Ontario Health
Quality

Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

May 2, 2020

Taddle Creek
Family Health Team

OVERVIEW

Taddle Creek Family Health Team (TC FHT) has two sites in downtown Toronto, Ontario: Bay/College & Bloor/Christie. TC FHT has 18553 enrolled patients and about 4564 active, non rostered patients. Our clinical team consists of 16 physicians, 3 nurse practitioners, 3 registered nurses, 4 social workers, 1 dietitian, 1 pharmacist and 1 physician assistant. We also have a Diabetes Education Program (DEP) who cares for both TC FHT and community patients living with diabetes. DEP staffing consists of 2 diabetes nurse educators and 2 dieticians. In total there are 50+ staff working to care for this population.

TC FHT has a Quality Improvement Committee (QIC) that meets quarterly with two physicians, interdisciplinary health providers and administration; there is representation from both sites. Our QIDSS (Quality Improvement Decision Support Specialist), in conjunction with the Executive Director, chair the QIC. The QIC is responsible to develop the Quality Improvement Plan (QIP), implement change ideas and monitoring progress. In drafting the F20/21 QIP, QIC considered Health Quality Ontario's (HQO) priority indicators & Practice Reports, the ON MOHLTC's Health Data Branch statistics, TC FHT's F19/20 QIP (including Patient Care Survey results) and TC FHT's 2015 Strategic Plan. The QIC also considered The People's Health Care Act, 2019, the government's mandate to address Ontario's health system capacity challenges. Once the QIP is finalized, the Executive Director discuss it with TC FHT's Board in June and then report on progress throughout the year. The QIC will also present at a late spring Clinical Meeting (where most staff are present).

Below is an overview of TC FHT's F20/21 QIP. For each measure, the following is provided: current performance/target, quality dimension, rationale and our change ideas.

1) Measure: % of hospital discharges (any conditions), where timely (within 48 hours) notification was received, for which f/u was done (any mode, any clinician) within 7 days of discharge.
Current Performance: 71% (Source: eMR) Target: 75%
Dimension: Efficient

Rationale: Discharged patients require ongoing support from primary care once discharged from hospital. When we receive notice from hospitals that one of our patients has been discharged, we aim to contact the patient, ideally within 7 days of their discharge to discuss discharge instructions, discharge medications, home-care needs, f/u with specialist appts, in-home supports and their need to come in for an appointment. By following up with patients we ensure their conditions have stabilized and their care is coordinated supporting an effective transition from hospital to home and potentially avoid readmissions.

Change Ideas: F19-20 was the 1st year TC FHT collected data for all conditions (not just selected conditions). We did this to reduce the burden on Administrative Staff who had difficulty deciphering from hospital discharge summaries if the discharge was for a selected condition and b/c there may be pts discharged, for other reasons (other than selected condition), who need support. We send a message to the Primary Care Provider (PCP) to review the chart to determine if contacting pt is necessary (and provide method to indicate 'Contact NOT Necessary' - cases removed from denominator) and to document in the already inserted '7-day Post

Hosp Disch. F/U Encounter Assistant (EA).' Although the importance of completing the EA consistently and accurately was communicated, often it is not, necessitating Admin. to audit and complete. It is for this reason that monitoring and reminding PCPs to complete that EA consistently and accurately is continuing for F20-21. A second change idea is to monitor the use of a new malnutrition screening tool - 3 questions (imbedded into the EA). We know that 30-50% of seniors are malnourished upon hospital admission and that only 11% are referred to a dietitian for malnutrition management post discharge (i.e. referral to FHT's dietitian if score <22).

2) Measures: % of patients able to see a doctor or nurse practitioner (NP) on the same or next day, when needed.
Current Performance: 77% (Source: 19-20 Survey). Target: 80%
% of patients who stated that when they see the doctor or NP, they or someone else in the office always/often involve them as much as they want to be in decisions about their care and treatment
Current Performance: 97% (Source: 19-20 Survey) Target: 97%
Quality Dimensions: Timely/Patient-Centred

Rationale: In May 2015, the Institute of Medicine defined patient-centered care as: "Providing care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions. Being patient-centred means listening to, informing and involving patients in their care." Since 2013 TC FHT has been surveying our patients because we want to hear what our patients are saying about access, about the care and treatment they are receiving and how they think we can improve. We will continue to survey our patients, support a patient advisory committee (PAC) and act on what we hear to the best of our ability.

Change Ideas: We will continue to pose the following questions on our Patient Care Survey: The last time you were sick or were concerned you had a health problem, now many days did it take from when you first tried to see your doctor or NP to when you actually saw him/her or someone else in the office? When you see your doctor or NP or someone else, how often do they involve you as much as you want to be in decision about your care and treatment? We also want to continue using our online patient portal (Health Myself) to administer the survey to maintain the efficiency gained in F19-20. We will continue to collect, once a month, for all physicians/NPs, the number of days to their third next available (TNA) appointment and present to our Board the '% of months with a TNA <=1 day.' Our last change idea for this measure is to add the other remaining 6/19 physicians/NPs to use e-booking.

3) Measure: % of non-palliative patients newly dispensed an opioid prescribed by any provider in the healthcare system within a 6-month reporting period.
Current Performance: 3.3% (Source: FY18-19 HQO PCPR)
Target: 3%
Quality Dimension: Safe

Rationale: Opioids are natural or synthetic substances used to reduce pain in clinical settings, but are also produced and consumed non-medically. Common opioids include oxycodone, hydromorphone and fentanyl. While they can be an effective part of

pain management for some medically supervised patients, opioid-related harms such as addiction and overdose present a significant challenge for public health. The City of Toronto's number of suspected opioid overdose calls received by Toronto Paramedic Services, from December 9, 2019 to March 1, 2020 was 800 with 33 fatalities.

Change Ideas: F19-20 TC FHT worked to understand what part we should play in this complex health and social issue and how it impacts our patient population. Since 2010 we have had a policy/procedure in place for prescribing of opioid (Narcotic) medications (posted on our website). Our policy/procedure was based on The College of Physicians and Surgeons of Ontario's 2000 Evidence-based Recommendations for Medical Management of Chronic Non-Malignant Pain. In F19-20 we updated our existing policy/procedure to ensure best practices (we used a lot of the HQO resources provided at their Feb 11, 2019 webinar). In F19-20 we also implemented a Opioid Resource Custom Form that includes pain/risk/f/u assessments, our tx agreement, clinical tools and pt education documents. In F20/21 we plan to build on this by monitoring that all pts newly prescribed opioids (by TC FHT providers) or first renewal of opioids (by TC FHT providers) when prescribed by external healthcare providers, have a signed opioid contract in their eMR

4) Measure: % of pts who receive a medication reconciliation, within 7 days, after discharge from hospital.
Current Performance: 21% (Source: eMR) Target: 25%

Rationale: A recent Canadian adverse events study indicates that the most common types of adverse events include drug-related events (Baker, Norton, Flintoft, Blais, Brown, Cox, Etchells, Ghali, Hébert, Majumdar, O'Beirne, Palacios-Derflingher, Reid, Sheps and Tamblyn, JAMC, 2004). The study found that 3.1% of 3745 charts reviewed retrospectively had documented an adverse drug reaction. However, this is likely underestimated as unplanned hospital admissions or readmissions due to medication non-adherence may not be captured.

Change Ideas: In F19/20 we improved our MedRec documentation tools in order to calculate % of pts who receive a medication reconciliation, within 7 days, after discharge from hospital. Our Quality Improvement Decision Support Specialist (QIDSS) converted our MedRec stamp to a MedRec Custom Form (CF) that can be used independently and also imbedded the CF into our '7-day Post Hosp Disch. F/U Encounter Assistant (EA). Our pharmacist educated the team on using the MedRec CF and EA and also how to do a MedRec.

For F20/21 we plan to calculate % of pts who receive a medication reconciliation, within 7 days, after discharge from hospital. Numerator will be # pts with a 7 day Post Hospital Discharge F/U EA with 'yes' to Med Rec, denominator will be # pts with a 7-day Post Hosp Disch. F/U EA. We also plan to develop a Medical Directive that allows an interdisciplinary approach MedRec. This would allow TC FHT to eventually expand the MedRec initiative to other patient sub-populations (i.e. complex pts and frail elderly).

5) Measure: % of patients, >=18yrs, screened for poverty.
Current Performance: 1.6% (Source: eMR) Target: CB
Quality Dimension: Equitable Care

Rationale: A recent report by Statistics Canada (Cause-specific Mortality by Income Adequacy in Canada: A 16-year Follow-up Study) demonstrated that income inequality is associated with the premature death of 40,000 Canadians a year. Income is a social determinant of health, if we start to discuss income problems we can improve health. We want to continue screening our population for poverty by asking two questions: Do you have difficulty making ends meet at the end of the month? Have you filled out and sent in your tax forms? If patients confirm they have difficulties making ends meet or have not done their taxes, we then will inform, intervene and connect. More specifically we will provide information on free community tax clinics and federal/provincial social benefits.

