fully achieved, while three others showed strong improvement, even if they weren't fully met. The final target requires further evaluation and has been carried forward to the next fiscal year.

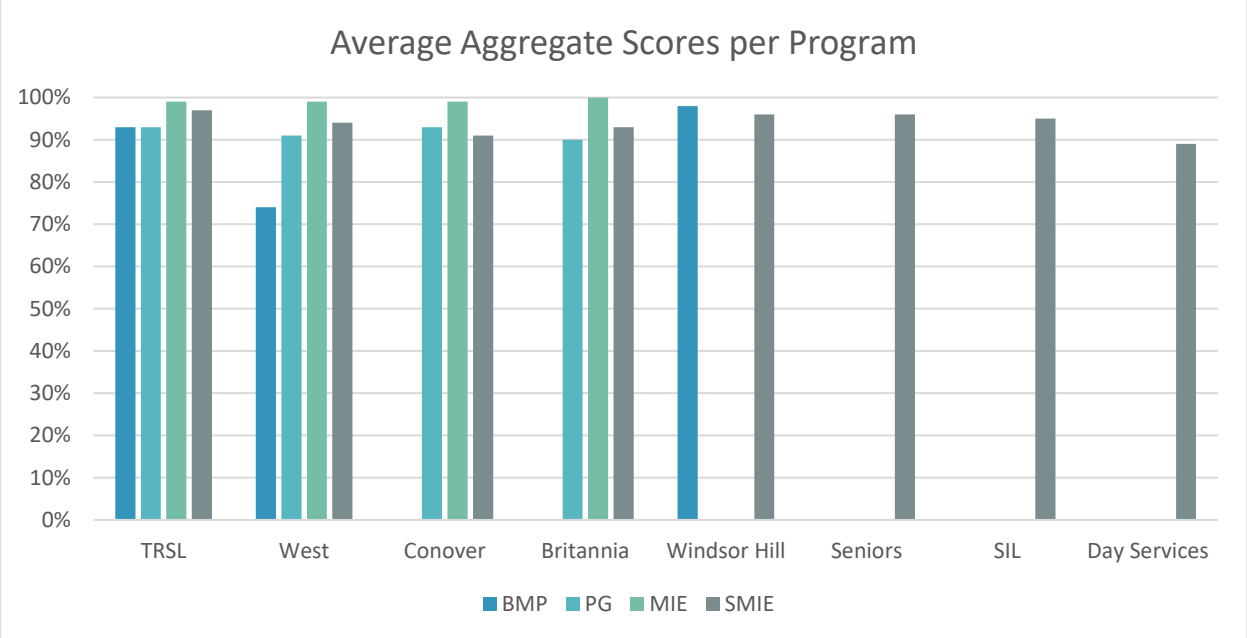
Notably:

- **Digitization, Training, and Quality Assurance Measures** were successfully completed.
- **Client Satisfaction Surveys, Intake Process, and PDS Assisted Living** showed significant progress despite not fully meeting their benchmarks.
    - A **65% increase** in the survey response rate signals greater engagement.
    - **Intake process improvements** led to a major reduction in wait time from two months to just **17 days**—a substantial achievement. However, service initiation remains challenging due to a limited number of suitable applications.
    - **PDS Assisted Living** didn't meet the annual benchmark, but was successfully achieved for **three consecutive months**.
- **DAS** will require more evaluation and has been prioritized for the 2025–2026 fiscal year.

