Access and Flow

Measure - Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Alternate level of care (ALC) throughput ratio	O	Ratio (No unit) / ALC patients	WTIS / July 1 2023 - September 30, 2023 (Q2)	0.64	1.00	Will help meet the provincial and OH-E target, Will also keep us in par with our peers.	

Change Ideas

Change Idea #1 1. Collect, monitor and regularly review the set of ALC-related processes and outcome measures by senior leaders, managers, physicians and staff.

Methods	Process measures	Target for process measure	Comments
1. The ALC executive sponsors/ leads shall Identify and invite stakeholders to be included in the ALC working committee. 2. The ALC working group shall monitor, review and report ALC outcome measures like % of bed days along with causes of delayed transitions, admission, length of stay etc for individuals designated as ALC. at the program level.	The ALC working group shall review and report ALC outcome measures like % of bed days along with causes of delayed transitions, admission, length of stay etc on a monthly basis.	The ALC working group shall review and report ALC outcome measures like % of bed days along with causes of delayed transitions, admission, length of stay etc on a monthly basis.	

Change Idea #2 Develop escalation process, including direction on when and how to engage leadership around challenging barriers to transition			
Methods	Process measures	Target for process measure	Comments
Engage senior leadership and clinical leadership for accountability purposes. To facilitate in removing constraints to extended length of stay, discharge etc of ALC patients.	Reporting to be provided to senior leadership on a regular basis.	Reporting to be provided to senior leadership on a regular basis.	

Change Idea #3 Develop at risk ALC rounds format for review of cases			
Methods	Process measures	Target for process measure	Comments
Establish an ALC case conference approach to identify constraints and to provide continuum of care. Clinical leaders from programs to be engaged in case conference for patients with extended LOS and discuss clinical support options. Every program with ALC patients to do ALC rounds and ALC conferences.	ALC case conferences with program clinical leaders to be completed on a monthly basis.	ALC case conferences with program clinical leaders to be completed on a monthly basis.	

Change Idea #4 Develop “ALC at-risk” resolution table where barriers to transition can be discussed and addressed.			
Methods	Process measures	Target for process measure	Comments
ALC working group to facilitate discussion on all ALC patients, acknowledge barriers and explore possible next steps around ALC patients.	ALC working group to facilitate discussion on all ALC patients, acknowledge barriers and explore possible next steps around ALC patients on a monthly basis.	ALC working group to facilitate discussion on all ALC patients, acknowledge barriers and explore possible next steps around ALC patients on a monthly basis.	

Equity

Measure - Dimension: Equitable

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% of staff who have completed relevant equity, diversity, inclusion, and /or indigenous cultural education	C	% / Staff	In house data collection / April 1, 2024 - March 31, 2025	CB	50.00	This is a reasonable target to achieve in the first year for front line staff. Lower target for employees due to size of group and challenges of reaching shift staff/casual staff, more likelihood of optimal outcomes, leadership to model the way, setting an expectation for EDI education.	

Change Ideas

Change Idea #1 Identify EDI education needs amongst staff

Methods	Process measures	Target for process measure	Comments
Completion and analysis of EDI education needs assessments. Identify common threads of education needs.	Completion of needs assessment, analysis and review and or org dissemination	Completion of needs assessment, analysis and review and or org dissemination by April 30, 2024	

Change Idea #2 Identification and development of education/ training plan

Methods	Process measures	Target for process measure	Comments
Learning needs assessment to refine delivery of training. Evaluate the results on the EDI needs assessment to develop an informed education and change strategy. Development of change strategy including defining the why, the what and the how. Developing change mitigations and change communications centered on staff needs.	% representation from across organization/programs/staff roles	100% representation from across organization/programs/staff roles	

Change Idea #3 Provide education to all staff members. .

Methods	Process measures	Target for process measure	Comments
Menu of topic options/modalities to ensure relevant application to team/role/client care at the right time. Curriculum design/speakers/facilitators identified, learning outcomes created, tracking and evaluations done via PALMS	% of executives, management, employee group completing EDI education	100% executives, 80% management, 50% employee group completing EDI education by 31st march 2025	

Safety

Measure - Dimension: Safe

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of workplace violence incidents resulting in lost time injury	O	% / Staff	Local data collection / Most recent consecutive 12-month period	0.94	0.85	The lost time injury reported metric was a three high in 2023 and we think 10% reduction is a reasonable target to achieve. It will help us to benchmark amongst our peers.	

