Winnipeg Regional Health Authority | Office régional de la santé de Winnipeg
Quality and Accreditation | Services de la qualité et de l'agrément

QUALITY IMPROVEMENT ROADMAP

FISCAL YEAR: 2014 TO 2015

PROGRAM NAME: Child & Adolescent Mental Health Services
DATE OF SUBMISSION: October 15, 2014
QUALITY TEAM CO-CHAIRS: Doris Dong, Dr. Andrew Hall

QUALITY ISSUE (WHY)	OBJECTIVES (QUALITY INITIATIVES)	PLAN OF ACTION (WHAT, WHO, BY WHEN)	ROP?	PERFORMANCE MEASURES (HOW)	OUTCOME (HOW)	COMPLETE DATE OF COMPLETION
Why were changes needed? Quality Dimension addressed Check those coming out of Quality Performance Roadmap (QPR)	**Identify what team intends to accomplish by when Ex. To increase … to 95% by Aug 3, 200…**	**A detailed description of what action(s) will take place, by who, by when**		**How will you measure success?**	**A description of success**	**Check off Complete and Enter Date**
Quality Issue: The use of seclusion and restraint is a restrictive intervention in the management of patient aggression, and is seen by patients as having limited therapeutic value. Risk of physical and psychological injury to both patient and staff is significant during and following the seclusion process. **Quality Dimension:** Safety, Work Life **Champion for Initiative:** Deb Melanson and Andrea Funk **Recommendation (AC):** N/A **QPR Flag:** N/A	1. Number of seclusion episodes decreases by 50% by June 30, 2015. 2. Duration of time spent in seclusion decreases by 60% by June 30, 2015.	1. Determine baseline seclusion data for both HSC and MATC inpatient data from 2013-2014 year by December 31, 2014. 2. Initiate training and implementation of 6 Core Strategies for all inpatient areas in Child and Adolescent Mental Health by December 31, 2014. 3. Compare baseline data Pre and Post implementation of 6 core strategies by June 30, 2015.		1. Number of seclusion episodes. 2. Duration of time spent in seclusion.	1. Number of seclusion episodes decreases 50% by June 30, 2015. 2. Duration of time spent in seclusion decreases by 60% by June 30, 2015.	

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Quality Issue: Services have not sufficiently addressed the needs of high risk and/or hard-to-reach populations. **Quality Dimension:** Population Focus **Champion for Initiative:** Marg Synyshyn, Doris Dong, Lori Middendorp **Recommendation (AC):** 2009 Effectiveness: It is recommended that the team partner with community health centers to promote mental health and well-being particularly for marginalized populations. Addressing Needs: ensure that cultural needs are being addressed along the continuum. **QPR Flag:** Yellow	1. To increase utilization of services via Tele health by 25% to First Nations communities currently involved in MATC RANTS (Rural and Northern Tele-health Service) by September 2013. 2. To increase overall utilization of HSC Tele-health services to rural and Northern First Nations communities by 25% by September 2013. 3. To promote professional development opportunities for all program Staff in the area of cultural competency so that 100% of staff has access to appropriate training by Sept 2013.	1. RNTS staff will continue to promote service delivery information and access to service within targeted First Nations Communities on an ongoing calendar basis, as well as circulate brochures to communities. 2. HSC is increasing resources ie, physician, clinician and SW to provide telehealth follow-up to rural and remote communities not currently serviced by RANTS. 3. Managers will circulate PD information ie conferences, workshops , and provide opportunities for participation in PD activities that are culturally and clinically appropriate to service areas on an ongoing basis.	NO	1. Number of referrals to Tele-health will increase as will number of clients and families seen at appointment by 25%. As measured by recorded statistics. 2. As Above 3. All Service areas will receive information for PD activities that are culturally and clinically appropriate.	MATC Telehealth activity to First Nations communities increased 140% from 2010 to 2013. A third clinician was added to the Rural and Northern Telehealth program effective September 2014. Expansion of the service into additional communities expected by December 2014. An evaluation of the MATC telehealth program has commenced with expected date of completion December 2014. HSC is providing 100% telehealth to all patients from rural and northern communities where HSC physician coverage is available. Cultural awareness training was rolled out. All service areas receive information on cultural training from the WRHA Aboriginal Health programs. Other cultural training opportunities are readily distributed amongst program areas.	Completed Completed Completed – May 2014