Change Ideas: We did not get traction using our eMR Custom Forms (CF) (Socioeconomic Status Screen, Seniors Care, Diabetes Intake) designed to measure % of pts screened for poverty (FY 2019 = 1.6% and 92% from Diabetes Intake CF). For FY20-21, our QIC decided to get baseline data, to calculate prevalence of poverty in our population, using our Patient Care Survey. We will be adding 2 questions to our 2020 Pt Care Survey - Do you ever have difficulty making ends meet at the end of the months? Have you filled out & send in your tax forms? We will also, on our Pt Care Survey, direct pts to the FHT's website for additional resources, pt handouts and appointment booking information for our Single Session Counselling.

6) Measure: % of pts, turning 50, who complete fecal immunochemical test (FIT).
Current Performance: 15% (Source: eMR). Target: 33%
Quality Dimension: Equitable

Rationale: Research shows almost 7 out of 10 people diagnosed with colorectal cancer have no family history of the disease. It is important people get screened even if they do not have a family history of the disease. Research has shown most people diagnosed with the disease are older than age 50. Getting screened helps find colorectal cancer early, when it is easier to treat. When colorectal cancer is caught early, 9 out of 10 people with the disease can be cured. If someone does not get screened, they could have colorectal cancer and not know it. This is why most people should start screening for colorectal cancer at age 50 (https://www.cancercareontario.ca/en/types-of-cancer/colorectal) and why we are targeting pts turning 50 (to get them use to the fact that they have to been screened moving forward in their lives).

Change Idea: In Jan 2014, we initiated a 'Turning 50 FOBT' QI initiative and have continued with this initiative until the introduction of the FIT (introduced in Jun 2019). Our 'Turning 50 FOBT' QI initiative involved generating a list of pts turning 50, RNs auditing chart for appropriateness and then if appropriate, mailing a letter, FOBT kit & lab req encouraging pt to do the test. The RN then would f/u with the pt in a couple of months to see if test had been completed. The 'Turning 50 FOBT' QI initiative was successful, for example for the months of Mar-Apr 2019 - 33% were completing the FOBT test. With the success of the FOBT QI initiative, we wanted this to continue with the FIT but knew the process needed revision. For example, with the FIT, when the physician/NP sees the pt they complete the lab req. and then Lifelabs mails the kit directly to the pt. With Lifelabs sending out the kit, it now changed the process significantly. The FOBT QI Initiative was stopped in Jul 2019 (with the introduction of the FIT)

and we immediately saw a drop in the % of pts Turing 50 completing the test (Jul-Aug 2019 = 14.6% & Sep - Feb 2020: 15.3%). We have revised the process using the Preventative Care Summary Report in our eMR and plan to continually measure until we once again meet a target of 33%.

7) Measure: % of patients with diabetes, aged 40 or over, with two or more glycated hemoglobin (HbA1C) tests within the past 12 months.
Current Performance: 56% (Source: eMR) Target: 60%
Quality Dimension: Equitable Care

Rationale: In 2017, Statistics Canada reports 7.3% of Canadians aged 12 and older (roughly 2.3 million people) reported being diagnosed with diabetes. This is obviously a population health concern. Good diabetes care can reduce the impact of the disease (i.e. premature deaths, hospitalization for cardiovascular/renal disease, etc.). We want to make sure our patients are managing their diabetes by ensuring excellent ongoing diabetes care and one way to do that is for patients suffering from diabetes to visit us.

Change Ideas: We will provide reports of patients who have not had two or more HbA1C tests in the past 12 months in the fall of 2020 to primary care providers and to our Diabetes Education Program [for FHT patients historically seen by the DEP but not in the past 12 months (for them to follow up with these patients)].

Summary

TC FHT's 2020 QIP initiatives are ambitious but worthwhile. We continue to follow up with pts within 7 days of a hospital discharge and follow up with pts living with diabetes who haven't had 2 HbA1c tests in 12 months. We are also transitioning our colorectal cancer screening process for the FIT and working to address income inequity. To improve safety, we are improving our opioid prescribing and medication reconciliation practices. Lastly we are listening to our patients' voice via our patient care survey.

DESCRIBE YOUR ORGANIZATION'S GREATEST QI ACHIEVEMENT FROM THE PAST YEAR

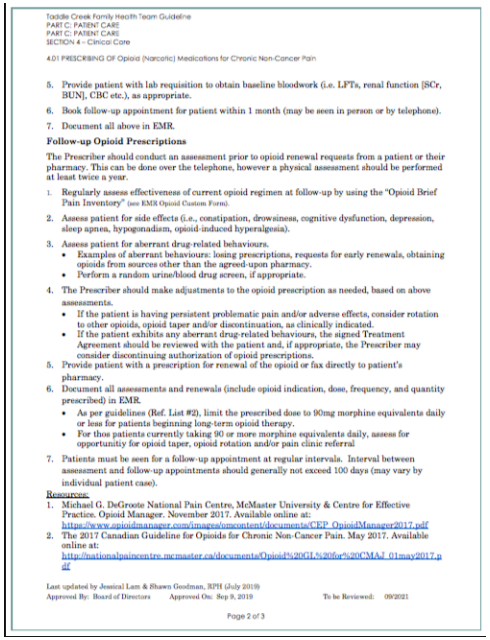
In F19-20 we had a goal to optimize pain management strategies while ensuring opioids are used safely and patients are well-informed of the potential risks and benefits before starting and continuing therapy. We believe we made major strides towards this goal thus making it our greatest QI achievement. To achieve this goal we updated our Prescribing of Opioid (Narcotic) Medications for Chronic Non-Cancer Pain Policy & Procedure and our Treatment Agreement (see attached). We also built and implemented a Opioid Custom Form (CF) (see attached) in our electronic medical record for clinicians to use. The CF includes: pain/risk/f/u assessments, our tx agreement, clinical tools and pt education documents. Our Quality Improvement Committee [more specifically our Pharmacist and Quality Improvement Decision Support Specialist (QIDSS)] presented the work to the FHT on Nov 26, 2019. The material was well received. To ensure our patients were aware, we posted the Policy & Procedure on our Website and wrote an article in our patient newsletter (published Spring 2020). In F20/21 we plan to build on this work by tracking the % of patients with newly dispensed or renewed opioids with signed opioid contract in the eMR.

Opioid (Narcotic) Resources Custom Form

Updated: October 2019

PAIN ASSESSMENT	RISK ASSESSMENT	TREATMENT AGREEMENT	CLINICIAN TOOLS	FOLLOW-UP ASSESSMENT	PATIENT EDUCATION
Brief Pain Inventory DN4 Questionnaire	Opioid Risk Tool - Male ...ioid Risk Tool - Female	Policy & Procedure Treatment Contract Opioid Letter to Pharmacist	MEQ Calculator Opioid Manager PHQ-9	UDS Lab Req	Opioid Info Opioid Overdose Storage & Disposal Problematic Use

Latest UDS: Latest ORT (Male/Female): /



Taddle Creek Family Health Team Guideline
PART C: PATIENT CARE
PART C: PATIENT CARE
SECTION 4 – Clinical Care

4.01 PRESCRIBING OF Opioid (Narcotic) Medications for Chronic Non-Cancer Pain

5. Provide patient with lab requisition to obtain baseline bloodwork (i.e. LFTs, renal function [SCr, BUN], CBC etc.), as appropriate.
6. Book follow-up appointment for patient within 1 month (may be seen in person or by telephone).
7. Document all above in EMR.

Follow-up Opioid Prescriptions

The Prescriber should conduct an assessment prior to opioid renewal requests from a patient or their pharmacy. This can be done over the telephone, however a physical assessment should be performed at least twice a year.

1. Regularly assess effectiveness of current opioid regimen at follow-up by using the "Opioid Brief Pain Inventory" (see EMR Opioid Custom Form).
2. Assess patient for side effects (i.e., constipation, drowsiness, cognitive dysfunction, depression, sleep apnea, hypogonadism, opioid-induced hyperalgesia).
3. Assess patient for aberrant drug-related behaviours.
   - Examples of aberrant behaviours: losing prescriptions, requests for early renewals, obtaining opioids from sources other than the agreed-upon pharmacy.
   - Perform a random urine/blood drug screen, if appropriate.
4. The Prescriber should make adjustments to the opioid prescription as needed, based on above assessments.
   - If the patient is having persistent problematic pain and/or adverse effects, consider rotation to other opioids, opioid taper and/or discontinuation, as clinically indicated.
   - If the patient exhibits any aberrant drug-related behaviours, the signed Treatment Agreement should be reviewed with the patient and, if appropriate, the Prescriber may consider discontinuing authorization of opioid prescriptions.
5. Provide patient with a prescription for renewal of the opioid or fax directly to patient's pharmacy.
6. Document all assessments and renewals (include opioid indication, dose, frequency, and quantity prescribed) in EMR.
   - As per guidelines (Ref. List #2), limit the prescribed dose to 90mg morphine equivalents daily or less for patients beginning long-term opioid therapy.
   - For thos patients currently taking 90 or more morphine equivalents daily, assess for opportunitiy for opioid taper, opioid rotation and/or pain clinic referral
7. Patients must be seen for a follow-up appointment at regular intervals. Interval between assessment and follow-up appointments should generally not exceed 100 days (may vary by individual patient case).