Change Ideas

Change Idea #1 Increase debriefed notes from codes.

Methods	Process measures	Target for process measure	Comments
Managers to follow up with staff members,	%of debriefed notes documented from codes.	100% of debriefed notes documented from codes.	

Change Idea #2 Provide training for staff members on completing the debriefed notes from codes.

Methods	Process measures	Target for process measure	Comments
Completion of mandatory training for all managers on completing the debriefed notes from codes. M	% of managers having competed the training on documenting debriefed notes from codes.	100% of managers having competed the training on documenting debriefed notes from codes.	

Change Idea #3 Assess, evaluate and update all Workplace violence policies procedures

Methods	Process measures	Target for process measure	Comments
Complete an assessment of Workplace violence policies procedures. Review the findings of the contracted safety management consultant group.	Get final approval of all WV prevention policies	Get final approval of all WV prevention policies by Q4 (Jan-March 2025)	

Measure - Dimension: Safe

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Client focused Resident rounding (Royal Ottawa Place)	C	% / LTC home residents	In house data, interRAI survey / April 1, 2024 to March 31, 2025	0.00	100.00	Aligns with BPSO guidelines for LTC. Resident rounding has shown to greatly reduce falls, pain med use, call bell use, and increase continence, as well as increase resident satisfaction and staff job satisfaction.	

Change Ideas

Change Idea #1 Completion of Resident Care Rounds by PCA staff			
Methods	Process measures	Target for process measure	Comments
Usage of the 6 P's questions checklist to be used by staff for resident rounding. The staff will ask residents within their groups on the following topics:• Possessions, personal, pain, position, protect, promise. • Each resident will have a resident rounding focus in their care plan, with unique questions that reflect the 6 P's, but are written with that residents needs/behaviors in mind.	Staff charting on Point of Care that rounding is done each hour, except for meal times, or when staff are on break. Audits of POC, interviews with residents and physical auditing of rounding being done. Pre and post implementation survey with residents	100% by end of 2025, launch will occur in March/April after education and protocol development. Then mgmt. will expect to see at least 75% compliance within first 6 months and then 100% thereafter.	

Change Idea #2 Development of protocol, educational sessions, POC rounding development in point click care			
Methods	Process measures	Target for process measure	Comments
Team will develop a protocol, and education champion sessions with education for staff	% staff, including PCA/RPN/RN/RT will receive education on rounding by April 30th 2024. New employees will receive this education during LTC orientation.	100% staff, including PCA/RPN/RN/RT will receive education on rounding by April 30th 2024. New employees will receive this education during LTC orientation.	

Change Idea #3 Care Planning of rounding with unique interventions for each of the 6 p's to reflect their unique needs.			
Methods	Process measures	Target for process measure	Comments
Each resident will have a care plan focus of resident rounding with specific interventions that are personalized for that resident and tasked to the PCA so it shows on the Kardex.	Number of residents with a unique Care Plan update	All 64 audit of care plans to be completed	

Change Idea #4	1.Evaluate, review and analyze impact of the rounding through Pre and Post survey of residents. 2. Evaluate and review the impact of the rounding on other outcome measures like Falls and Pain		
Methods	Process measures	Target for process measure	Comments
1. A survey will be created to ask capable residents if they feel the staff check on them consistently and do they feel their 6P's are currently met. This will be completed during the educational period (prior to April 31st). Post survey will be completed 6 months after the launch. Residents who have a CPS score of 1,2 or 3 will be included (~ 70% of our residents eligible). 2. The impact of resident rounding will be evaluated and reviewed on other contributing measures like falls and pain.	1.Completion of pre and post survey. 2. Review and report impact of rounding on other contributing measures like falls and pain on a regular basis.	1. 50% of resident complete survey, and by 6 months at post survey, 75% of our residents are satisfied with the rounding. 2. Report the impact rounding on measures for falls (incident reports) and pain (PointClickCare) will be reviewed every quarter.	

