Mental Health and Addictions Central Zone Quality Program

Annual Report
September 2015 - August 2016

nova scotia health authority

Table of Contents

Introduction 3

Quality Program Annual Retreat 4

Standing Subcommittees of Quality Council 5

Feedback and Experience Action Team (FEAT) 5

Patient Safety Steering Committee (PSSC) 5

Quality Program Priority Areas 7

Collaboration 7

Information Sharing Guidelines 7

Relapse Prevention / Crisis Management Plan 7

Transitions of Care 8

Accreditation 8

Self-Assessment Surveys and Questionnaire 9

Quality Assurance / Chart Audits 9

Quality Team Updates 10

Acute Care 10

Community Mental Health and Addictions 14

Crisis Services 16

Developmental Disorders 18

East Coast Forensic Hospital (ECFH) 20

Recovery and Integration (R & I) 22

Seniors Services 26

Specialty Services 28

Appendix A 30

Appendix B 31

Appendix C 35

Introduction

The Mental Health and Addictions Quality Program in the Central Zone of the Nova Scotia Health Authority (including the Halifax area, Eastern Shore, and West Hants) is committed to ongoing improvement and evaluation of services provided to patients and their families. The accomplishments and challenges of the September 2015 to August 2016 quality year are highlighted in this report alongside the status of longstanding priority areas including collaboration, transitions of care, patient safety, and accreditation.

Within the quality program structure, each of the 40+ service areas of Mental Health and Addictions belong to one of eight quality teams grouped by service type. In addition to the quality teams, there are two standing sub-committees: the Patient Safety Steering Committee (PSSC) and the Feedback and Experience Action Team (FEAT). These committees report to the Mental Health and Addictions Quality Council which coordinates quality improvement and patient safety work. Please see Appendix A for an illustration of the quality program structure and team composition.

The Annual Report is organized into the following sections:

- Quality Program Annual Retreat
- Standing Subcommittees of Quality Council
- Quality Program Priority Areas
- Quality Team Updates

Quality Program Annual Retreat

The 2015 annual Mental Health and Addictions Quality Retreat occurred on September 24 at the Nova Scotia Hospital site with over 40 participants including physicians, managers and staff from a range of health disciplines, family members, and people with lived experience. The purpose of the retreat was to review the accomplishments and examine the challenges of the past year; analyze the current priority areas of the Mental Health and Addictions Quality Program; and discuss plans for the upcoming year.

Helen Cameron, quality and patient safety leader with NSHA Quality and System Performance, provided an interactive discussion on how to develop effective Quality Award submissions and poster presentations. Each quality team was challenged to develop a poster for the 2015 Quality Summit, and five were submitted from Mental Health and Addictions.

Norma Lewis, health services manager with Recovery and Integration, provided an overview of the *Mental Health Commission of Canada's Recovery Declaration* which was then examined in the context of the Accreditation standards. In small working groups, participants discussed this subset and if they felt the program was meeting these standards. The themes that emerged supported a continued focus on collaboration and transitions of care, and thus validated the decision to maintain focus on these priority areas.

Standing Subcommittees of Quality Council

Feedback and Experience Action Team (FEAT)

This team is unique as it is comprised of equal parts people with lived experience, family members and staff. It is mandated to oversee the patient and family experience survey process and to make recommendations to the program on areas for improvement. The Inpatient and Outpatient Mental Health and Addictions Experience Surveys (developed by and used with permission from Accreditation Canada) and the Family Experience Survey (developed by FEAT) were first introduced to all Mental Health and Addictions service areas in the fall of 2014. The first set of reports on the results of the patient and family experience surveys were distributed in spring 2016.

Every service with an adequate number of responses received an overview of their results highlighting the top areas for improvement and top performing areas. Service areas, in collaboration with their quality teams, are examining the results closely to determine priority areas for developing improvement initiatives, some of which are underway.

FEAT reviewed the program-wide results carefully and developed a set of recommendations presented to both Quality Council and Leadership. These recommendations will be incorporated into the plan for the upcoming year. The full report can be viewed in Appendix B.

Patient Safety Steering Committee (PSSC)

This committee coordinates the formal quality review process for Mental Health and Addictions. With four rotating quality review teams, select patient safety events are examined and relevant recommendations are submitted to the PSSC. The PSSC records all recommendations, monitors associated action plans, and ensures accountability for their implementation. In addition, the steering committee coordinates an annual education session for all quality review team members as well as an annual meeting of the team leads.

The third annual education session, held on November 30th, 2015, focussed on the year in review including the identification of themes arising from the recommendations. There was also opportunity for team members to discuss potential areas for improvement regarding the Quality Review process and for supporting review team members and leaders. Some recommendations for improvement included an orientation for new members, education for team leads, and the potential to cluster cases to improve the efficiency of review time.

Over the past year 17 reviews have been completed resulting in 19 recommendations. An example of a significant change made this year is the implementation of the Notification of Death Protocol to create a consistent and sensitive approach to notifying clinicians of a death. In addition, an intentional focus on improving coordination and communication with Emergency Services is in progress. This included a one-day Psychiatric Emergency Services retreat with representation from Psychiatry, Emergency Medicine, Family Medicine, Addictions, Long Term Care and the IWK. This retreat resulted in recommendations to streamline services for those presenting to emergency departments with mental health and addiction concerns. Topics included medical clearance, referrals from family practitioners, addictions, elderly and pediatric-specific concerns, transfers between departments, and community and client expectations of care. This work will continue to unfold in the coming year.

Furthermore, a provincial patient safety reporting system was implemented in the Central Zone, effective April 26, 2016. It is called the Safety Improvement and Management System (SIMS) and will improve the ability of the Nova Scotia Health Authority to monitor and respond to trends. Implementation of this new system presented an education opportunity for all staff, which covered an overview of what patient safety events include, patient safety culture concepts, the importance of reporting to improve patient safety, how to enter patient safety events and the follow-up process.