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Quality Issue: Not all services have outcome measures in place and/or the resources available to implement and evaluate effectiveness of intervention(s). **Quality Dimension:** Effectiveness **Champion for Initiative:** Marg Synyshyn, Dell Ducharme **Recommendation (AC):** 2009 It is recommended that the team develop a process to regularly monitor and evaluate service outcomes and incorporate information into quality initiatives. **QPR Flag:** N/A	1. 75% of those services who do not have an outcome measurement in place will identify one by February 2013. 2. 75% of these services will have begun implementing their identified outcome measure by April 2013.	Program Director will inform all services by January 2013 that Outcome measures need to be implemented across all service areas with the exception of the St. Boniface Hospital services whose program is in transition. Ongoing discussion will continue between program Director and sites regarding the lack of resources as it relates to OM evaluation.	NO	At least 75% of the services will have identified-via team consultation and management collaboration. An Outcome measurement tool that will be implemented by April 2013 and be reported back by program managers to the Program Director. Outcome measures will be implemented across most services through team discussion, literature reviews and/or consultation with outside resources (WRHA Research and Evaluation Unit, University of Manitoba etc.) and the resulting information will be used to evaluate and guide intervention.	All service areas will have identified an outcome measurement tool appropriate to their service area by May 1, 2014. Each service to implement an outcome measure by September 30, 2014.	Completed 2 services remain outstanding in implementing an outcome measure. Goal is to implement by October 30 2014.

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Quality Issue: To ensure ongoing consistent reconciling of medications upon admission or transfer/Discharge **Quality Dimension:** Safety **Champion for Initiative:** Deb Melanson, Doris Dong and Lesli Shafer **Recommendation (AC):** N/A **QPR Flag:** Yellow, Red	1. All services will be able to identify when medication management is a component of the care for a client within their Program.	1. Definition of medication management will be sought to ensure consistent implementation of medication reconciliation across the Program. 2. All clinical staff responsible for documenting medication reconciliation at any/all points of client care will continue to complete same. 3. Service Managers will provide appropriate orientation to Medication Reconciliation requirements to new staff.	YES 14.3	All Service Area Managers will complete a random chart audit by November 30, 2013 to identify baseline information on staff understanding and implementation of medication reconciliation.	All service areas responsible for medication management are compliant in medication reconciliation. Achieved September 2014.	Ongoing monitoring of compliance.

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Quality Issue: To ensure ongoing (where clinically appropriate) consistent client assessment for risk of harm and suicide and appropriate treatment planning is in place in accordance with a risk population base of Child and Adolescent Mental Health **Quality Dimension:** Safety **Champion for Initiative:** Lesli Shafer, Marg Synyshyn, Doris Dong **Recommendation (AC):** **QPR Flag:** Green	To increase to 100% staff awareness of SRA protocol on an ongoing basis. To increase SRA interviews and documentation to within 90% of all clients, recognizing that it may be counter therapeutic to have 100% client interviews – ie children in Early Childhood Clinic, NDS etc.	All Staff will continue to complete SRA and document same with corresponding Treatment plan. New Staff will be orientated and trained in Program SRA protocol by service manager or designate.	YES 9.7	100% of staff areas demonstrate accurate knowledge on SRA processes and documentation of same. 100% of appropriate clients have documentation on their charts re: SRA and a corresponding Treatment plan as measured via chart audits conducted by service area managers.	The sub-committee conducted a spot audit to of the inpatient units and found deficiencies in the documentation of suicide risk in patient's charts. In Response to audit results a refresher roll out education session will be initiated by each service at each site. To be completed by January 2015.	Completed Spring 2014

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Quality Issue: To ensure that all sites have integrated CODI language and services into day-to-day care provided to clients and their families. **Quality Dimension:** Continuity of Service and Effectiveness **Champion for Initiative:** Lori Middendorp **Recommendation (AC):** N/A **QPR Flag:** N/A	To increase CODI literacy to 100% across all programs. To ensure integration of CODI assessment and treatment plans where clinically appropriate.	All staff will be advised of CODI training modules and will be encouraged to participate in appropriate training as required in their clinical practice. Determine feasibility of job shadowing between mental health and AFM by May 2013. Complete CODI audit to assess current integration of assessment and treatment planning to appropriate charts. Program leadership will complete COMPASS self- audit by May 2013. The CODECAT will be available for individual clinicians to complete to assess level of CODI competency as it relates to integration of principles into practice.	NO	% of service areas that area aware of PD opportunities will increase. Feasibility of Job shadowing and sharing of information is explored with various program sites. 100% of appropriate clients have documentation on their charts re: CODI and a corresponding Treatment plan as measured via chart audits.	CODI training information was distributed to staff through all service areas. The feasibility of job shadowing was postponed by the CODI steering committee in March 2013 due to changes within the committee representation. CODI audit completed in September 2012 with recommendations forwarded to Program leaders for consideration. Youth Addiction Centralized Intake Service met with all clinically appropriate service areas to provide support, resources and direction for collaboration on co-morbidity issues as required. CODI audit to be distributed to all staff for review via their program managers. A secondary random chart audit is to be completed by program managers by October 28, 2014 to re-assess implementation of CODI principles into documentation. CODI COMPASS results were shared with Standards and Quality Committee members in June 2013.	Completed Completed Completed Completed Completed