Resources:

1. Michael G. DeGroote National Pain Centre, McMaster University & Centre for Effective Practice. Opioid Manager. November 2017. Available online at: https://www.opioidmanager.com/images/concurrent/documents/CEP_OpioidManager2017.pdf
2. The 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain. May 2017. Available online at: http://nationalpaincentre.mcmaster.ca/documents/Opioid%20GL%20for%20CMAJ_01may2017.pdf

Last updated by Jessica Lam & Shawn Goodman, RPH (July 2019)
Approved By: Board of Directors Approved On: Sep 9, 2019 To be Reviewed: 09/2021

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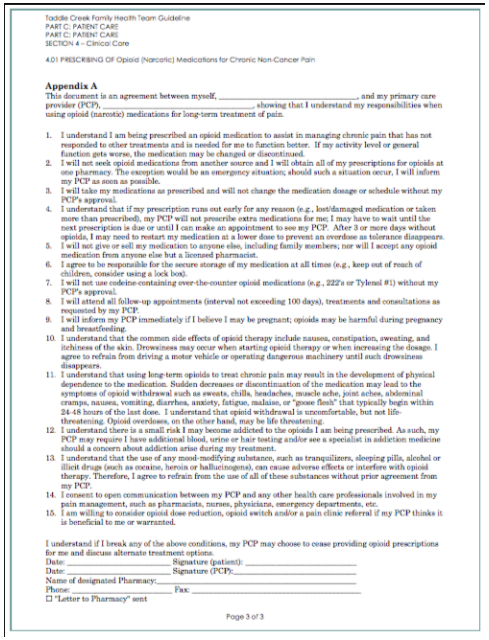

Taddle Creek Family Health Team Guideline
PART C: PATIENT CARE
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SECTION 4 – Clinical Care

4.01 PRESCRIBING OF Opioid (Narcotic) Medications for Chronic Non-Cancer Pain

Appendix A

This document is an agreement between myself, _____, and my primary care provider (PCP), _____, showing that I understand my responsibilities when using opioid (narcotic) medications for long-term treatment of pain.

1. I understand I am being prescribed an opioid medication to assist in managing chronic pain that has not responded to other treatments and is needed for me to function better. If my activity level or general function gets worse, the medication may be changed or discontinued.
2. I will not seek opioid medications from another source and I will obtain all of my prescriptions for opioids at one pharmacy. The exception would be an emergency situation; should such a situation occur, I will inform my PCP as soon as possible.
3. I will take my medications as prescribed and will not change the medication dosage or schedule without my PCP's approval.
4. I understand that if my prescription runs out early for any reason (e.g., lost/damaged medication or taken more than prescribed), my PCP will not prescribe extra medications for me; I may have to wait until the next prescripcion is due or until I can make an appointment to see my PCP. After 3 or more days without opioids, I may need to restart my medication at a lower dose to prevent an overdose as tolerance disappears.
5. I will not give or sell my medication to anyone else, including family members; nor will I accept any opioid medication from anyone else but a licensed pharmacist.
6. I agree to be responsible for the secure storage of my medication at all times (e.g., keep out of reach of children, consider using a lock box).
7. I will not use codeine-containing over-the-counter opioid medications (e.g., 222's or Tylenol #1) without my PCP's approval.
8. I will attend all follow-up appointments (interval not exceeding 100 days), treatments and consultations as requested by my PCP.
9. I will inform my PCP immediately if I believe I may be pregnant; opioids may be harmful during pregnancy and breastfeeding.
10. I understand that the common side effects of opioid therapy include nausea, constipation, sweating, and itchiness of the skin. Drowsiness may occur when starting opioid therapy or when increasing the dosage. I agree to refrain from driving a motor vehicle or operating dangerous machinery until such drowsiness disappears.
11. I understand that using long-term opioids to treat chronic pain may result in the development of physical dependence to the medication. Sudden decreases or discontinuation of the medication may lead to the symptoms of opioid withdrawal such as sweats, chills, headaches, muscle ache, joint aches, abdominal cramps, nausea, vomiting, diarrhea, anxiety, fatigue, malaise, or "goose flesh" that typically begin within 24-48 hours of the last dose. I understand that opioid withdrawal is uncomfortable, but not life-threatening. Opioid overdoses, on the other hand, may be life threatening.
12. I understand there is a small risk I may become addicted to the opioids I am being prescribed. As such, my PCP may require I have additional blood, urine or hair testing and/or see a specialist in addiction medicine should a concern about addiction arise during my treatment.
13. I understand that the use of any mood-modifying substance, such as tranquilizers, sleeping pills, alcohol or illicit drugs (such as cocaine, heroin or hallucinogens), can cause adverse effects or interfere with opioid therapy. Therefore, I agree to refrain from the use of all of these substances without prior agreement from my PCP.
14. I consent to open communication between my PCP and any other health care professionals involved in my pain management, such as pharmacists, nurses, physicians, emergency departments, etc.
15. I am willing to consider opioid dose reduction, opioid switch and/or a pain clinic referral if my PCP thinks it is beneficial to me or warranted.

I understand if I break any of the above conditions, my PCP may choose to cease providing opioid prescriptions for me and discuss alternate treatment options.

Date: _____ Signature (patient): _____
Date: _____ Signature (PCP): _____
Name of designated Pharmacy: _____
Phone: _____ Fax: _____
☐ "Letter to Pharmacy" sent

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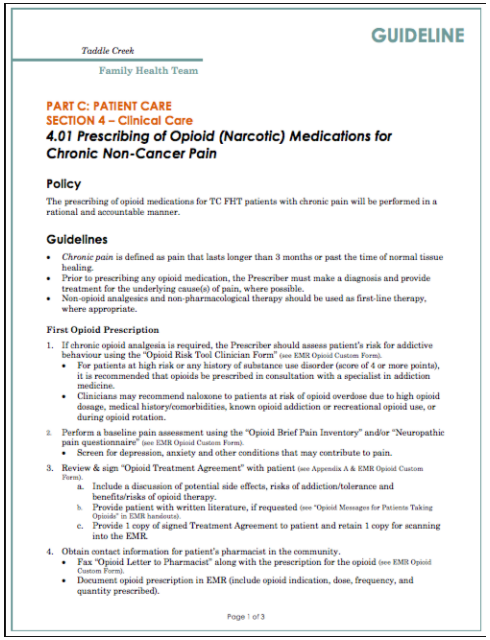

GUIDELINE

Taddle Creek
Family Health Team

PART C: PATIENT CARE
SECTION 4 – Clinical Care
4.01 Prescribing of Opioid (Narcotic) Medications for Chronic Non-Cancer Pain

Policy

The prescribing of opioid medications for TC FHT patients with chronic pain will be performed in a rational and accountable manner.

Guidelines

- *Chronic pain* is defined as pain that lasts longer than 3 months or past the time of normal tissue healing.
- Prior to prescribing any opioid medication, the Prescriber must make a diagnosis and provide treatment for the underlying cause(s) of pain, where possible.
- Non-opioid analgesics and non-pharmacological therapy should be used as first-line therapy, where appropriate.

First Opioid Prescription

1. If chronic opioid analgesia is required, the Prescriber should assess patient's risk for addictive behaviour using the "Opioid Risk Tool Clinician Form" (see EMR Opioid Custom Form).
   - For patients at high risk or any history of substance use disorder (score of 4 or more points), it is recommended that opioids be prescribed in consultation with a specialist in addiction medicine.
   - Clinicians may recommend naloxone to patients at risk of opioid overdose due to high opioid dosage, medical history/comorbidities, known opioid addiction or recreational opioid use, or during opioid rotation.
2. Perform a baseline pain assessment using the "Opioid Brief Pain Inventory" and/or "Neuropathic pain questionnaire" (see EMR Opioid Custom Form).
   - Screen for depression, anxiety and other conditions that may contribute to pain.
3. Review & sign "Opioid Treatment Agreement" with patient (see Appendix A & EMR Opioid Custom Form).
   a. Include a discussion of potential side effects, risks of addiction/tolerance and benefits/risks of opioid therapy.
   b. Provide patient with written literature, if requested (see "Opioid Messages for Patients Taking Opioids" in EMR handouts).
   c. Provide 1 copy of signed Treatment Agreement to patient and retain 1 copy for scanning into the EMR.
4. Obtain contact information for patient's pharmacist in the community.
   - Fax "Opioid Letter to Pharmacist" along with the prescription for the opioid (see EMR Opioid Custom Form).
   - Document opioid prescription in EMR (include opioid indication, dose, frequency, and quantity prescribed).