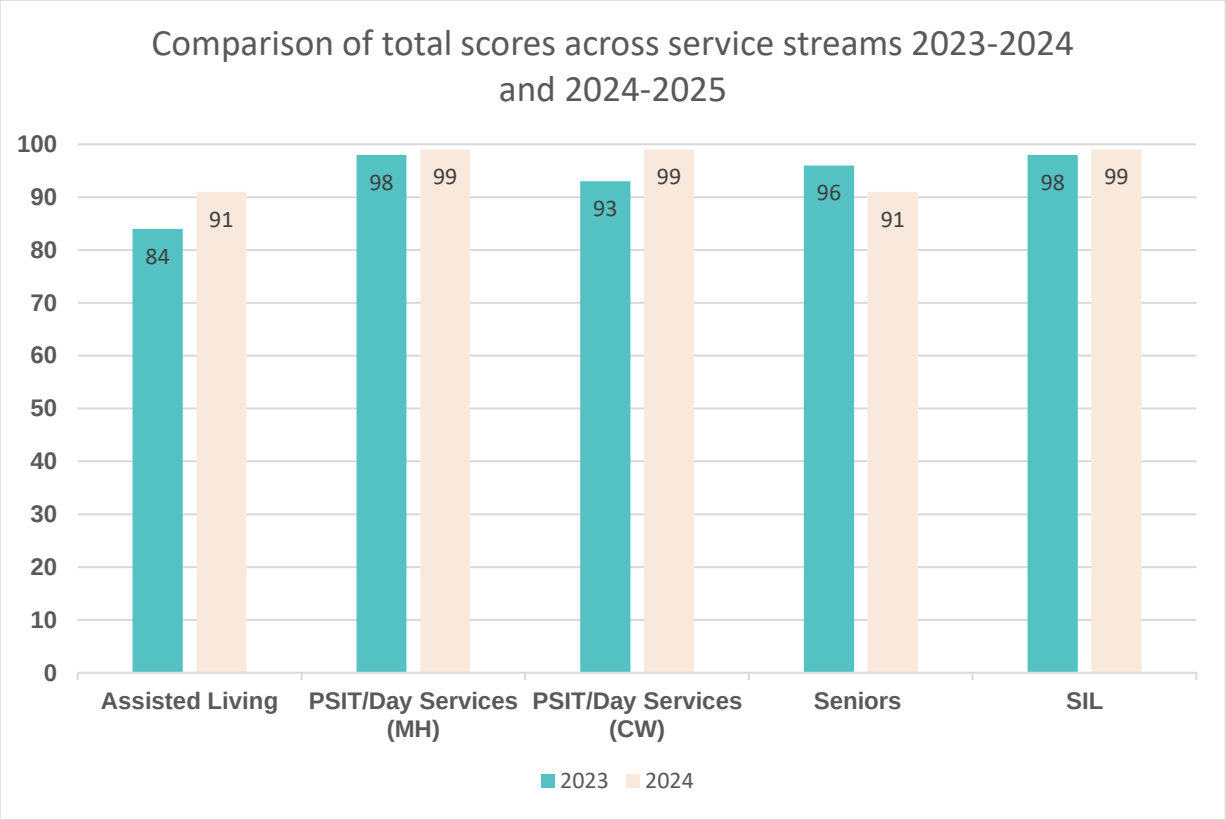
Summary of Quality Activities

Q1 Program/Medication Implementation Evaluations

