2024-2025 Quality Improvement Plan
"Improvement Targets and Initiatives"

camh

Aim		Measure						Change				
Issue	**Quality Dimension**	**Measure/ Indicator**	**Unit/ Population**	**Source/ Period**	**Current Performance**	**Target (2024/2025)**	**Target Justification**	**Planned Improvement Initiatives (Change Ideas)**		**Methods**	**Process Measures**	**Target for Process Measure**
Theme I: Timely and Efficient Transitions	**Timely**	Median Wait Time from Referral to First Offered Consult Appointment	Days /referred outpatients	Local data collection/ January – December 2024	48 days	51.5 days	Target is based on a 30% reduction in wait times from the quarterly average in 2021-22.	**Year 2 (2024)**	1) Strategy implemented to address data quality issues across CAMH (e.g. non-compliance with Wait Times PowerForm completion in I-CARE) to ensure every outpatient clinic is reporting accurate wait times	Analyse, validate and disseminate Wait Time data results (e.g. highest/lowest)	1) % of Wait Time PowerForm completion rates across all programs 2) Wait times in key priority dashboard will be monitored by outpatient clinical services 3) Establish wait time targets across all outpatient clinics through best available evidence and/or consensus gathering and implement use of established targets in pilot clinics	1) 80% of Wait Time PowerForms completed by March 2024 2) Wait times in key priority dashboard monitored by outpatient clinical services weekly 3)Wait time targets established across all outpatient clinics by September 2024 and implement use of established targets as part of wait time reduction initiatives in pilot clinics by December 2024
									2) Begin evaluation process of the pilots, modify, and adapt pilots as needed	Evaluate the three pilots and month-to-month reductions in wait times (CYEA, Acute and CCR)	1) Evaluation of the three pilots 2) Wait time reduction in all three pilot areas	1) Evaluation of the three pilots completed by September 2024 2) 30- 50% of wait times reduced in all three pilot areas by December 2024
									3) Set the conditions for scale and spread of the pilot projects to other outpatient clinics within each program	Identify additional areas in other outpatient clinics within CYEA, Acute and CCR.	1) Additional areas identified in other outpatient clinics within CYEA, Acute and CCR 2) MD and non-MD level sponsor leader identified in each clinic	1) Additional areas identified in other outpatient clinics within CYEA, Acute and CCR by September2024 2) MD and non-MD level sponsor leader identified in each clinic (Y/N)
Theme II: Efficient	**Efficient**	**Vacancy Rate**	Percentage/workers	Local data collection/ January – December 2024	8.5%	8%	Target is comparable to OHA vacancy rate.	**Year 2 (2024)**	1) Analyze and evaluate data on recruitment and retention drivers and develop standardized reports indicating key metrics. Expand pilot improvement initiatives	1) Improve tool and process for obtaining exit interviews. Continue to conduct exit interviews to identify drivers for retention for all full-time and part-time nurses (s and RPNs) who leave CAMH within 2 years of their start date and for all physicians who leave CAMH	1) % increase of exit interviews completed for nurses leaving 2) % increase physician participation in exit interviews from Year 1 3) Exit interview tool revised as required based on data collected	1) 10% increase in participation from Year 1 2) 100% of physicians who leave CAMH will be invited to participate in an exit interview. 10% increase in participation from year 1 3) Minimum of 2 process improvements made to tool
		Voluntary Turnover	Percentage/workers	Local data collection/ January – December 2024	9.5%	9.2%	Target of 9.2% is based on a 99% confidence interval from the average of the past 2 years.		2) Improve measurement and reporting to support recruitment and retention	1) Design and launch P&E dashboard across all programs	Meet semi-annually with each Director to review P&E dashboard and identify initiatives to support recruitment and retention	Meet with 25% of Directors each quarter (100% throughout 2024) and identify 2 initiatives each quarter
										2) Identify and track measures relating to CAMH staff and physician wellness [e.g., Wellness centre usage numbers, lost time (sick, WSIB, STD, LTD) and overtime data]	Number of hours paid due to WSIB, STD, LTD, and leaves (excluding vacation). Measure data by clinical inpatient unit and support services for year 2 compared to FTE staff count and compare to Year 1	Based on comparative data, identify top 5 programs/units with highest paid hours by December 2024
									3) Enhance diversity, equity and inclusion and psychological health & safety of staff and physicians. Continued implementation of the CAMH Workplace Mental Health Strategy	1) Make professional development opportunities available to more people embedding best practices in psychological health and safety	1)Incorporate and implement development goals into performance evaluation for non-union and management 2)) Design CAMH specific training for physician leadership and management to support psychological safety for teams in the workplace	1)Development goals incorporated into performance evaluation by June 2024 and implemented by September 2024 2) CAMH specific training designed by September 2024 and pilot by December 2024 with physician leaders and management.