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COLLABORATION AND INTEGRATION

TC FHT is actively collaborating in the development of the Mid-West Toronto Ontario Health Team (MWT-OHT). TC FHT's Board has discussed OHTs during their last 4 Board meetings and was listed as a 'supporter' on the MWT-OHT Self-Assessment submitted to Ontario Health in Apr 2019. We are involved in a number of community committees, for example TC FHT's Executive Director attends the MWT-OHT Partnership Mtgs, one Physician Lead attends the Mid-West Toronto Sub-Region (MWTSR) Primary and Community Care Committee mtgs and another Physician Lead attends the Mid-West FHT Collaborative Mtgs. By engaging in these forums, TC FHT works with healthcare community partners in our region (i.e. hospitals, home care, primary care, mental health and community support agency partners).

At the patient level, TC FHT has many examples of integration benefiting both our patients and patients in our community, here are a few:

1. A Community Care Access Centre coordinator is embedded into our PrimaryCare@Home Team. This allows us to improve integration and coordination of home care for 50+ frail seniors with complex needs.
2. We continue to accept referrals from UHN's Emergency Department as part of MWTSR's RED (Referrals from Emergency Department) Project. These referrals are for complex, unattached patients who frequently visit UHN's Emergency Department. In calendar 2019, TC FHT accepted 17 RED referrals.
3. The Centre for Addiction and Mental Health (CAMH) and TC FHT's Mental Health Program formed a partnership in Jan 2018 to provide quicker access to Cognitive Behavioural Therapy (CBT) Groups at TC FHT for patients suffering from mild to moderate depression and anxiety. This partnership continues to grow, in F19/20, 7 CBT groups were held for 51 patients.
4. We continue to accept referrals for our Telemedicine Impact Plus (TIP) Clinics, also a MWTSR Project. These referrals are for community physician's complex patients. TIP clinics are an inter-professional clinic that uses telemedicine equipment to connect with the patient and the community physician. TC FHT hosted 6 TIPs in F19-20.
5. Our Diabetes Education Program continues to accept referrals from 250 community physicians.

TC FHT knows large-scale system improvements require collaboration and integration with other healthcare partners. TC FHT will continue to work with the MWT-OHT and engage in MWTSR projects to improve services for both our patients and community patients in our region.

PATIENT/CLIENT/RESIDENT PARTNERING AND RELATIONS

Our patient engagement strategy includes both formal and informal mechanisms. Formal patient engagement is received via our Patient Advisory Committee (PAC) and by conducting focus groups. Informal patient engagement is received via patient care surveys and group/clinic evaluations all of which impacted our F20-21 quality improvement plan (QIP).

FORMAL

Seniors Advisory Volunteer Initiative (SAVI) is TC FHT's PAC (10-12 seniors). SAVI meets quarterly with the Executive Director and a

physician. The purpose of SAVI is to receive input on FHT programs/clinical activities, to promote senior services at TC FHT and to disseminate knowledge/ideas related to the health and well being of seniors. The following is a list of how SAVI impacted our F20-21 QIP:

1. SAVI reviews (Apr mtg) 2018 Pt Care Survey Results & offers QI ideas
2. SAVI works with Diabetes Education Program (DEP) to review DEP letter sent to patients who did not have 2 or more HbA1c tests within the past 12 months
3. SAVI writes articles for Taddler Newsletter Re: How to Get the Most from your Appointment (suggesting patients be involved in decisions about their care & treatment)
4. SAVI hosts Senior Seminar - When you Have to Leave Your Own Home (see Alternative Level of Care Section)

Our last focus group was held in F18-19 Q4 for the DEP's 'Your Path to Prevention' workshop. In F20-21, the DEP analyzed the focus group input and started to plan for improvements. Some modifications were made however further improvements were put on hold due to the decision to pursue re-certification with Diabetes Canada via their Standards Recognition Program (SRP). Improvements, based on the Focus Group input, will resume in F20-21.

INFORMAL

The FHTs F19-20 Patient Care Survey (sample size >10% population) tells us what we are doing well and what we could improve. The survey results can be a powerful staff motivator and a treasure trove of QI ideas. For example, responses to the question, 'What We Could Do Better' yielded the following common suggestions:

Technology

1. All suites should have eBooking and eBooking availability needs to be increased
2. Allow emailing physicians directly
3. Pt accessible eMR
4. Reduce 'wait time' to see physicians when patients are booked & eMessage patients if running late
5. Offer option of virtual appts/eConsults

Access

6. All phone systems should allow patients to leave a voice message and not close during the lunch hour
7. Increase mental health resources/services
8. Increase after hour clinics
9. Schedule groups after business hours

Care

10. Consistent locums when physicians on leave

Customer Service

11. Consistent messaging Re: TC FHT accepting patients & same day access
12. Photo board of staff/positions

Our F20-21 QIP focuses on HQO priority indicators and we try to blend in patient care survey suggestions where possible. For example, we continue to collect third next available appointment to identify access issues & are expanding e-Booking. We also plan to enhance our website so that patients living in poverty can access resources and mental health services. With the COVID crisis we quickly transitioned to virtual appointments/eConsults and are likely

to continue to offer this service in the future.

As part of the Diabetes Canada's SRP, the DEP conducted a randomized DEP specific Patient Satisfaction Survey in F19-20. The survey consisted of 27 questions for 20 patients. The full results are available in their SRP Application, however all expected outcomes were achieved:
1. 96% of pts agree or strongly agree that their habits have improved since attending the DEP.
2. 88% of pts agree or strongly agree that the diabetes educator 'always' involves them in decisions re: care
3. 88% of pts agree or strongly agree that they 'always' get to ask questions during visits
4. 84% of pts agree or strongly agree that they feel the diabetes educator spent enough time with them
Although survey results were positive there is always room for improvement and the qualitative data provided many pearls for improvement. The DEP will be analyzing and reviewing the qualitative data for further improvements in F20-21.

We also receive informal patient input via group/clinic evaluations. TC FHT provides a plethora of groups/clinics and evaluations are analyzed to assist with planning and priorities. In addition to using evaluation analysis data for program changes, it is also used to improve clinician performance.

WORKPLACE VIOLENCE PREVENTION

Workplace violence prevention has been a strategic priority at TC FHT ever since we had a Ministry of Labor Inspection on Jul 10, 2018. The Inspector formally ordered TC FHT to assess the risk of workplace violence. TC FHT took this very seriously and started by conducting a risk assessment for all 7 suites (utilizing template developed by the Occupational Health & Safety Council of Ontario). These assessments were presented at the Nov 13, 2018 Board Meeting and resulted in many physical changes being implemented (i.e. locks on doors and OTC medications, installation of glass barriers, creating safe areas to congregate if a workplace violent incident were to occur, etc). One item on the assessment asked if TC FHT had a Policy & Procedure (P&P) to identify, evaluate and inform workers about specific high-risk patients, situations, or locations. We did not have a P&P like this and thus our Joint Health & Safety Committee (JH&SC) invested a significant amount of time researching and drafting a P&P for the Board to approve. It should be noted that this item was on both the Board and the JHSC's quarterly meeting agendas since Sep 4, 2018. Many questions and concerns needed to be addressed before the Board was comfortable approving the attached 'Worker's Safety & Violent Patient P&P' on Nov 11, 2019. Our next step is to present the P&P to the entire team in conjunction with the Pubic Services Health & Safety Association at our May 26, 2020 Clinical Meeting.

POLICY

Taddle Creek
Family Health Team

PART D: OCCUPATIONAL HEALTH AND SAFETY
SECTION 1 Health & Safety
1.02 Workers Safety and Violent Patients

Reference: Public Services Health & Safety Association/Communicating the Risk of Violence A Flagging Program Handbook for Maximizing Preventative Care

Purpose
The purpose of this policy is to provide a safe environment by communicating preventive measures to workers regarding patients who present a history and/or risk of violent, aggressive or responsive behaviour. The policy outlines Taddle Creek Family Health Team's (TC FHT) expectations with regard to establishing/maintaining an Alert Program for at-risk patients. It also aims, in accordance with legislative and regulatory requirements, to prevent occupational injury/illnesses and to ensure that safe patient care and dignity are maintained.

Policy Statement
TC FHT is committed to identifying and addressing occupational health and safety hazards. This includes providing workers with information related to the risk of violence for a patient with a history and/or potential for violent, aggressive or responsive behaviours.

Patients with a known history and/or potential for violent, aggressive or responsive behaviours, will be screened using a Violence Assessment Tool (VAT) and when deemed necessary, have a Violence Alert put in their electronic medical record (eMR) to protect workers and patients. All relevant documentation (i.e. VAT/behaviour care plans, violent incident progress note) will be retained in the patient's eMR.