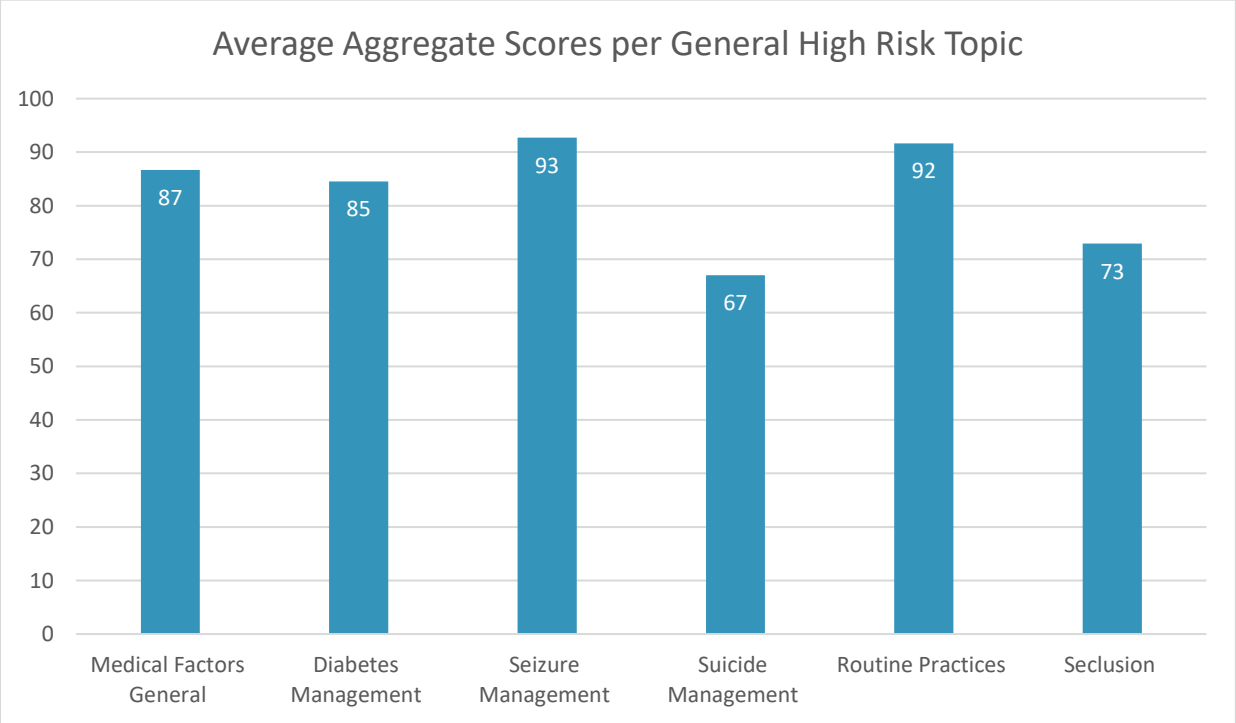




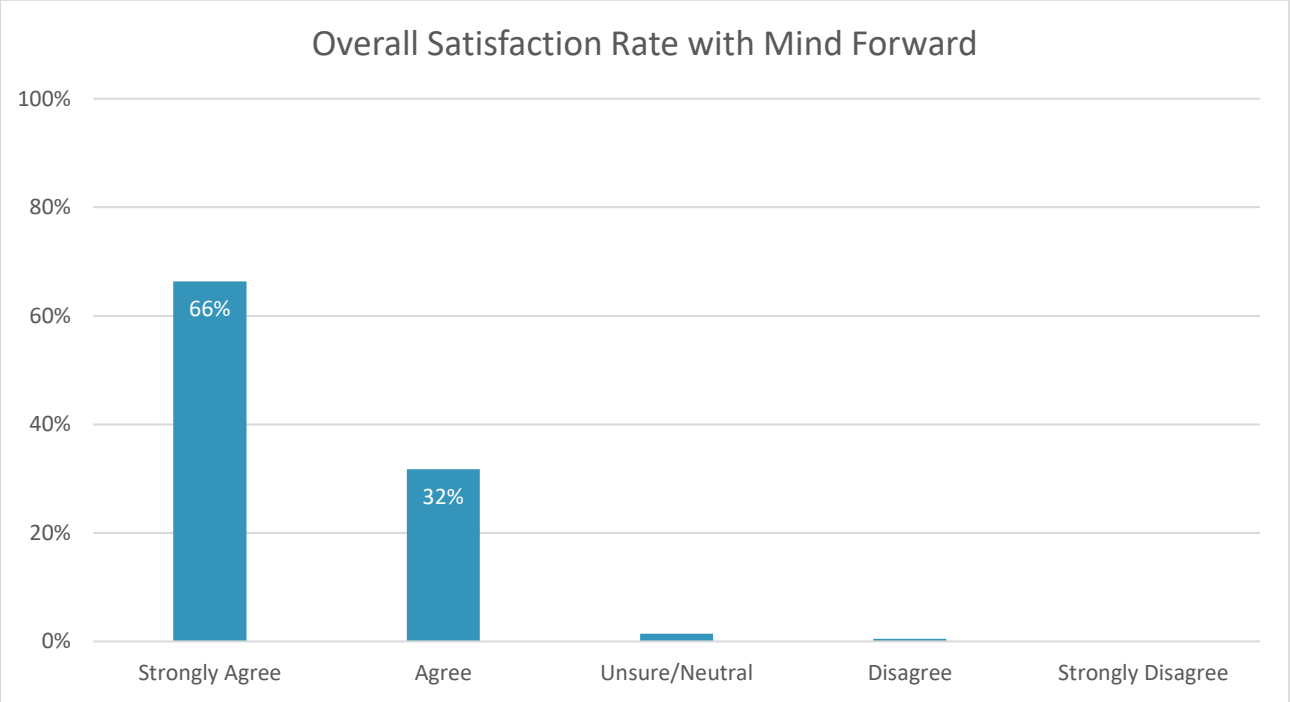
Q2- Administrative Client Record and Quality of Service Scores