Quality Program Priority Areas

Collaboration

Improving collaboration of patients, families and care providers continues to be a major focus of quality improvement work across Mental Health and Addictions. Families Matter education and support sessions continue to be offered along with specific family therapy approaches. In addition, a number of inpatient and specialty areas offer family support programs tailored specifically to the service. These include the Affected Others program in Addictions, the Nova Scotia Early Psychosis Program's Family Education and Support Group, and the Mental Health Acute Care Family Education and Support Group.

Information Sharing Guidelines

Sharing information within the circle of support (including people who provide practical and emotional support to the person, such as family and friends) is a cornerstone to collaboration. The Information Sharing Guidelines were first introduced in 2011 to provide clinicians with guidance regarding what types of information can be shared with and without consent, while maintaining their duty of confidentiality and at the same time support their patients' families and friends. Revisions were completed on the guidelines this year to improve clarity and ensure alignment with current privacy legislation. In addition to these revisions, a form was implemented to facilitate conversations on involving the circle of support in care; allow for a quick reference for clinicians; and also clarify what types of information can be shared with whom.

Relapse Prevention / Crisis Management Plan

The Wellness Plan was developed by the Recovery and Integration Quality Team to engage people in their recovery. The plan included relapse prevention, self-care tools, and an introduction to Personal Directives (i.e. making decisions about future health care and treatment should the person become unable to make decisions themselves). The Wellness Plan was evaluated using data and feedback from clinicians, people with lived experience and family members. This evaluation resulted in a set of recommendations, one of which was to have a primary focus on relapse prevention and crisis management. As a result, a small working group developed a Relapse Prevention

and Crisis Management Plan for Mental Health and Addictions. This new plan replaced the Wellness Plan in June 2016.

Relapse Prevention and Crisis Management Plans are tools to help people and their families notice early signs of illness, identify appropriate actions to avoid or reduce the severity of a potential relapse, and know what to do in a crisis situation. These plans belong to the individual and their families and should be completed collaboratively in a manner that is most useful for them. Support for the implementation of these plans within all service areas of Mental Health and Addictions will continue throughout the upcoming year.

Transitions of Care

The focus on inter-service collaboration continues to improve transitions between services of Mental Health and Addictions. These collaborative efforts between services have become a regular agenda item for most quality teams and have improved communication and transfer protocols at many common transition points such as Psychiatric Emergency Services to Community Mental Health (and vice versa); East Coast Forensic Hospital to Connections (Recovery and Integration); and Acute Care to Simpson Landing and Community Mental Health.

Accreditation

As one of the most effective ways to regularly and consistently examine and improve the quality of health services, Accreditation is an ongoing focus of the Mental Health and Addictions Quality Program. The next onsite visit for evaluation by Accreditation Canada will take place in October 2017. The two standard sets selected for Mental Health and Addictions in the Nova Scotia Health Authority are the *Mental Health Services Standards* and the *Community-Based Mental Health Services and Supports Standards* which have both recently been updated. The standards are based on five key elements of service excellence: clinical leadership, people, process, information, and performance. The concepts of client and family-centred care are now clearly imbedded in each of the key elements.

Self-Assessment Surveys and Questionnaire

In preparation for the onsite Accreditation Survey, the health authority launched two surveys and one questionnaire in May 2016: the Work Life Pulse (WLP) and Patient Safety Culture (PSC) surveys and the Self-Assessment Questionnaire (SAQ) supplied by Accreditation Canada. These surveys provide an opportunity for staff to rate how their work experiences measure up against national standards and best practice.

Mental Health and Addictions has evaluated the results for the Central Zone and has developed action plans for improvements to implement prior to the onsite survey in October 2017. Each of the quality teams will also have the opportunity to review results specific to their service areas and determine how to best act on the results.

Quality Assurance / Chart Audits

All service areas now participate in monthly audits on a random sample of charts to ensure documentation significant to patient safety and quality of care is present. The list of required documentation was developed by examining the Required Organizational Practices (ROPs) and High Priority Criteria from the Accreditation standards and the associated policies and procedures of the NSHA. An example of this template is in Appendix C. Quality teams have also incorporated elements specific to their services to audit. The results of these audits are shared at team meetings to improve local documentation practices and are also regularly discussed at quality team meetings.

Quality Team Updates

In addition to working on program wide projects and priority areas identified here, each of the eight quality teams develop service-specific initiatives to create improvements specific to their areas. The teams have provided a summary of their main accomplishments and ongoing work.

Acute Care

Services Represented:

1) 6 Lane
2) 7 Lane
3) Mayflower
4) Addictions Intensive Treatment Services (ITS)

Key Accomplishment(s) 2015/16:

Title: **Chart Audits**
Description: Identified a standardized process for chart audits in keeping with the score card and Accreditation standards.
Indicators/Outcomes: Clear process for monthly reviews identified and implemented in June 2016.

Title: **Electronic Discharge**
Description: All licensed professional disciplines can access and document on the electronic discharge summary once it is opened and started by the psychiatrist.
Indicators / Outcomes: Consistent use of e-discharge across Mental Health Acute Care by psychiatrists. Now working to implement this practice with Addictions ITS.

Title: **Improved Discharge Outcomes**
Description: This initiative was developed to improve discharge outcomes and facilitate the discharge process. Two new positions were filled in July 2015 in Mental Health Acute Care as part of this initiative. In addition, a dedicated position to facilitate patient flow and bed management was introduced.

Indicators / Outcomes:

Data was collected and reviewed to evaluate the impact of this initiative on patient flow and capacity for new admissions. The results for the first 6 months indicate evidence of improved patient flow. The impact of this initiative will continue to be monitored and evaluated over the coming year.