Violence Alerts are not intended to stigmatize at-risk patients, and will be conducted in a manner that respects ethical principles and aligns with TC FHT's duty to care (e.g. being mindful of patients who have a history of trauma and ensuring behaviour care plans are in place that support the philosophy of trauma informed care while also protecting workers).

TC FHT recognizes that everyone must work together to identify at-risk patients and ensure appropriate Violence Alerts are in place and communicated to workers at risk. TC FHT will, in consultation with the Joint Health and Safety Committee (JHSC), take every precaution reasonable in the circumstances to protect workers and minimize risks in a proactive and timely manner. TC FHT will ensure that elements of the Alert Program meet requirements under the Occupational Health & Safety Act (OHSA) and its regulations.

Policy Scope
All workers, students, volunteers, contractors, and agents of TC FHT are required to comply with this policy and related procedure.

Policy Principles
TC FHT,
- Is committed to providing a safe and respectful environment, and implementing measures and procedures to prevent, control and minimize the risk of violence
- Considers any violent behaviour unacceptable, and will provide the necessary measures to protect workers, along with the training they require to understand and implement this alert protocol and to prevent and respond to incidents in a timely, efficient and safe manner

- Acknowledges various circumstances, such as medical conditions or cognitive illness, that may cause a patient to be violent, TC FHT seeks to use information about violent incidents to improve patient care while protecting workers safety
- Supports the application of the precautionary principle when taking all reasonable steps to prevent and manage workplace violence (when in doubt, will initiate Violence Alert)
- Takes seriously its responsibility for personal health information (PHI) under its control, and shall limit the collection, use, and disclosure of such information to that which is necessary to protect the safety of workers and provide safe, competent, ethical care

Roles and Responsibilities
Board of Directors
- Ensures TC FHT complies with requirements under OHSA, including the duty to warn and protect workers from workplace violence
- Verifies that Ministry of Labour's (MOL) orders and requirements related to violence towards workers are addressed
- Holds Executive Director accountable for the development and implementation of an effective violence-prevention and Alert Program

Executive Director
- Is familiar with alert requirements and duties under this policy
- Takes every precaution reasonable in the circumstances to protect workers
- Assesses and manages the risks of workplace violence
- Establishes and puts into effect written procedures and training for the early recognition and alerts for patients with a known history and/or potential for violent, aggressive or responsive behaviour, in consultation with the JHSC and reports any violence-related incidents to the JHSC
- Keeps training records related to workplace violence and Alert Program
- Provides method to inform workers of patients with a known history and/or potential for violent, aggressive or responsive behaviours
- Designates Primary Care Providers (PCPs) to implement and maintain Alert Program
- Provides personal safety alarms
- Ensures policy, procedures and risk assessments are reviewed regularly
- Monitors and enforces compliance with this policy

Primary Care Providers (PCP - Physicians/Nurse Practitioners)
- Are familiar with alert requirements and duties under this policy
- For their patients,
  - Conduct violence assessments [Appendix A – Community Care Violence Assessment Tool (VAT)]
  - Develops/implements patient care-plans (Appendix B – Behaviour Care Plan Tool)
  - Engages patients, families and substitute decision-makers (SDM) in identifying history of violence, behaviours, triggers, and prevention/safety measures for workers and the patient
- Directs Medical Secretary to add Violence Alert for patients assessed as moderate, high to very high risk
- Inform at-risk patients (or SDM) of Violence Alert status (it is up to the PCP how they inform patient; Appendix D provides sample notification letters)
- Consider sending VAT & Behaviour Care Plan during transfers of accountability/transitions of care for high or very high risk patients (optional for moderate risk)*
- Advise other workers and Executive Director when Violence Alert added
- Respond to known or reported incidents of violent, aggressive or responsive behaviours and/or risks to other workers within FHT to ensures workers are protected

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- Ensure alert status is updated/added post incident and prior to discharge or transfer-of-accountability
- Conduct regular reviews of Violence Alerts to update Behaviour Care Plans

All Healthcare Workers (PCPs & IHPs)
- Are familiar with alert requirements and their duties under this policy
- Prior to seeing patients,
  - Check reminder (REM) in patient eMR profile for Violence Alert, if noted
    - Review Behaviour Care Plan
    - Consider speaking with PCP prior to visit
- Participate in training provided by TC FHT
- Complete an Incident Report documenting violent, aggressive and responsive behaviour incidents to Executive Director [according to TC FHT's Safety Reporting Policy & Procedure (1.04)]
- Participate in complaints-management process
- Test their personal safety alarm monthly to ensure they work and contact S306 Administration for maintenance needs

Medical Secretaries
- Are familiar with alert requirements and their duties under this policy
- When PCP directs, adds Violence Alert in patient's eMR (see Appendix C – Creating a Patient Alert) & ensures 'End Date' is 100 years in future
- When patient requests appointment, Violence Alert appears, inform scheduled care provider(s) of Violence Alert

Joint Health and Safety Committee (JHSC)
- Reviews this policy at least annually/as needed
- Assists with hazard identification and control
- Provides written recommendations (e.g., measures, procedures, training, education) to Executive Director where necessary to improve the policy/program, minimize identified risks and protect workers
- Is consulted in development of measures, procedures, training and education, and evaluates the effectiveness of training related to this policy
- Reviews and analyzes reported incidents/injuries of violence towards workers, as well as relevant OHS reports to help determine corrective actions

Procedures – Violence Alert
Note: Violence Alerts are not intended for all patients
Note: Violent behaviour can be either intentional or unintentional

1. PCP/NP to conduct patient violence assessment (Appendix A - Community Care Violence Assessment Tool - VAT) if,
   - Patient has a known history and/or potential for violent, aggressive or responsive behaviors
   - Patient is demonstrating behaviours associated with increased risk of violence
   - Violence Alert is present (in REM field in profile) but there is no violence assessment
2. PCP/NP to direct Medical Secretary to add Violence Alert if violence assessment score is moderate (score 1-3), high (4-5) or very high (6+). The 3 Violence Alert messages are as follows,
   Violence Alert - Moderate Risk-Inform Care Provider
   Violence Alert - High Risk-Inform Care Provider
   Violence Alert - Very High Risk-Inform Care Provider
3. Medical Secretary to add Violence Alert (See Appendix C – Creating a Violence Alert in Telus Practice Solutions)
4. PCP/NP to develop a Behaviour Care Plan (see Appendix B – Behaviour Care Plan Tool),
   - For patient with known history and potential for violence

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   - If patient is demonstrating behaviours associated with increased risk of violence
   - If Violence Alert present but there is no Behaviour Care Plan
5. PCP/NP to,
   - Notify patient or SDM, of the Violence Alert when safe to do so [optional how to notify; Appendix D - Sample Notification Letters for Patients & Substitute Decision Makers (SDM)]
   - Reassess patient's Violence Alert and response to Behaviour Care Plan interventions as often as necessary and revise/remove as necessary
   - If a patient with a Violence Alert of high or very high is referred/transferred to another external facility/provider, consider sending to receiving party a copy of VAT and Behaviour Care Plan*
6. Prior to seeing patients, PCPs and Healthcare Workers
   - Check in eMR reminder (REM) field (in patient profile) for Violence Alert, if noted
   - Reviews VAT & Behaviour Care Plan
   - Considers speaking with PCP if VAT/Behaviour Care Plan if more direction is needed

Procedure - Incidents Involving Violent Patient
1. If a patient behaves in a disruptive or threatening manner, the team member(s) involved should attempt to calm the individual by using the following strategies:
   - Tell the patient their behaviour is not acceptable
   - Stay calm, avoid criticizing, judging and arguing
   - Allow a comfortable distance between yourself and the individual, if appropriate, direct them to a larger room (i.e. S306 Education Room) to hear their concerns.
   - Acknowledge the patient's anger and allow the patient to express his/her concerns (i.e. "I can see that you are angry. I want to help you. If you stop shouting, I will listen to your concerns").
2. If the situation is not resolved, ask the person to leave immediately or you will call the police
3. If the situation continues to escalate or the individual refuses to leave, signal team by:
   - Activating your personal safety alarm that you require assistance
   - Calling out for help or call 911 (or ask someone to call 911)
4. If the incident is taking place in an exam room, the worker should attempt to leave the room and request immediate help from the nearest person such as "Can you come out here? I need your help right now". Other workers will quietly remain near the exam room, ready to intervene as necessary.
5. If a provider is in an exam room and another team member is concerned (hears loud noises/voices), the colleague should knock on the door. If there is no immediate response, enter the exam room to assist. Based on the situation, it may be necessary to call 911.
6. If the incident occurs in an open area or a group setting, responding workers will go to the area, creating a quiet presence (without overwhelming or crowding the agitated individual) and will intervene/support the worker involved, as required. Workers will communicate with one another who will take on the role of the *Backup* (individual ready to intervene if the *Lead needs* support).
7. Workers will ensure the safety of patients and/or group participants. This may include redirecting patients/group participants to a safe area. Workers will call 911 if anyone is in danger.