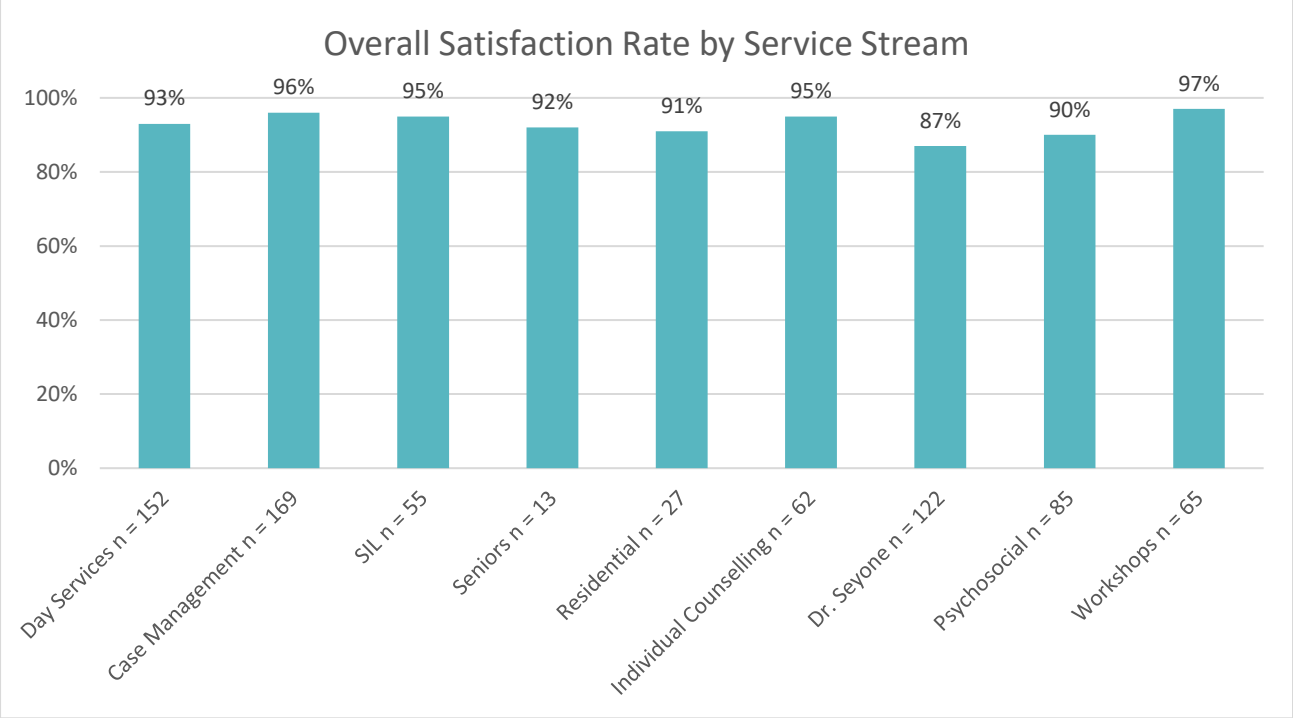


Q3- High Risk Audits



Q4 – Client Satisfaction Survey Results





Quality Improvement Plan 2025-2026

Target Indicators with addressing healthcare issues	Target	Rationale	Improvement Initiatives
Client Satisfaction Surveys Addresses: Experience	Number of completed satisfaction survey to reflect 65% of clients served.	Improve the reliability of the survey results.	☐ Complete Surveys throughout the fiscal ☐ Continue to coordinate survey completion with ISPR completion ☐ Monitor survey completion on PDS ☐ Collect data on client refusals and inability to complete survey
Daily Activity Schedules (DAS) Addresses: Experience and Safety	Baseline TBD	DAS framework aligns with the three pillars of clinical services and has proven to reduce clients' maladaptive behaviours.	☐ Provide DAS training as applicable to sites and employees ☐ Improve quality of the TRSL DAS
Intake Addresses: Access and Flow	Complete 24 in-services during fiscal Receive 6 suitable applications per month 4 service initiations per month	Raising awareness about ABI and Mind Forward services along with increasing service initiations directly affects and supports individuals affected by ABI.	☐ Collect Data on in-services completed ☐ Build relations/ partnerships with relevant populations ☐Raise awareness about Mind Forward in the community
PDS- Assisted Living Addresses: Experience and Safety	85%	Current client documentation ensures clients are receiving individualized rehabilitation programming.	☐Senior Program Manager to review PDS ongoingly with Program Managers ☐Continuation of Directors monitoring PDS compliance rates for Manager Supervision ☐ Continuation of site specific PDS rates ☐ ISPRs outstanding for more than one month should be assigned a due date during clinical supervision
RDSP Addresses: Equity and Experiences	Baseline TBD	Enrollment in RDSP provides improved financial stability for clients.	☐ Provide RDSP information to clients during transition meeting ☐ Confirm receipt of RDSP information and interest during ISPR review ☐ Confirm RDSP enrollment during ISPR review