Measure - Dimension: Safe

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% Inpatients with a Clinical Assessment Protocol (CAPS) in the Recovery Plan of Care (RPOC) tool updated in 28 days	C	% / All patients	In house data collection / April 1, 2024 - March 31, 2025	61.20	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.	

Change Ideas

Change Idea #1 Assess, evaluate and analyze lessons learned and the impact of the efforts			
Methods	Process measures	Target for process measure	Comments
Engage SME's to undertake brainstorming exercise to develop approached to closing the performance gaps.	Closing performance gap, incremental gaps between current and desired performance.	Closing performance gap, incremental gaps between current and desired performance.	

Change Idea #2 Examine the current workflow associated with the completion of the CAPS in RPOC and address the gap			
Methods	Process measures	Target for process measure	Comments
Identify staff resources and workflow with each program, work with individual programs to help ensure that completion of the CAPS in RPOC within 28 days is possible given their structure. Invite each program manager not yet meeting the target to address barriers at the committee meeting.	Number of programs not yet meeting the target to attend the committee meeting.	All programs not yet meeting the target to attend the committee meeting.	

Change Idea #3 Provide required education and training to eliminate barriers identified by program managers			
Methods	Process measures	Target for process measure	Comments
Provide Education and training as required.	Education and training to be provided to staff from programs not meeting the target	Education and training to be provided to staff from all programs not meeting the target	

Measure - Dimension: Safe

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% Psycho-Social Assessments completed within 21 days of admission	C	% / All inpatients	In house data collection / April 1, 2024 - March 31, 2025	64.60	85.00	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.	

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 and oriented.	% of new social workers who are educated on this standard within two weeks of starting their role	100% of new social workers who are educated on this standard within two weeks of starting their role	

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
Identify staff resources and workflow with each program manager, work with individual program managers to help ensure that completion of the PSA within 21 days is possible given their structure. Invite each program manager not yet meeting the target to address barriers at the committee meeting.	Number of programs not yet meeting the target to attend the committee meeting to address barriers	All programs not yet meeting the target to attend the committee meeting to address barriers	

Change Idea #3 Provide required education and training to staff to eliminate barriers identified by program managers

Methods	Process measures	Target for process measure	Comments
Identify and provide required Education and training to staff from programs to eliminate barriers.	Provide Education and training to staff from programs not meeting the target	Provide Education and training to staff from all programs not meeting the target	

Measure - Dimension: Safe

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Medication and Patient Scanning rates for Inpatient Medication Administration	C	% / All inpatients	In house data collection / April 1, 2024 - March 31, 2025	88.00	95.00	HIMSS target for inpatient scanning is 95% and this target is in place at peer hospitals	

Change Ideas

Change Idea #1 Increase the usage of reports on uptake with mangers and directors.

Methods	Process measures	Target for process measure	Comments
1.Gather feedback by reviewing reports on uptake with managers. 2. Provide training and education to managers and directors on how to read uptake reports	Number of managers and directors trained and educated on how to read reports.	All managers and directors trained and educated on how to read reports.	

Change Idea #2 Improve all medication and patient scanning rates.			
Methods	Process measures	Target for process measure	Comments
Individual follow up with managers to identify focus and to identify targeted end users who are not scanning medications and patients.	% of end users scanning medications and patients accurately.	100% of end users scanning medications and patients accurately.	

Change Idea #3 Provide standardized support to managers and directors to address barriers for stepwise intervening for staff for low medication and patient scanning.			
Methods	Process measures	Target for process measure	Comments
1. Create brief modules on medication and patient scanning with self declaration on PALMS. 2. Develop scripts in collaboration with HR as needed.	% of medication and patient scanning completed accurately.	95 % of medication and patient scanning completed accurately by 31st March 2025.	

Change Idea #4 Improve reporting and communication to pharmacy in case of missing bar codes for medication scanning.			
Methods	Process measures	Target for process measure	Comments
Develop standardized process to report and communicate to pharmacy in case of missing bar codes for medication scanning.	% of incidents reported and communicated to pharmacy in case of missing bar codes for medication scanning.	100% of incidents reported and communicated to pharmacy in case of missing bar codes for medication scanning.	