Ongoing Initiatives:

Initiative Name	Description	Status	Activities
Accreditation 2017	To prepare and address needs for accreditation	June 2017	Initiatives developed to address Patient Safety Culture (PSC) and Work Life Pulse surveys (as outlined below). Other Accreditation prep as determined by Program Quality Council
Initiatives based on Patient Safety Culture (PSC) and Work Life Pulse (WLP) survey results: i) PSC item # 7	Staff/team follow up from a patient safety incident	Ongoing	SIMS reports and resulting actions to be discussed monthly at team meetings
ii) PSC item # 21	Post serious incident considerations for correction	Ongoing	Improve communication of serious incidents to staff, and engage staff in developing recommendations for improvement
iii) PSC item # 22	Overall grade on patient safety	Ongoing	Improve staff engagement in patient safety reporting and problem solving, as described above

iv) WLP item #3	Staff/team consulted about change affecting my job	Ongoing	Improve communication from management regarding updates or changes. Lunch and Learn to be held for staff on change management in the workplace
v) WLP item #17	Senior Managers effectively communicate the organization's goals	Ongoing	Print and post communications from senior management. Invite senior management to attend staff meetings once or twice a year
vi) WLP item #19	Senior managers act on staff feedback	Ongoing	Provide opportunities for staff to provide feedback to senior management (as above)
vii) WLP item # 24	Work life balance	Ongoing	Discuss during annual performance evaluation process. Nurse educators to discuss during staff meeting. Lunch and Learn on the Employee & Families Assistance Program (EFAP) to be offered. Spiritual care clinician to be invited for a lunch and learn.

Patient Safety (SIMS)	All SIMS reports will be reviewed at quality team meetings	Sept 2017 – Ongoing	Identify any follow-up required
Data Reports	Service data will be reviewed at quality team meetings to explore "impact on practice"	Sept 2017 – Ongoing	Review of key indicators related to outcome monitoring
Person & Family Centered Care	Quality assurance: family education groups, family information and family meetings at discharge.	Ongoing	Surveys, chart reviews and Kardex checks
Transitions of Care: partner with Community Mental Health (CMH) to focus on the process of setting up appointments at discharge for improved transfer of care and increased support for treatment in the community.	This initiative involves a coordinated approach from multiple disciplines in both Acute Care and CMH. The intent is to improve transfer of care so patients leave with a date for an appointment and Acute Care improves the time frame for getting the discharge summary to the receiving team.	Dec 2016	Ongoing meetings between CMH and Acute Care and meetings with leadership in Acute Care
One assessment tool for all disciplines (part of ongoing Collaborative Care Initiative work)	To have one assessment on each chart rather than several individual discipline assessments	Spring 2016	Ongoing work with clinical educator support

Community Mental Health and Addictions

Services Represented:

1) Community Mental Health and Addictions (CMH&A) Including:
    a. Bayers Road CMH&A
    b. Bedford-Sackville CMH&A
    c. Cole Harbour CMH&A
    d. Dartmouth City CMH&A
    e. Hants CMH&A
    f. Bedford Row Addictions services
    g. Wyse Road Addictions services

Key Accomplishment(s) 2015/16:

Title: **Integration of Community Mental Health and Addictions Community-Based Services Quality Teams**

Description: As a result of reorganization across Mental Health and Addictions the Community Mental Health and Addictions Services merged to become one quality team. First voice and affected others from each area are part of the newly integrated Community Mental Health and Addictions Quality Team.

Indicators / Outcomes: A survey was completed at one of our first joint meetings measuring items such as: effectiveness of meetings, goal direction and whether participants felt they had an opportunity to contribute to the meetings. The survey will be repeated in June 2017 to monitor team outcomes.

Title: **Diversity and Inclusion**

Description: Educate clinicians on utilizing the diversity lens toolkit in their everyday practice. The toolkit was introduced at team meetings with attention to focus areas such as generating conversations about diversity in communities and increasing the awareness of resources.

Indicators / Outcomes: The next step, which is in alignment with the NSHA organizational plan, is for staff to be involved in cultural competence training specific to Indigenous people. An indicator used to monitor success is numbers of staff attending and a standing agenda item for team meetings to facilitate dialogue and increased awareness.

Title: **Inter-Service collaboration**

Description: A collaborative process that facilitates the flow of clients in a client centered manner. The focus of Community Mental Health was with Psychiatric Emergency Services and the Mobile Crisis Team. Addictions Services was collaborating with Addictions Inpatient Treatment Services (ITS) and Addictions Central Intake. Both initiatives involved relationship building. With the Community Mental Health initiative there were standards developed for collaboration between the services. In Addictions, Community Based Services adopted Treatment Matching.

Indicators / Outcomes: Continue to monitor the effectiveness of these collaborative relationships. At present this is done informally through conversations between services.

Title: **Chart Audits**

Description: 10 charts are being audited each month by each service area to assess whether the program is meeting documentation standards.

Indicators / Outcomes: Trends are monitored to improve documentation at the team level. Next steps include sharing the chart audit results at the Quality Team level and determining what initiatives should be implemented in this regard.