										2) Provide tools and supports for staff and physicians to foster a Fair & just CAMH for all	1) Number of training sessions developed and launched for managers and physician leaders on leading discussions to create an inclusive environment for everyone at CAMH	1) 5 sessions for managers developed and launched by June 2024

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Theme III: Safe and Effective Care	**Safe**	Workplace Violence Lost Time Injury Frequency (# of WPV incidents/100 FTEs)	Count per FTE / Worker	Local data collection / January - December 2024	0.4	0.29	CAMH achieved lowest rates in 2023 and further improvement may be unrealistic.	**Year 2 (2024)**	1) Expand and enhance implementation of Safe & Well CAMH program, and the Workplace Violence Prevention Committee	1) Complete the adoption of the recommendations from the risk assessments completed on high-acuity units	% of recommendations in progress or completed	100% of recommendations completed
										2) Urgent TIDES education consultations	Time of referral to time of urgent consultation initiation	Time of referral to time of urgent consultation initiation <24 hours
									2) Continue locally driven change initiatives to ensure compliance with : 1) This is Me, 2) Safety and Comfort Plan; and, 3) Client/Patient Debriefing	Inpatient unit leadership teams to continue: 1) To review workplace violence incident data,mitigation strategies and training requirements with teams 2) In collaboration with Professional Practice and TIDES, develop and implement local-level strategies based on best practices to increase completion of This is Me, Safety and Comfort Plan and Client/Patient Debriefing in compliance with CAMH documentation standards and policy	1) % of new admissions with "This is Me" completed within 7 days of admission (in our EHR) 2) % of Safety and Comfort Plans completed within 72 hours of admission 3) % of Client/Patient Debriefs completed within 72 hours of the restraint event	1) 40% of new admissions with "This is Me" completed within 7 days of admission (in our EHR) 2) 67% of Safety and Comfort Plans completed within 72 hours of admission 3) 50% of Client/Patient Debriefs completed within 72 hours of the restraint event
									3) Deliver and evaluate a simulation training on disclosure of errors.	Deliver and evaluate the disclosure simulation to clinical staff every month.	1)Number of staff who complete the simulation training 2) Collect and analyze evaluation data to highlight commitment to practice change (e.g. change in confidence) 3) Evaluate and report on the innovative training format and identify needs for modification and additional scenarios if needed	1) 25- 40 staff will complete the simulation training by December 2024 2) Collect and analyze evaluation data to highlight commitment to practice change (e.g. change in confidence) by December 2024 3) Evaluate and report on the innovative training format and identify needs for modification and additional scenarios, if needed, by December 2024
Theme III: Safe and Effective Care	**Safe**	% of patients physically restrained during inpatient stay	% / All inpatients	Local data collection/ January – December 2024	4.2%	4.8%	CAMH achieved lowest rates in 2023. The goal for 2024 will be to keep all quarters below this rate.	**Year 2 (2024)**	1) Plan and implement locally driven change initiatives to ensure compliance with 1) This is Me; 2) Safety and Comfort Plan; and 3) Client/Patient Debriefing (e.g. unit champions, utilizing team huddles, chart audits, education and awareness, sharing compliance rates).	All inpatient unit leadership teams, in collaboration with Professional Practice and TIDES, to develop and implement a local-level strategy based on best practices to increase completion of This is Me, Safety and Comfort Plan and Client/Patient Debriefing in compliance with CAMH documentation standards and policy.	1) % of new admission with "This is Me" completed within 7 days of admission (in our EHR) 2) % of Safety and Comfort Plans completed within 72 hours of admission 3) % of Client/Patient Debriefing completed within 72 hours of the restraint event	1) 40% completion rate of This is Me within 7 days of admission by the end of 2024 2)67 % completion rate of Safety and Comfort Plans within 72 hours of admission by the end of 2024 (TBD) 3) 50% completion rate of Client/Patient Debriefing within 72 hours of the restraint event by the end of 2024 (TBD)