Note: Workers can use Telus Practice Solutions instant messaging function when they wish to be interrupted but not to call 911. Type, 'interrupt me' and send message to someone in office. Individual receiving message should go to office/area and calmly state, *"Sorry to interrupt, there is a problem I need your help with."* Workers proceed to leave then individual who requested interruption provides direction.

Post Incident
- Advise PCP/NP of incident, PCP/NP to notify pt or SDM need to complete/review patient's VAT & Behavioural Care-Plan to manage risks and identify prevention/safety measures to protect workers and patients

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- Notify Executive Director
- PCP/NP to let care team know when patient Behaviour Care Plan developed
- Worker to complete/submit Incident Report Form

Security

Women's College Health Research's Building (790 Bay) 'Security & Access Policy & Procedure' states, for crisis situations requiring an immediate response call 911. They have confirmed their security guard is not to intervene. Bloor does not have a security guard on the premise.

Other Safety Measures

- Efforts should be made for healthcare workers not be alone when seeing pts (i.e in an After-Hours Clinic there should be a medical secretary)
- If a healthcare worker must work alone, they should not see patients with Violent Alert.

Reporting and Documentation

The following documents support this policy and procedure:

- Appendix A - Public Services Health & Safety Association (PSHSA) – Community Care Violence Assessment Tool (VAT)
- Appendix B – Behaviour Care Plan Tool (PSHSA)
- Appendix C – Creating a Violence Alert in Telus Practice Solutions
- Appendix D - Sample Notification Letters for Patients & Substitute Decision Maker (SDM)
- TC FHT's Complaints Resolution Process (1.01)
- TC FHT's Safety Reporting Policy & Procedure (1.04)]

Complaints management/ Reconsideration Process

- Questions regarding the Alert Program should be directed to the PCP
- Requests to remove a Violence Alert should be in writing to the PCP
- The Executive Director can be identified in the Notification Letter as an option for the person to contact for complaints & for the reconsideration process
- Decisions and rationales will be communicated in writing
- All decisions must consider objective findings and exercise a precautionary approach.

*Legislative Requirement

Under Ontario's Occupational Health and Safety Act (OHSA), TC FHT must take every precaution reasonable in the circumstances for the protection of a worker against workplace violence [25(2)(h); 27(2)(c)]. As well, under clause 25 (2)(a), TC FHT has a duty to provide information to workers, and under s. 27(2)(a) TC FHT must advise workers of actual/potential workplace hazards. If a worker is expected to encounter a person with a history of violent behaviour in the course of their work, TC FHT must disclose as much information as needed, including personal information, to protect the worker from physical injury while respecting patient privacy as much as possible [32.0.5(3) and (4)]. This is an extension of the TC FHT's duty to warn and protect.

The Health Care and Residential Facilities Regulation 67/93 requires TC FHT, in consultation with the Joint Health and Safety Committee, to develop, establish and put into effect written measures and procedures for the health and safety of workers [s.8 and s.9]. Workplace violence prevention is of primary importance and a continuing objective. All TC FHT workers are expected to work in compliance with OHSA laws and with safe work practices and procedures established by the TC FHT.

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Definitions

At-risk Patient: A patient who poses a risk for violent or response behaviours.
Behaviour Care Plan: A written plan that details the care to be provided to prevent or control violent, aggressive or responsive behaviours. It is developed by PCP in collaboration with (when possible) the team, the patient and/or substitute decision-maker (SDM).
Complaints Management/Requests for Reconsideration Process: In the context of adding a Violence Alert, the complaints management/reconsideration process is the act of addressing a patient's and/or SDM's concern with an alert decision. The process involves:

- Open communication and sharing of information
- Explanations of alert policy and procedure
- Decisions and rationales
- The complaints management/request for reconsideration process shall align with the TC FHT's Complaints Resolution Process (1.01)

Enhanced prevention practices: These are heightened measures used to prevent violent, aggressive or responsive behaviours in at-risk patients to protect workers based on care needs and risk assessment.
Alert: An electronic alert used to: inform workers of a risk of violent, aggressive or responsive behaviours or to signal additional and individualized care-needs and preventive measures. A standardized method to communicate safety concerns to workers.
Violence Assessment Tool (VAT): A tool used by PCPs (& healthcare workers if directed) for evaluating a patient's likelihood of violent, aggressive or responsive behaviour.
Responsive Behaviours: A protective means by which persons with dementia or other conditions may communicate an unmet need (e.g. pain, cold, hunger, constipation, boredom) or reaction to their environment (e.g., lighting, noise, invasion of space).
Routine Prevention Practices: Violence-prevention strategies such as active listening and empathy that are used with all patients to prevent violent, aggressive or responsive behaviours.
Transfer of accountability/transition of care (TOA / TOC): An interactive process for transferring patient information from one healthcare worker/team to another in order to ensure continuity of care, as well as worker and patient safety. Examples include: Clinician-to-clinician when care is assigned to another clinician, referral from one patient-care area to another, referral to an outside organization
Trigger: A circumstance or situation that may initiate, provoke or impact patient behaviour. Triggers may be physical, psychological or activity-related.
Violent Behaviour: Acts of violence such as but not limited to choking, punching, hitting, shoving, pushing, biting, spitting, shouting, swearing, verbal threats, groping, pinching, kicking, throwing objects, shaking fists, and threatening assault.
Violent Behaviour Early Signs: Signs of escalating violent, aggressive or responsive behaviours such as:

- Changes in autonomic nervous system e.g., sweating, flushed face, changes in pupil size, increased muscle tension
- Rapid, loud, or profane speech
- Sudden changes in level of consciousness e.g., increased disorientation and confusion
- Motor agitation e.g., agitated pacing and inability to remain still
- Hallucinations, which can be auditory or visual and may be benign or command-orientated
- Sudden changes in extremes or affect e.g., exhilaration, grandiosity
- Sudden lack of affect in someone who was previously very agitated and threatening, which may indicate a decision to take violent action
- Use of alcohol or drugs

Workplace Violence: Under the OHSA, workplace violence means:

1. the exercise of physical force by a person against a worker, in a workplace, that causes or could cause physical injury to the worker;
2. an attempt to exercise physical force against a worker, in a workplace, that could cause physical injury to the worker; or,
3. a statement or behaviour that it is reasonable for a worker to interpret as a threat to exercise physical force against the worker, in a workplace, that could cause physical injury to the worker.

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Appendix A - Community Care Violence Assessment Tool (VAT)

This form is to be completed by Primary Care Provider (PCP) or clinical healthcare worker when directed by the PCP.

Right click on the box above, select 'insert image' to insert your logo

Client's Name: Click here to enter text.

Identification #: Click here to enter text.

☐ **Initial Assessment** ☐ **Reassessment**

Section A: Risk Indicators

Read the list of behaviours below and identify behaviours that will require specific care interventions. A score of 1 is applied for past occurrence of any of the History of Violence behaviours; and additional scores of 1 are applied for each observed behavior. Add the scores — **the maximum is 12.**

HISTORY OF VIOLENCE: Score 1 for past occurrence of any of the following:	SCORE
• Exercising physical force, in any setting, towards any person including a caregiver that caused or could have caused injury • Attempting to exercise physical force, in any setting, towards any person including a caregiver that could cause injury • Statement or behaviours that could reasonably be interpreted as threatening to exercise physical force, in any setting, against any person including a caregiver that could cause injury	Click here to enter text.
OBSERVED BEHAVIORS: Score 1 for each of the observed behaviour categories below.	**SCORE**
Confused (Disoriented – e.g., unaware of time, place, or person)	Click here to enter text.
Irritable (Easily annoyed or angered; Unable to tolerate the presence of others; Unwilling to follow instructions)	Click here to enter text.
Boisterous (Overtly loud or noisy – e.g., slamming doors, shouting etc.)	Click here to enter text.
Verbal Threats (Raises voice in an intimidating or threatening way; Shouts angrily, insulting others or swearing; Makes aggressive sounds)	Click here to enter text.
Physical Threats (Raises arms / legs in an aggressive or agitated way; Makes a fist; Takes an aggressive stance; Moves / lunges forcefully towards others)	Click here to enter text.
Attacking Objects (Throws objects; Bangs or breaks windows; Kicks object; Smashes furniture)	Click here to enter text.
Agitate/Impulsive (Unable to remain composed; Quick to overreact to real and imagined disappointments; Troubled, nervous, restless or upset; Spontaneous, hasty, or emotional)	Click here to enter text.
Paranoid / suspicious (Unreasonably or obsessively anxious; Overly suspicious or mistrustful – e.g., belief of being spied on or someone conspiring to hurt them)	Click here to enter text.
Substance intoxication / withdrawal (Intoxicated or in withdrawal from alcohol or drugs)	Click here to enter text.
Socially inappropriate / disruptive behaviour (Makes disruptive noises; Screams; Engages in self-abusive acts, sexual behaviour or inappropriate behaviour – e.g., hoarding, smearing feces / food, etc.)	Click here to enter text.
Body Language (Torso shield – arms / objects acting as a barrier; Puffed up chest – territorial dominance; Deep breathing / panting; Arm dominance – arms spread, behind head, on hips; Eyes – pupil dilation / constriction, rapid blinking, gazing; Lips – compression, sneering, blushing / blanching)	Click here to enter text.
TOTAL SCORE	Click here to enter text.
Client's Risk Rating: ☐ Low (0) ☐ Moderate (1-3) ☐ High (4-5) ☐ Very High (6+)	

Completed By (Name/ Designation) Click here to enter text.________________ **Date:** Click here to enter text.