Ongoing Initiatives:

Initiative Name	Description	Status	Activities
Relapse Prevention Plan and Information Sharing Guidelines	For all service areas to be aware of the template and use as appropriate Use it as an adjunct to the Circle of Support consent form	March 2017	Quality leader going to site meetings and service level "champions" sharing information and addressing concerns
Care Plans	Chart audits will identify gaps. Standards are under development to determine what needs to be in place for care planning	Ongoing	Scan of care plans underway

Family Sensitive Care	Education for staff to focus on family centered care	Ongoing	Educational opportunities as a program

Crisis Services

Services Represented:

1) Short Stay Unit
2) Psychiatric Emergency Service (PES)
3) Mental Health Mobile Crisis Team (MHMCT)
4) Urgent Care Service

Key Accomplishment(s) 2015/16:

Title: **Revise Brief Mental Health Assessment Form**
Description: The Brief Mental Health Assessment Form used by PES, MHMCT and others was revised and piloted in February of 2016. In addition, the revised form was formatted for electronic entry (i.e. fillable form). Key changes include the addition of circle of support information to engage family supports early in care, and a suicide risk index to help support clinicians.
Indicators / Outcomes: Assessments are completed collaboratively by the inter-disciplinary team and consistency has improved in the documentation of the assessment of risk. Engagement and communication has improved with family / supports.

Title: **Inter-Service Collaboration Information Sharing Document**
Description: Information Sheets were exchanged between PES and MHMCT and Community Mental Health Services to clarify referral processes.
Indicators / Outcomes: Improved patient flow between services.

Title: **Implementation of Relapse Prevention Plans on Short Stay Unit**
Description: The Short Stay Unit, in collaboration with the Mental Health and Addictions Relapse Prevention Plan initiative, launched the Relapse Prevention Plan.

Indicators/Outcomes: Improved client and family involvement in care planning. Plans are shared via the health record to ensure continuity as clients return to the community.

Title: **Crisis Portfolio Retreat Day**
Description: Services of the Crisis Portfolio gathered in February of 2016 for a day of education on clinical management of crisis and knowledge exchange. Dr. Ron Fraser provided the education to the group.
Indicators/Outcomes: Improved knowledge base and understanding of roles and responsibilities amongst crisis services. Greater clinical skill set resulting from the education session provided by Dr. Fraser on clinical interventions.

Title: **Revise and Re-Launch of the Mental Health Program Alert Form**
Description: The alert form used throughout the Mental Health Program was reviewed, revised and re-launched. This was completed to improve the program's capacity to alert crisis services of concerns for clients who may require their care due to increased risk or decompensation.
Indicators/Outcomes: Improved treatment and outcomes for clients presenting at PES or MHMC due to the additional information provided on the alert form on suggested management plans from their clinician.

Ongoing Initiatives:

Initiative Name	Description	Status	Activities
Emergency Department/PES Retreat Day Recommendations	Improve mental health client experiences within emergency departments and improved transitions of care.	Ongoing	Working Groups for tasks have started. Recommendations have been themed and clustered by service areas. Tasks will be prioritized.
Inter-service Collaboration	Information Exchange with other services, as was completed with	Ongoing	Awaiting readiness of other portfolios to form new

	Community Mental Health		partnerships
Accreditation Required Organizational Practices (ROPs)	Addressing ROPs as identified by the self-assessment surveys and questionnaire.	Fall 2017	Process in initial phase

Developmental Disorders

Services Represented:

1) Community Outreach Assessment and Support Team (COAST)
2) Emerald Hall

Key Accomplishment(s) 2015/16:

Title: **Improving safety on Emerald Hall**

Description:

- Installation of security cameras and panic buttons
- Creation of Safe Work Practices and Safe Operating Practices
- Provision of personal protective equipment
- Safety Talks meetings every 3 weeks
- Updating Violence Prevention Plan

Indicators / Outcomes:

- Staff are able to recognize unsafe situations
- Staff are reporting incidents to the SAFE Line and management
- Staff are participating in SAFE Line investigations
- SAFE Line statistics are shared at staff meetings

Title: **Family Engagement**

Description: To increase family involvement in care planning and decisions regarding care

Indicators / Outcomes:

- Family participation in Clinical Care Planning Meetings
- Suggestion box for family members and care givers
- Experience based co-design project

Title: **Creation of a multi-disciplinary team**

Description: To build a multi-disciplinary team to improve patient outcomes

Indicators / Outcomes:

- Recruited a second Psychiatrist
- Recruited a Board Certified Behavioral Analyst (BCBA)
- Recruited a Recreation Therapist
- Recruited 2 full time Therapeutic Assistants (TA) and a 0.9 TA
- Recruited a full time Occupational Therapist
- Recruited a new Supervisor of Clinical Operations

Ongoing Initiatives:

Initiative Name	Description	Status	Activities
Recruit a Psychologist	Improve our capacity to support individuals with psychological needs	2017	To post for the position
Recruit a second BCBA	Improve our capacity to support individuals with behavioral needs	2017	To repost for the position
Environmental Restructuring	To provide an improved therapeutic environment for patient engagement	2017-2018	To create a design/ plan for structural improvement. To create proposal for funding
Practice Changes – Emerald Hall	Manage the increasing demands of patient care by improving the utilization of available resources	Ongoing	Reviewing constant observation and the interdisciplinary mix on the service. Improve training opportunities for staff. BCBA working with staff on positive behavioral support. Recreation Therapist working with all staff

			on therapeutic engagement with patients

East Coast Forensic Hospital (ECFH)

Services Represented:

1) Forensic Sexual Behaviour Program (FSBP)
2) Offender Health Services (OHS)
3) Mentally Ill Offender Unit (MIOU)
4) Rehabilitation Units
5) Community Program

Key Accomplishment(s) 2015/2016:

Title: **Inter-Service Collaboration with Recovery and Integration (R & I) Services**

Description: To improve the transition of care between ECFH and R & I Services. Allow a seamless transition to R & I from ECFH with increased comfort and trust.