Day Program Addresses: Experience	Increase client reported skill development by 15%	A targeted focus on skill improvement aligns with providing rehabilitation to clients.	☐ Create pre and post program assessments ☐ Complete the pre and post program assessment for two day services groups ☐ Analyze the results from the pre and post surveys
Safe Management Addresses: Experience and Safety	Review Safe Management at 90% of the AL Team Meetings	Safe Management is essential training that equips staff with the tools to interact effectively with clients and respond appropriately during behavioural crises.	☐ Have safe management as a standing agenda item on team meetings ☐ Meet as SMG group to identify priorities for training and establish an action plan
Audit standardization Addresses: Experience and Safety	Develop a standardized set of guidelines to for audit completion.	Establishing clear audit guidelines will promote consistency and reliability.	☐ Utilize information from the inter-rater reliability exercise to create guidelines ☐ Obtain feedback from auditors on guidelines prior to implementation
Program Sign-Off Addresses: Experience, Equity and Safety	Collect baseline on program review and sign-off by staff	Program sign off confirms that client programming has been reviewed and understood.	☐ Collect data from a random sample of programs across all sites ☐ Review the aggregate data with the leadership team
Equity, Diversity, and Inclusion. Addresses: Equity and Experiences	Analyze client demographics data and make service recommendations	Having client centred EDI initiatives improves services accessibility and quality	☐ Review Health 8 Equity Questionnaire ☐ Make recommendations on current processes and service delivery based on data review and analysis

Report Completed By: Tanya Singh, Director of Clinical Operations

_____ **Date:** Jun 03 2025

Signature

Approved By: Hunter Saggar, Chief Executive Officer

Hunter Saggar

_____ **Date:** Jun 04 2025

Signature