Measure - Dimension: Safe

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
To improve staff wellness and retention by implementing superior master schedule	C	Other / Staff	In house data, interRAI survey / April 1, 2024 - March 31, 2025	0.00	100.00	Implementation of a superior master schedule will help to inform future training requirements and the spread of this initiative across the organization. Also will help to identify and reduce OT.	

Change Ideas

Change Idea #1 Assess, evaluate and analyze the impact of the implementation of optimized master schedule in the Geriatrics program.

Methods	Process measures	Target for process measure	Comments
1.Conduct a pre and post survey on satisfaction with work schedule to assess, evaluate and analyze the impact of the implementation of the optimized master schedule in the Geriatrics program. 2. Conduct an analysis of the post survey to assess, evaluate and analyze the impact of the implementation of the optimized master schedule in the Geriatrics program. 3. Conduct a comparative analysis of the staff engagement surveys to assess, evaluate and analyze the impact of the implementation of the optimized master schedule in the Geriatrics program compared to previous survey.	1. Completion of the post survey to assess, evaluate and analyze the impact of the implementation of the optimized master schedule in the Geriatrics program. 2. Completion of the analysis of the post survey to assess, evaluate and analyze the impact of the implementation of the optimized master schedule in the Geriatrics program. 3. Conduct a comparative analysis of the latest staff engagement surveys to assess, evaluate and analyze the impact of the implementation of the optimized master schedule in the Geriatrics program.	1. Completion of the post survey to assess, evaluate and analyze the impact of the implementation of the optimized master schedule in the Geriatrics program, by the end of Q3(Oct-Dec 2024) 2. Completion of the analysis of the post survey to assess, evaluate and analyze the impact of the implementation of the optimized master schedule in the Geriatrics program by the end of Q4(Jan-Mar 2025). 3. Conduct a comparative analysis of the latest staff engagement surveys to assess, evaluate and analyze the impact of the implementation of the optimized master schedule in the Geriatrics program by the end of Q4(Jan-Mar 2025).	

Change Idea #2 Review the decision to implement optimized master schedule in an additional service area

Methods	Process measures	Target for process measure	Comments
Based on the evaluation of the impact of the optimized master schedule in the Geriatrics program, review decision of implementing an optimized master schedule in an additional service areas.	Make a decision of implementing an optimized master schedule in an additional service areas by Q3(Oct-Dec2024)	Make a decision of implementing an optimized master schedule in an additional services area by Q3(Oct-Dec2024)	

Change Idea #3 Analyze and evaluate the Over Time of staff.

Methods	Process measures	Target for process measure	Comments
Conduct an comparative analysis of over time of staff of previous three fiscal years with next fiscal year	Complete an comparative analysis of over time of staff of previous three fiscal year with next fiscal year	Complete an comparative analysis of over time of staff of previous three fiscal year with next fiscal year by end of Q4 (Jan-Mar 2025)	

Change Idea #4 Reduce the number relief/vacant shifts required after implementation of the optimized master schedule in the Geriatrics program.

Methods	Process measures	Target for process measure	Comments
Evaluate the number of scheduling calls made to fill vacancies in the Geriatrics program.	Number of calls made to fill vacancies in the Geriatrics program.	Reduction in the number of calls made to fill vacancies in the Geriatrics program.	

Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 19, 2024

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 committed to bringing access, hope, and new possibilities to clients and families with mental health and addictions needs across the region and beyond. As an academic health sciences centre we combine specialized mental health care, advocacy, research and education to transform the lives of people living with complex treatment-resistant mental illness. The Royal's strategic plan, which was created in 2020-2021, is a roadmap developed to shape the future of The Royal and our community and was developed with broad consultation 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
6. Support staff and physician well-being

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. Indicators and quality improvement projects for The Royal and ROP are reported separately but

included within one QIP document to ensure clear and appropriate oversight of work undertaken.