Indicators / Outcomes:

- Improved handover of care from ECFH to R & I Services
- Improved communication between the two services
- Improved discharge planning
- Education sessions offered for the two services
- Evaluation of the transfer of care

Title: **Medication Safety (Rehab)**

Description: Decrease medication errors and increase patient safety

Indicators / Outcomes:

- Install two Pyxis machines for medication delivery
- All RN / LPN staff trained on Pyxis machines

Ongoing Initiatives:

Initiative Name	Description	Status	Activities
Communication with Community Doctors (Inpatient Rehab/ Community)	There will be a process in place that ensures the appropriate community doctors get information on forensic clients at the time of discharge and while in the community program.	Ongoing – December 2016	Assess and analyze the current process, create an enhanced process to improve communication.
Remodel of Rehab Service Delivery	A comprehensive model of service delivery for ECFH Rehab Program that is efficient, easy to understand, responsive, client-centered and provides opportunities for client collaboration will be developed.	Ongoing – March 2017	Retreats, program logic model in development, docket schedule developed and launched, intake process developed and launched, etc.
Psychiatric Intensive Care Unit (PICU)	To stabilize individuals and repatriate them back to their referring service.	Ongoing – March 2017	Evaluation of services offered by the program; Imminent Risk Rating Scale (IRRS) data, number of cases meeting admission criteria and number of cases meeting length of stay criteria being reviewed.

Admission Health Assessment Expansion (Offender Health)	1. To identify on admission those offenders who may be at imminent risk to harm themselves or others. 2. To provide more timely access to mental health assessment and treatment.	Ongoing – March 2017	Final revisions to SIROS (Screener: Imminent Risk in Offender Health Services), and Offender Health Services admission health assessment. Forms completed, formatted and in use.
Recidivism Study (FSBP)	To complete a recidivism study and publish same, in order to inform our own treatment program targets, and add to the general literature.	Ongoing – June 2017	Hire Research Assistant and apply for ethics review.

Recovery and Integration (R & I)

Services Represented:

1) Connections Dartmouth, Halifax and Sackville
2) East Coast Forensic Hospital Rehabilitation Services
3) Simpson Landing
4) Community Transition Program (CTP)

Key Accomplishments 2015-2016

Title: **Information Sharing about Recovery &Integration (R & I) Services to all stakeholders**

Description: To develop various types of information on R& I Services using different mediums to inform new participants, their circle of support and other stakeholders about our services.

Outcomes: a) Handout about R&I Services developed and put on the web site

b) Welcome & Orientation Packages refined and staff education provided
c) Submission to " Our Voice", the Mental Health and Addictions Newsletter, on a regular basis
d) Ongoing presentations about R&I Services to various stakeholders

Title: **Psychological Services within R & I**

Description: To provide psychological assessments, interventions (individual and group), consultation, training and supervision to staff delivering Cognitive Behavioural Therapy (CBT).

Outcomes: a) CBT Assessment Clinic has been implemented to evaluate readiness of clients for psychological interventions

b) 45 clients have been seen for CBT (28 completed, 12 partially completed, 5 assessments/ recommendations given to treatment team). Approximately 25 people are on a waiting list.

c) "Facing your Fears" and "Hearing Voices" groups were developed & delivered

d) Consultations /Case Reviews provided with complex individuals across R & I Services

e) Trained approximately 20 staff on Emotional Regulation

f) CBT Peer Supervision offered weekly

g) Trained approximately 45 staff in Motivational Interviewing and up to 28 staff received follow up supervision over a 3 month period

Title: **Health Services: Metabolic Monitoring**

Description: To review the basic standards of care for antipsychotic medication monitoring and recommend guidelines

Outcomes: a) Creation of metabolic monitoring guidelines for individuals taking psychotropic medication successfully piloted at Connections Sackville. Will now be implemented across all Connections Services

b) Medication Reconciliation completed for all new clients

Title: **Family Sensitive Care**

Description: To provide a variety of services/programs to engage families and friends in the care of their loved ones

Outcomes: a) Simpson Landing has successfully offered monthly engagement sessions since Sept 2015

b) Connections services has offered quarterly social gatherings with families and friends

c) Monthly supervision sessions for staff trained in Family Work will begin in October 2016

Title: **Centralized Intake of R & I Services**

Description: To improve the efficiency of Centralized Intake after 4 years of operation

Outcomes: a) Revised Recovery and Integration Services Referral Form (August 2016)

b) Developed a Recovery and Integration Transfer of Care Form

c) Created information on the Centralized Intake Process

d) Provided education sessions on the new Centralized Intake process to various stakeholders

e) Generated reports on Centralized Intake (e.g. # of referrals received, referral sources, and outcomes)

Title: **Addressing safety issues within R & I Services**

Description: To address common safety issues within R & I Services that emerged from the Work Place Violence Assessments and from incidents reported in patient and staff safety systems (SIMS/SAFE).

Outcomes: a) Connections Dartmouth and Halifax have panic buttons installed and an associated protocol developed

b) Emergency Car Kits and Emergency Community Outing Kits are being provided for all community outreach staff

c) All staff have key emergency phone numbers programmed in their cell phones

d) A Joint Occupational Health and Safety Committee (JOHSC) has been established at Simpson Landing (SL)

- A Work Place Improvement Committee at Simpson Landing was established
- Admission Guidelines to Simpson Landing were completed
- Algorithm and guidelines developed for managing clients with aggression
- Developed and Implemented Personal Safety Plans

Title: **Documentation Guidelines for R & I Services**

Description: To establish common documentation guidelines to be used across all R & I Services according to NSHA, professional & legal standards

Outcomes: a) Documentation guidelines manual is completed and revised as needed

b) Education sessions to R & I staff are provided and offered as needed

Ongoing Initiatives:

Initiative Name	Description	Activities	Status
Inter-Service Collaboration between R & I Services, Acute Care, and ECFH	To improve the Transition of Care of individuals between Acute Care, ECFH, Housing First, Mental Health Court and R & I Services	a)Meetings between ECFH & Acute Care staff and R & I Services are taking place a few times per year to establish action plans b) Early Identification Team going on a weekly basis to Acute Care Team meetings c) To meet with Housing First and Mental Health Court regarding transitions of care	a) Ongoing b) Ongoing c) To initiate
R & I Service Delivery Model (Matrix)	To define and refine R & I services based on evidence based practice to better respond to the needs of our target	a) An improved service delivery proposal has been developed but not yet implemented.	a) On hold until the NSHA MH&A provincial report is completed and distributed (Fall

	population		2016)
Evaluation of R & I Services	To set up various initiatives to evaluate the effectiveness of R & I Services.	a) Establish a framework for evaluating R & I Services (Logic Model) b) Recommendations of specific evaluation tools c) Refine our data collection and reporting with our present systems (STAR/PHS) d) Establish monthly chart audits on the documentation guidelines	a)In progress b)Completed but not yet implemented c) In progress d) In progress

Seniors Services

Services Represented:

1) Seniors Mental Health
    a. Seniors Outpatient Mental Health (Halifax and Dartmouth)
    b. Seniors Inpatient Mental Health (Willow Hall)
    c. Seniors Outreach
2) Electroconvulsive Therapy (ECT)

Key Accomplishment(s) 2015/16:

Title: **ECT & Seniors Mental Health Pamphlets Updated**
Description: All ECT and Seniors Mental Health pamphlets were reviewed and updated

Title: **Emergency Health Services (EHS) Patient Transports**
Description: In collaboration with EHS, a new system for booking patient transports for ECT was developed and utilized.
Indicators / Outcomes: EHS and ECT staff both report improvements.

Ongoing Initiatives:

Initiative Name	Description	Status	Activities
Comprehensive Initial Assessment on admission to Willow Hall	To develop one comprehensive assessment form to improve accessibility to the information and reduce redundancy of information collected	Spring 2017	Assessment forms currently used will be reviewed
Patient Relations	Purchase stamps with Patient Relations information on them to put on Seniors Mental Health pamphlet and other communications	Fall 2016	Stamps are in the process of being purchased for each department
Inter-service communication between Acute Care and ECT	To improve communication between the two service areas	Spring 2017	Discussions with leadership regarding improvement strategies
Develop Chart Audit Tools for Seniors Outreach and ECT	To develop a chart audit tool that can be used to audit documentation	Fall 2016	

Specialty Services

Services Represented:

1) Nova Scotia Early Psychosis Program
2) Eating Disorders
3) Sleep Disorders
4) Mood Disorders
5) Day Treatment Program
6) Neuropsychology
7) Centre for Emotions and Health
8) Consult Liaison Service
9) Operational Stress Injury Clinic

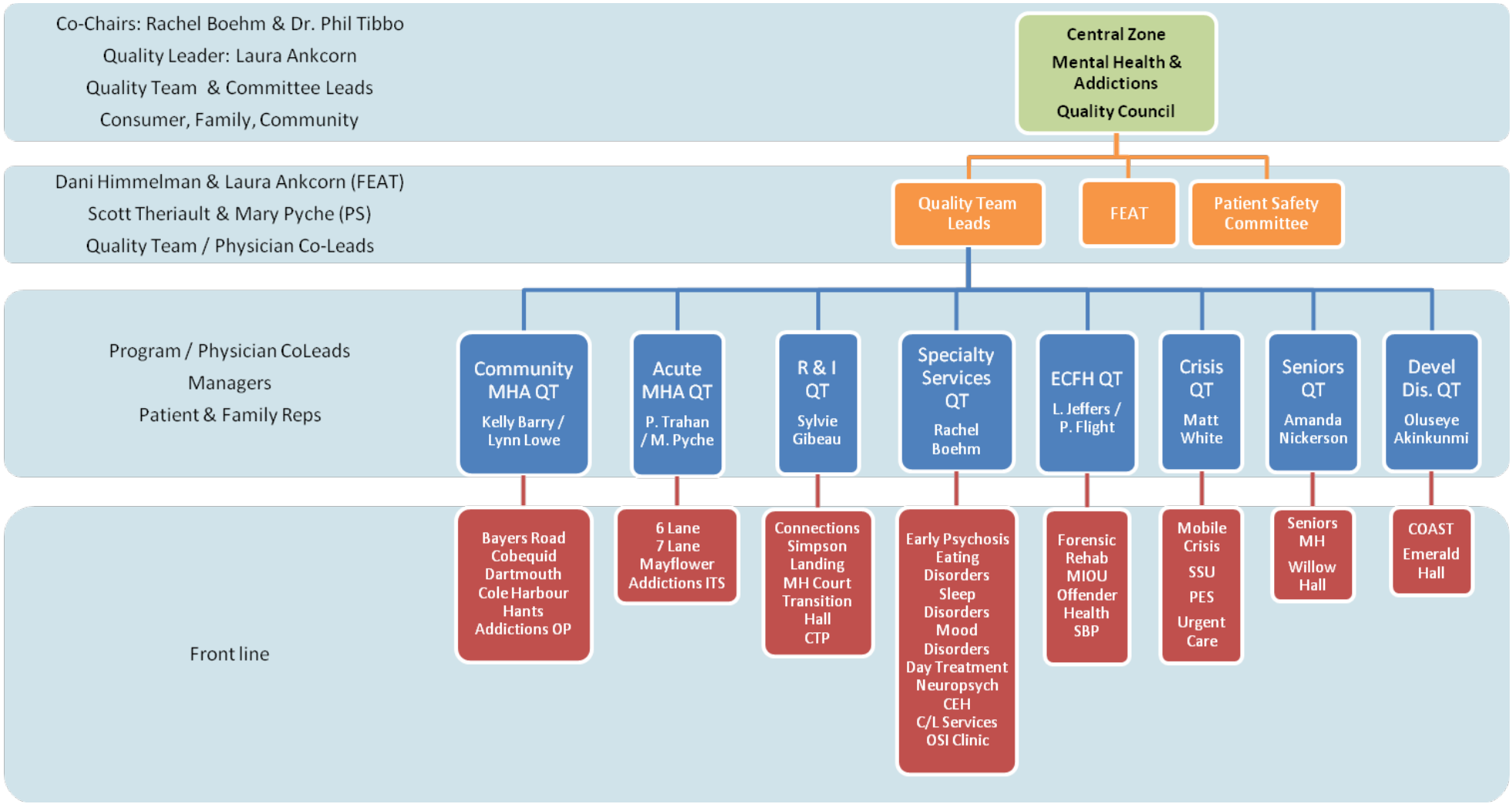
Ongoing Initiatives:

Initiative Name	Description	Status	Activities
Inter-service communication between Specialty Services and Community Mental Health	To improve communication between the two service areas	Spring 2017	Presenting to Community teams about Specialty Services and Admission criteria
Develop Chart Audit Tools	To have all Specialty teams completing monthly chart audits and reporting findings to team	Spring 2017	Develop tool for each team using template and implement
Improve consistency and compliance in regards to registrations in STAR and HPF	Complete reviews of STAR and HPF processes within each team to ensure consistency with other Mental Health and Addiction services.	Fall 2016	Reviewing current processes and identifying any areas of non compliance or needed improvements
Using data to inform decision making on teams	Identify which reports teams need to make decisions (e.g. no show,	Fall 2016	Begin to review data reports with teams regularly so that this

	wait times data)		information can inform decision making
Implementation of Relapse Prevention Plans in Specialty Teams (where applicable)	To have all relevant Specialty teams using the Relapse Prevention plans	Spring 2017	Introduce the form to teams where it has not yet been implemented and provide training/support to staff to effectively implement use of form
Accreditation 2017	To prepare and address needs for accreditation	June 2017	Initiatives developed to address Patient Safety Culture and Work Life Pulse surveys. Other Accreditation prep as determined by Program Quality Council

Appendix A

Mental Health and Addictions Quality Program Structure



Appendix B

Mental Health and Addictions
Patient and Family Experience Survey Results

Halifax Area, Eastern Shore, West Hants
October 2014 – March 2016

The Feedback and Experience Action Team (FEAT)

This committee gathers feedback from Mental Health and Addiction patients and their family and friends, and is made up of patients, family members, providers/managers, and community support groups. This report is based on the inpatient, outpatient, and family and friends experience surveys. FEAT will use this information to provide recommendations to leadership to help improve services across Mental Health and Addictions. Individual services will receive results specific to their service to evaluate and make improvements in their area.

Survey Tools	*Method*
The Mental Health and Addictions Inpatient and Outpatient Experience Surveys were developed by Accreditation Canada and adopted by the health authority, with permission. The Family and Friends Experience Survey was developed in-house to gather information on the experience of care specifically from family and friends.	All surveys are confidential and anonymous. They are available on-line and in all service areas year-round. There are bi-annual "blitz" weeks, where all patients, family and friends are offered an opportunity to complete a survey. The surveys can be completed on-line, returned to a staff member, or returned by mail using the pre-paid return envelope. This report covers an 18 month period. Typically, this information will be reported on an annual basis.

What Was Measured

The surveys look at the experience of mental health and addictions care from the perspective of inpatients, outpatients and their family and friends across the following eight dimensions of care:

- Access
- Collaboration
- Dignity and Respect
- Effectiveness
- Environment
- Information
- Rights
- Overall Experience

Additional questions are asked about demographics and space is provided for comments on what went well and what could have been improved.

What These Results Mean

The target (or goal) is to achieve a 90% positive response rate or higher. Positive response rates between 70% and 89% indicate work is required to meet target. Positive response rates below 70% are not meeting target.

What We Found

Over the 18 month period 1000 outpatient, 312 inpatient and 121 family and friends experience surveys were returned[1]. The following is a summary of results by care dimension. The percentage indicates the average positive response in each dimension.

Dimension	***Outpatient*** *(% positive results*)*	***Inpatient*** *(% positive results*)*	***Family and Friends*** *(% positive results*)*
Access The length of time waiting for services to start, time for staff to return phone calls, time spent waiting for appointments, time spent waiting to get to a hospital room, and the availability of activities when in hospital.	**90%**	**63%**	**77%**
Collaboration Being involved in decisions about treatment, understanding the care plan, feeling supported for improvement and recovery, support for having family and friends involved in care, and involvement in planning for discharge from hospital.	**84%**	**69%**	**88%**
Dignity and Respect Having individual needs, preferences and values taken into account in treatment, being treated with respect, being treated unfairly for any reason, care regarding physical health problems, and receiving a special diet in hospital (if required).	**87%**	**75%**	**89%**
Effectiveness The results of care such as feeling better prepared to deal with daily problems, accomplishing the things you want to do, and being helped by the program or service.	**72%**	**64%**	**73%**
Environment The cleanliness of the facility, feeling safe, having enough privacy, the quality of hospital food, and if the area around hospital room is quiet at night.	**95%**	**80%**	**-****
Information Staff explaining the purpose of medication and possible side effects, being informed about other services and supports available in the community, and the daily routine when arriving for a hospital stay.	**78%**	**71%**	**73%**
Rights Feeling able to refuse treatment, and knowing how to make a complaint.	**49%**	**45%**	**-****
Overall Experience Overall rating of the services and if the same service would be chosen if treatment was needed again.	**91%**	**73%**	**80%**

*Positive Score 90-100%: Meeting Target 70-89%: Needs Work <70%: Not Meeting Target

**There were no questions corresponding to this domain in the Family and Friends Survey

[1] These numbers represent approximately 6% of outpatients and 15% of inpatients in this time period.