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Section B: Overall Risk Rating

Apply the total behaviour score to the Risk Rating Scale to determine whether the client's risk level is low, moderate, high or very high. Each level provides cues for further action to consider. If moderate or high/very high risk is determined, complete Section C to identify factors that may trigger or escalate violent, aggressive, or responsive behaviour and ensure the care plan includes measures to avoid or reduce risk behaviours identified.

Overall Score	Actions to take
Low **Score of 0**	• Continue to monitor and remain alert for any potential increase in risk • Communicate any change in behaviours, that may put others at risk to Team and Executive Director • Ensure Personal Safety Alarm and processes are in place – (e.g., phone, personal safety alarm, check-in protocol; respectfully terminate patient engagement/visit if concerns arise)
Moderate **Score of 1-3**	• Apply flag alert – Moderate Risk of Violence • Communicate any change in behaviours, that may put others at risk to Team and to Executive Director • Ensure reception staff and team know to call 911 if necessary • Scan environment for potential risks and remove if possible • Arrange to meet patient in a public location as needed • Ensure Section C is completed and Create Care Plan (Appendix B) – care plan should address known triggers, behaviours and include safety measures appropriate for the situation for patients and workers • Use effective therapeutic communication (e.g., maintain a calm, reassuring demeanor, remain non-judgmental and empathetic, and provide person-centered care). • Be prepared to apply de-escalation procedures (as per Oct 2017 Training) • Ensure Personal Safety Alarm and processes are in place – (e.g., phone, personal safety alarm, check-in protocol; respectfully terminate patient engagement/visit if concerns arise) • Inform patient or SDM of VAT results, when safe to do so • Other: __________
High **Score of 4-5** **OR** **Very High** **Score of 6+**	• Apply flag alert – High or Very High Risk of Violence • Promptly notify Executive Director so he/she can ensure Team is aware and prepared to respond • Ensure reception staff and team know to call 911 if necessary • Scan environment for potential risks and remove if possible • Arrange to meet client in a public location as needed • Ensure Section C is completed and Create Care Plan (Appendix B) – care plan should address known triggers, behaviours and include safety measures appropriate for the situation for patients and workers • Initiate applicable referrals • Use effective therapeutic communication (e.g., maintain a calm, reassuring demeanor, remain non-judgmental and empathetic, and provide person-centered care • Be prepared to apply de-escalation procedures (as per Oct 2017 Training) • Ensure Personal Safety Alarm and processes are in place – (e.g., phone, personal safety alarm, check-in protocol; respectfully terminate patient engagement/visit if concerns arise) • Communicate any change in behaviours, that may put others at risk, to Executive Director • Inform client of VAT results, when safe to do so • Other: __________

Section C: Contributing Factors

Physical, psychological, environmental, and activity triggers can lead to or escalate violent, aggressive or responsive behaviours. Documenting known triggers and behaviours and asking your patient or their substitute decision maker (SDM) to help identify them can help you manage them more effectively and safely. Use the information collected and the intervention resources listed on p.2 and p.11 of the PSHSA Individual Client Risk Tool to develop an individualized violence prevention care plan and a safety plan to protect workers at risk.

QUESTION FOR CLIENT:	CONSIDERATIONS – Select any that Apply			
	PHYSICAL	**PSYCHOLOGICAL**	**ENVIRONMENTAL**	**ACTIVITY**
To help us provide the best care possible, please describe if there is anything during your stay that could cause you to become agitated, upset or angry e.g., I am agitated when…	☐ hunger ☐ pain ☐ infection ☐ new medication ☐ other Click here to enter text.	☐ fear ☐ uncertainty ☐ feeling neglected ☐ loss of control ☐ being told to calm down ☐ being lectured ☐ other Click here to enter text.	☐ noise ☐ lighting ☐ temperature ☐ scents ☐ privacy ☐ time of day ☐ days of the week ☐ visitors ☐ small spaces/ overcrowding ☐ other Click here to enter text.	☐ bathing ☐ medication ☐ past experiences ☐ toileting ☐ changes in routine ☐ resistance to care ☐ other Click here to enter text.
What works to prevent or reduce the behaviour(s) e.g., When I am agitated, it helps if I…	☐ Go for a walk ☐ Listen to music ☐ Watch TV ☐ Draw ☐ Read (Bible/Book) ☐ Have space and time alone ☐ Talk 1:1 with Click here to enter text. ______ (who?) ☐ Participate in activities ☐ Consult a family member or friend	**POTENTIAL DE-ESCALATION TECHNIQUES** Identify potential de-escalation strategies using above information such as respect personal space, actively listen, offer choices, give eye contact, use humor Click here to enter text.		

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Appendix B: Behaviour Care Plan Tool Example

Patient Name: John Myers **Date Developed:** Mar 1, 2019

LIKES TO BE CALLED: Johnny
ENJOYS: Reading the Toronto Star, Jeopardy TV Show, Chocolate, Black Coffee
PEOPLE WHO KNOW HIM BEST: Wife, Jessica
RISK FACTORS FOR AGGRESSION/VIOLENCE:
☒ Dementia with Resistance to Care
☐ Hyperactive Delirium
☐ Substance Withdrawal/Intoxication
☒ History of Violence/prior incident at TC FHT
☐ Elopement Risk with Defensive Aggression
☐ Other

NARRATIVE
Johnny is an 89-year-old man with a history of dementia. He lives with his wife in his home. He has always been a very solitary man who tends to isolate himself life but now with his dementia progressing, he is getting lost in his community. He is fiercely independent by nature and always wants to be involved in the conversation and tries to communicate his needs. He is particularly uncomfortable with women examining him. He is also a WWII veteran and sometimes has flashbacks of being under enemy fire. He is very proud of his service.

TRIGGERS FOR AGGRESSION/VIOLENCE
1. Personal examinations by a female healthcare workers
2. Loud alarm/noises
3. Firm stance/telling him what he 'must do'

BEHAVIOURS CRUCIAL TO OBSERVE IN PATIENT
1. Quick glancing and quick movements
2. Loud or profane speech

RECOMMENDED CARE STRATEGIES
1. Give Johnny choices rather than firm directions e.g. ask "Would you like me to give you your heparin injection first or do your blood pressure first?" INSTEAD of saying "Okay Mr. Smith, time for your heparin shot"
2. Try to have male healthcare worker provide care
3. Only under extreme circumstances should a healthcare provider use their Personal Safety Devise, sounds of this nature sound irritate him and make him more aggressive when care is provided.
4. Ask him about his service in the war. It makes him feel valued and less dependent.
5. For any sustained care (ie any wound care) , provide care in pairs for enhanced safety.
6. Defer any non-urgent care if patient is verbally escalated or gruff on initial presentation at front desk

STAFF SAFETY MEASURES
Personal safety devises
Work in pairs
Review Violence Assessment Tool (VAT) for triggers/behaviours, proactive and reactive support from other staff

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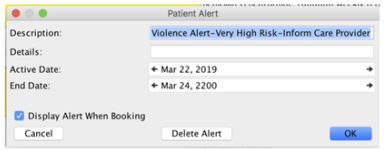
Appendix C: Creating a Violence Alert in Telus Practice Solutions

Steps

1. From the patient's chart, choose Settings > New Alert for <patient name>



2. Type in Description as above. REM field in patient's profile shows description, appointment alert shows description. Descriptions include,

Violence Alert - Moderate Risk - Inform Care Provider
Violence Alert - High Risk - Inform Care Provider
Violence Alert - Very High Risk - Inform Care Provider

3. The active date is today by default. Enter an end date at least 100 years in the future.
4. Select √ Display Alert When Booking
5. Click OK
6. To edit or delete an existing alert, double-click it in the REM field

A progress note is created to record when the alert was created, and the alert displays in blue in the REM field.