ACCESS AND FLOW

Access to the right care at the right place and the right time and patient flow are important concerns for the Royal within the broader health care system. The need for access to mental health care is significant in our region. The Royal has introduced or grown several initiatives in the last year to support access to care. Examples of increased access to ambulatory services include the Digital Front Door, and the Ozerdinc Grimes Regional Psychosis Clinic. The Ozerdinc Grimes Regional Psychosis program has been ramping up in the last year, offering care to people with schizophrenia and other psychotic illness in a community setting. An interdisciplinary team with specialized knowledge and experience supports people coming to the clinic for care that may not require hospital based ambulatory care or other more intensive supports. The Digital Front Door development leverages digital innovation to increase access to care for people with substance use health difficulties, so they can virtually “walk in” to care from where ever they are. The tool which was co-designed with the team at the Royal, has now spread and is in use in other organizations. In the coming year, we will continue efforts to match people seeking ambulatory mental health and addictions services with the right care at the right place and time.

Access to specialized mental health beds is a key part of regional mental health capacity. Recognizing the pressure across our system for mental health beds, ALC throughput ratio and ALC days will be part of our QIP this coming year. While ALC days and ratios are broadly in line with our peers and partners, we recognize that any ALC bed represents a patient experience of delayed discharge as well as an impact on local acute psychiatric services, who are may need to transfer patients to specialized care.

EQUITY AND INDIGENOUS HEALTH

The Royal is committed to an equity, diversity and inclusion approach in all we do. As health care providers, we want to address health inequities that exist in our communities. As part of our equity, diversity and inclusion work, we have initiated a needs assessment in preparation for development and roll out of EDI education across the organization, and we are pleased to include this effort on our QIP work plan for 2024/25. Some developments we would like to highlight from the past year include the launch of Black peer support training through a collaboration with the Canadian Women of Colour Leadership Network, many drop in education sessions on diverse topics such as the Indigenous Education series, Applying an Anti-Racism Approach at Work, Equitably serving 2SLGBTQIA+ and gender diverse community members. We continue to develop clinical and support programs that respect specialized needs, such as a Women's BIPOC Journaling group, and a Women's BIPOC wellness group. A current project to improve recognition of gender diversity in clinical care is to improve our ability to record a person's pronouns at the time of admission, so that this information stays with the patient throughout the continuum of care. This will require some programming in our health information software program, as well as workflow review and training.

PATIENT/CLIENT/RESIDENT EXPERIENCE

The client and family are at the centre of each healthcare journey, and the Royal recognizes and strives to demonstrate this in a consistent way. Our internal Quality Committee includes voting members from the client council and the family council, per the terms of reference (as do most corporate committees). The Quality Committee is an essential part of QIP development and has been well engaged this year as in other years. We will present the new QIP to the full client and family councils this spring. Clients and family members are also members of the program level quality improvement committees, participating in local QI ideas and projects. Our QIP this year again includes a focus on consistent care planning, as a key part of the client's experience of quality care. Client surveys are carried out annually and the results are tabulated and analysed, and can be used as outcome measures for various quality improvement initiatives. As a result of work done within the QIP last year, looking at optimizing timely feedback from clients and families, we will be introducing regular gathering of feedback from clients and families at key transition points such as discharge from inpatient care, rather that surveying clients in an annual, time limited way as we have done in the past. At this time we will continue to use a survey tool developed for mental health care feedback and that is currently in use by a number of peer sites, called the Ontario Perception of Care Tool for Mental Health and Addictions.

Several important developments supporting the client and family experience at the Royal include the opening of the Client and Family Resource Hub in May 2023, which was co-designed with clients and families, and the ongoing peer support programs available through partnerships with community agencies or directly through the Royal, as well as our active Client Relations service, including a role dedicated to family support. In October we had our Accreditation Survey and welcomed a client surveyor as part of that team. Clients and families were involved with Accreditation preparation at many levels and were key to a successful Accreditation.

PROVIDER EXPERIENCE

In a time of health human resources limitations, meeting the

challenges of understaffing, workplace violence and demanding shiftwork s essential. The Royal has experienced significant changes in leadership over the last year or two, and workplace culture can be affected by a period of uncertainty.

We are soon launching the Royal Culture Council as part of the REVEL engagement method to support engagement and positive workplace culture at the Royal. This is a program developed through the Public Health Agency of Canada in recognition of the widespread healthcare worker burnout being experienced by many healthcare workers in the last few years.

We are continuing with a quality improvement initiative this year looking at optimizing master schedules and scheduling practices for vacant shifts. One unit will be implementing a new master rotation this spring, and subsequent evaluation and preparation for expansion will be the focus for the coming year.