Top Strengths and Top Areas for Improvement

"Once I was referred by [ ], I began receiving services, fairly quickly… but prior to that I had been unable to obtain adequate referral, service, or information through my current doctor... I wish I could have regular therapy sessions with my psychiatrist"
– Outpatient Comment

Outpatient Experience Survey Results

Top Strengths

Cleanliness of areas where service is received	97%
Cleanliness of common areas	95%
Feeling safe at the program or service	95%
Feeling treated with respect by staff	95%
Time waiting when you have an appointment	94%

Top Areas for Improvement

Knowing how to make a complaint	26%
Feeling more ready to accomplish things you want to do	64%
Feeling better prepared to deal with daily problems	70%
Being informed about other services and supports in the community	74%
Consideration of physical health problems	74%

Inpatient Experience Survey Results

Top Strengths

Wait time to get to room	94%
Cleanliness of common areas	93%
Feeling treated with respect by staff	86%
Cleanliness of your room	86%
Cleanliness of your washroom	82%

Top Areas for Improvement

Knowing how to make a complaint	41%
Availability of activities on evenings and weekends	41%
Availability of activities of interest	52%
Feeling treatment can be refused	52%
Talking about discharge with staff	54%

"I truly value the professionalism, understanding and respect shown by this team. I trust this staff… I have a lot of work to do but I feel less alone... The staff, everyone has a great attitude… my voice was valued here."
- Inpatient Comment

Family and Friends Experience Survey Results

Top Strengths

Being treated with courtesy and respect	95%
Being acknowledged and welcomed by staff and clinicians	93%
Feeling safe leaving family/friend in the care of clinicians	90%
Knowledge and concerns valued and taken into consideration	89%
Comfort with sharing information with clinicians	88%

Top Areas for Improvement

Given or informed of the Family Handbook "Living with Mental Illness"	41%
Help and support for own health and wellbeing	49%
Information about community supports for self and others	62%
Information about community supports for the patient	71%
Enough information about signs and symptoms of relapse	74%

"All staff that worked with [us] were very kind, professional and caring. All our concerns and question were addressed and staff members definitely went out of their way to assist us and our patient. Thank you!!"
– Family/Friend Comment

Recommendations for Improvement

The following recommendations were developed by FEAT based on these results and presented to the leadership of Mental Health and Addictions:

It is recommended that…

1) Staff improve skills and competency to support the involvement of family and friends in care.
2) All patients have a care plan in place, developed in collaboration with the patient, family and provider. The care plan is to follow the guidelines established by Accreditation Canada.
3) More information is made readily available for patients on their rights and how to make a complaint.
4) Goals and expected results are identified in collaboration with the patient and their family and these are monitored regularly in accordance with the care plan.
5) Relevant and easily accessible information is made available for patients and families on topics such as medication (the purpose and potential side effects), supports available in the community, and the signs and symptoms of relapse.
6) Collaboration is improved with the client and family on inpatient units, particularly in making decisions about treatment, talking about and planning for discharge.
7) Activities currently available to inpatients are evaluated to determine, in consultation with patients, how they can be improved.
8) The duty of care to families is clarified to help in the planning and development of supports necessary for the health and wellbeing of families, and to ensure they get the help and support they need to manage day to day situations with their family member or friend.

Thank you very much for taking the time to complete a survey and provide this valuable feedback

We need your input to know what we are doing well and what needs improvement

We appreciate your ongoing feedback to see if our efforts are making a difference

Other ways to provide us feedback include:

- Filling out a comment card available in all service areas
- Speaking with the service manager (please ask a staff member for their contact information)
- Contacting a patient relations representative at (902)473-2133; toll free at 1-855-799-0990; or by e-mail at healthcareexperience@cdha.nshealth.ca

For more information on the surveys or providing feedback, please contact Laura Ankcorn at laura.ankcorn@nshealth.ca or by phone at (902)464-3445

Appendix C

nova scotia health authority

10 CHART/KARDEX MONTHLY AUDIT

Service / Unit: _____

Date of Audit :_____

Place **Y** (yes) or **N** (no)or **NA** (not applicable) under the appropriate chart for the appropriate criteria	Chart #1	Chart #2	Chart #3	Chart #4	Chart #5	Chart #6	Chart #7	Chart #8	Chart #9	Chart #10	% compliance
Accreditation and/or Provincial Standards											
#1) Consent to Treatment has been obtained and documented (Policy # CH 30-045)											
#2)Medication Reconciliation Form(s) completed as appropriate per Policy # MM50-003. **This does not replace the Safer Healthcare Now Med Rec Audit**											
#3)Falls Risk Assessement Completed signed, dated and reason for assessment(Policy # CC 05-045 or 46)											
#4a) Suicide Risk Assessment Completed at first contact and when deemed necessary thereafter (Policy # CC 65-037)											
#4b) Suicide Risk Assessment at moderate or high risk have a monitoring and management plan documented (Policy # CC 65-037)											
#4c) Suicide Risk Assessment, monitoring and management plan is communicated to others involved in the patients care, as appropriate (Policy # CC 65-037)											
#5a)TOA: Shift to Shift Transfer of Information documented in most recent Nursing Flow Sheet or Nursing Note (Policy # CH 30-060)											
#5b)TOA: Unit to Unit Transfer of Information upon transfer documented in most recent Nursing Flow Sheet or Nursing Note											
#5c)TOA: Unit to Unit Transfer of Information upon acceptance documented in most recent Nursing Flow Sheet or Nursing Note											
#6) Consent to Share Information with Family and Friends - Your Circle of Support form completed and documented (CD2781MR)											
#7) Individualised Care Plan for client is complete and documented.											
Service or Unit or Specific Audit Items											