Approved By: JHSC/Jul 2, 2019
Approved By: Board Nov 11, 2019
To be Reviewed Annually: Nov 2021

Appendix D – Sample Notification Letters for Patients & Substitute Decision Makers (SDM)

Date

Patient or Patient's SDM
Address

PRIVATE & CONFIDENTIAL

Notification Letter Re: Violence Alert

Dear Patient or SDM

As a result of your (or your loved ones) violent, aggressive or responsive behaviour exhibited in the clinic on <date>, I have added a 'Violence Alert' to your electronic health record (eMR) here at Taddle Creek Family Health Team (TC FHT). In order for you to continue your care at TC FHT, I need to formally assess your tendency towards violence in order to maintain a safe environment for our workers. **Please contact my office at _____ to schedule this appointment.**

After the assessment, if it is deemed you do not put our workers at risk of violence, the 'Violence Alert' will be removed. If it is deemed that you do put our workers at risk of violence we will then together establish a Behaviour Care Plan (also kept in your eMR) for you that allows you to continue to receive safe care that maintains your dignity but also protects the safety of our workers.

A 'Violence Alert' alerts Medical Secretaries, when you book an appointment, to advise any clinician(s) you will be seeing that they should review, prior to your visit, the Behaviour Care Plan which outlines your risks factors for aggression/violence, your triggers for aggression/violence, behaviours crucial for them to observe in you and recommended care strategies. It is also important for me to alert care providers, outside of TC FHT, of your violence alert, should I make a referral or transfer your care.

During subsequent visits, I will discuss the alert with you and update your Behaviour Care Plan.
In order to remove a 'Violence Alert', it will be necessary for you to put this in writing to me and then I will conduct another violence assessment.

TC FHT is committed to providing a safe and respectful environment and implementing Policies and Procedures to prevent, control and minimize the risk of violence is a legal requirement. TC FHT's complete Worker's Safety & Violent Patients Policy & Procedure (1.02) can be found on our website (http://taddlecreekfht.ca/patients/patient-policies-and-procedures).

Should you have any questions/concerns, please feel free to contact me at _____.
Alternatively, you are welcome to speak to TC FHT's Executive Director, _____ at 416-260-1315, ext 307.

Dr. _____

Approved By: JHSC/Jul 2, 2019
Approved By: Board Nov 11, 2019
To be Reviewed Annually: Nov 2021

Date

Patient or Patient's SDM
Address

PRIVATE & CONFIDENTIAL

Notification Letter Re: Violence Alert

Dear Patient or SDM

You have made me aware of your history of violent, aggressive or responsive behavior and the potential for violence in the future. It is important that formally assess your tendency towards violence in order to maintain a safe environment for our workers. **Please contact my office at _____ to schedule this appointment.**

After the assessment, if it is deemed you do not put our workers at risk of violence, there will be no further action. If it is deemed that you do put our workers at risk of violence, a 'Violence Alert' will be put on your electronic medical record and together we will establish a Behaviour Care Plan (also kept in your eMR) for you that will allow you to continue to receive safe care that maintains your dignity but also protects the safety of our workers.

A 'Violence Alert' alerts Medical Secretaries, when you book an appointment, to advise any clinician(s) you will be seeing that they should review, prior to your visit, the Behaviour Care Plan which outlines your risks factors for aggression/violence, your triggers for aggression/violence, behaviours crucial for them to observe in you and recommended care strategies. It is also important for me to alert care providers, outside of TC FHT, of your 'Violence Alert', should I make a referral or transfer your care.

During subsequent visits, I will discuss the alert with you and update your Behaviour Care Plan.
In order to remove a 'Violence Alert', it will be necessary for you to put this in writing to me and then I will conduct another violence assessment.

TC FHT is committed to providing a safe and respectful environment and implementing Policies and Procedures to prevent, control and minimize the risk of violence is a legal requirement. TC FHT's complete Worker's Safety & Violent Patients Policy & Procedure (1.02) can be found on our website (http://taddlecreekfht.ca/patients/patient-policies-and-procedures).

Should you have any questions/concerns, please feel free to contact me at _____.
Alternatively, you are welcome to speak to TC FHT's Executive Director, _____ at 416-260-1315, ext 307.

Dr. _____

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ALTERNATE LEVEL OF CARE

Alternative Level of Care (ALC) is a cross-sector challenge. Many patients continue to be in the wrong level of care (in an acute hospital bed) waiting to be transferred to another care environment.

We believe the work in this area needs to be done 'up stream.' On Oct 21, 2019, Taddle Creek & Women's College FHTs, in conjunction with TC FHT's Patient Advisory Committee, hosted a Seniors Seminar titled, 'When You have to Leave Your Own Home.' The facilitator was an independent planning specialist with expertise in aging and long term care. Participants learned the following:
- the difference between a Retirement Home, Senior Residence, Senior Community Living, Homecare and Nursing Home
- the difference between for profit, non profit, government assistance or no assistance
- when to remain at home, and when to start transitioning (what are the flags)
- planning for transitions
It was a great success by all accounts with more than 70 seniors attending. Evaluations were positive; 88% rated the quality of the seminar as excellent and 90% felt they got the information they were seeking. The slides can be found on TC FHT's website under Patients/HealthCare Resources – Downloads – SAVI Seminar Oct 2019.

TC FHT's Executive Director also attended two Mid-West Toronto Home Based Primary Care Meetings hosted by Drs. Pauline Pariser and Samir Sinha. At the first meeting (Sep 16, 2019) we,
- Reviewed TCLHIN data regarding primary care at home services for homebound seniors
- Planned for primary care at home services for homebound seniors
- Discussed collaborative practices that can improve care for this population and increase ease in delivery of this service for Primary Care at Home Programs.
The second meeting (Jan 27, 2020) focused on sharing resources, mapping of services and creating a formalized network.

TC FHT works closely with a Care Coordinator (previously CCAC Care Coordinator) to ensure patients receive adequate home-care to stay as long as possible in their homes and when they can no longer stay in their home, TC FHT primary care providers and social workers work collaboratively with our Care Coordinator to find alternative care. TC FHT also has a PrimaryCare@Home Program that supports up to 50 community based homebound patients. Again this work is done in conjunction with our assigned Care Coordinator.

VIRTUAL CARE

On Mar 17, 2020, the Government of Ontario legally closed many establishments and prohibited gatherings of over 50 people to stop the spread of COVID-19. On Mar 30, in an effort to further stop the spread and keep people home, the Government extended their Emergency Declaration by closing non-essential workplaces. On Mar 20, the ON MOHLTC encouraged all primary care providers (PCPs) to implement a system for virtual and/or telephone consultations when and wherever possible. TC FHT was well positioned to transition to virtual care. The majority of our PCPs were enabled to work remotely from home and had an eHealth ONEID which enabled them access eHealth's Clinical Viewer and Ontario Telemedicine Network's (OTNs) Hub to provide video

appointments. We also had a patient portal (HealthMyself) that enabled us to email securely with patients and send patient communiques widely. In addition, we maximized our Website's messaging power by creating alerts on our homepage.

In 'normal times', TC FHT has adopted digital healthcare tools in order to deliver virtual care. In terms of patient facing tools, our FHT subscribes to three digital platforms:
1) HealthMyself Patient Portal - enables patients to ebook appointments 24/7, communicate with FHT on non-urgent matters via a secure messaging system and to receive appointment reminders
2) CognisantMD OCEAN - enables practitioners to send patients medical screening and assessment instruments prior to attending in-office appointments
3) OTN - for virtual appointments

In terms of provider-facing tools, our electronic medical record (eMR) is fully accessible remotely using our remote virtual privacy network (rVPN) and is integrated with the following provincial digital platforms:
1) OntarioMD's Health Report Manager (HRM) - allows PCPs/NPs to seamlessly access hospital medical records and diagnostic imaging reports
2) Ontario's Laboratory Information System (OLIS) - allows seamless integration of lab results directly into our eMR

TC FHT will be adopting a new virtual care tool in 2020; Canada Health Infoway's PrescribeIT's digital platform for pharmacies and eMR Vendors. Our current prescribing process is to auto fax prescriptions from our eMR to pharmacies who in turn have to transcribe the prescription into their pharmacy management system creating opportunities for transcription errors. From a renewal or cancellation perspective, our process often involves multiple phone calls/faxes between pharmacists and a PCP (and/or their medical secretaries or pharmacy assistants). PrescribeIT is a secure digital platform between an authorized prescriber and a patient's pharmacy of choice. Using our eMR and the pharmacies management software, prescriptions/renewals/cancellations can be transmitted as data via an encrypted two-factor authentication process. Prescription details are auto-populated directly into the pharmacy software. As a result, prescription/renewal/cancellation data is transferred securely, transcription errors at the pharmacy are reduced, phone calls/faxes back and forth are decreased all leading to improved privacy, patient safety and decreased medication error rate.

CONTACT INFORMATION

Sherry Kennedy, Executive Director
Taddle Creek Family Health Team (TC FHT)
790 Bay Street, Suite 306, Box 57
Toronto, Ontario
M5G 1N8
416-260-1315 ext.307
Cell 416-570-0560

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 _____

_____
Board Chair

_____
Quality Committee Chair or delegate

_____
Executive Director/Administrative Lead

_____
Other leadership as appropriate

_____