Code whites are currently under review, bringing together expertise from clinical, occupational health and safety, and patient safety perspectives to review client safety along with staff safety at these higher risk moments in care delivery. This will support the QIP work plan item looking at lost time injuries in our environment. We have tracked incidents of workplace violence over the last two years in order to ensure robust reporting including reporting of more minor events. As this has been consistent, we are now able to include this more focused measure to work to reduce lost time injuries related to workplace violence.

The Royal's physician leadership is currently exploring the CPSO program available to lessen the burden of college mandated quality improvement activities for individual physicians, in favour of participation in a workplace based initiative. While this will not be in place for this year's QIP, we hope development this year will support its inclusion in the organization's QIP for next year.

SAFETY

A robust patient safety program is in place at the Royal, encompassing prospective analysis, near miss and incident reporting and review, recommendations tracking, and education sessions. Incidents are reviewed based on a severity rating, including a Quality of Care review for critical and severe incidents. Recommendations are shared within the organization, and followed up for support and completion. A well developed medication safety group is in place to support thorough review of serious medication incidents and our mean number of incidents monthly has gradually fallen over the past several years since the medication safety working group was established. Medication safety is supported through use of an electronic medication administration record (eMAR) and patient and medication scanning workflows. This year we have included scanning rates for medication administration on the QIP, and plan to dedicate some resources to a through analysis of near misses and incidents related to scanning or other factors. Computerized physician order entry is well established at the Royal and incorporates pharmacist review as well as alert generation. Falls and fall trends are monitored and we use an approach of universal fall precautions in ambulatory settings, as well as falls risk assessment of all inpatients on admission and as needed through admission. Hazards and patient safety concerns are discussed at safety huddles in the care areas. Risks of self harm are mitigated by regular mental status assessment and standardized nursing suicide risk assessment is in place in inpatient areas. Aggregated incident information is shared within the organization, and regular meetings are held with managers in the different care areas.

Many of the elements of a Just and Learning culture are in place at the Royal, however there is room for improvement along the path to truly just culture. Inclusion of staff in incident reviews helps

develop a learning culture in care areas.

POPULATION HEALTH APPROACH

The Royal is the specialized level mental health care provider in the region and as such exists as part of a system, with key partners in the community mental health and housing sphere as well as acute care hospital partners who provide Emergency Department services. The Royal also provides rapid access to consultation, and structured psychotherapy through Ontario Structured Psychotherapy program, and the Prompt clinic. Access to specialized care beds is coordinated through a central intake process, or through partnerships with key other partners for patients across the lifespan. Services for Youth are provided through partnership agreements for access and flow with the Children's Hospital of Eastern Ontario. Services for seniors requiring specialized care are coordinated with a key community partner as well as an extensive outreach support to long term care across the region. ECT services are provided to a broad range of patients living in the community as well as to inpatients as needed. Royal Ottawa Place, a long term care home is also a part of the spectrum of services. The Royal provides mental health outreach services to partners in the shelter sector, community housing, long term care, correctional facilities across the province, developmental services, and to transitional aged youth at risk for substance use difficulties.

The importance of acknowledging and addressing the impact of social determinants of health on people living with mental illness or substance use, has long been recognized at the Royal. Completion of a psychosocial assessment is an expectation for admitted patients. Monitoring of this indicator remains on the QIP for the coming year.

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 Presidents, Patient Care Services, and Chief Nursing Executive; Vice President of Research (President of the IMHR); and Chief information Officer.

Accountability for the execution of both the annual QIP and the Strategic plan are delegated to the Chief Executive Officer 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 may be allocated to the initiatives under the QIP and the strategic plan.

CONTACT INFORMATION/DESIGNATED LEAD

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

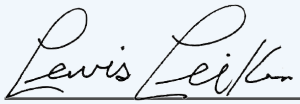
SIGN-OFF

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

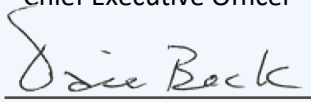
March 26, 2024

Board Chair



Board Quality Committee Chair

Chief Executive Officer



(Interim Chief of Staff)

Other leadership as appropriate