									2) Advance our Trauma-Informed De-Escalation Education for Safety and Self-Protection (TIDES) training implementation and sustainability, and the utilization of practice enhancements.	Train and support inpatient and outpatient clinical staff to become point-of-care facilitators (POCF) for their services. .	1)# of inpatient and outpatient trained POCFs 2)% of mandatory trainings facilitated by POCFs 3)% of POCFs who are facilitating program specific/on unit initiatives	1) Increase to 45 active POCFS by December 2024) 2)55% of mandatory trainings facilitated by POCFs by December 2024 3)50% of POCFs who are facilitating program specific/on unit initiatives by December 2024
									3) Implement, monitor and reinforce Registered Nurses' Association of Ontario (RNAO) Best Practice Guideline: Promoting Safety: Alternative approaches to the use of Restraints.	1) Update, and implement decision-making algorithms and assessment tools; prevention and safety strategies to ensure alignment with RNAO BPG 2) Conduct documentation audits to establish baseline to identify gaps in the use of assessment and prevention strategies,	1) # of decision-making algorithms and assessment tools; prevention and safety strategies updated and implemented to align with RNAO BPG 2) % of documented evidence of the use of assessment and prevention strategies, alternative	1) Four decision making algorithms and assessment tools; prevention and safety strategies updated and implemented by December 2024 2) Establish baseline performance data for de-escalation and debriefing assessments in three program areas.

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										alternative approaches, and assessment strategies for physical restraints and provide focused education to address identified gaps 3) Conduct ongoing quarterly chart audits to monitor and reinforce alternative strategies to physical restraint use 4) Work with Reporting and Analytics to monitor CAMH wide physical restraint use quarterly	strategies to physical restraints use 3) % documented increase in the use of assessment and prevention strategies, alternative strategies to physical restraints use 4) % of physical restraints used across CAMH	3) 65% documented evidence of assessment, de-escalation, crisis interventions, restraint alternatives and behavior monitoring strategies, prior to physical restraints use 4) 50% decrease in the use of physical restraints at CAMH by December 2024
									4) Engage physicians in development of change ideas for effective use of chemical restraints order sets based on baseline data obtained from Year 1. Review chemical restraint data to identify clear indicators of effective use.	1) Review data and identify change ideas to implement in 2-3 acute care areas to optimize pharmacotherapy to reduce mechanical restraint use.	Implementation of change ideas in 2-3 acute care areas focused on improving pharmacotherapy practices to reduce mechanical restraint use.	Implementation of 2 change ideas by April 2024
										2) Monitor chemical restraint indicator data (Year 1) linked to change ideas to inform improvement cycles and effectiveness on physical restraint reduction	1) Monitor chemical restraint data 2) Develop and implement change ideas to address gaps 3) Communicate to staff best practice indicator and change ideas	1) Monitor chemical restraint data and identify gaps in care by September 2024 2) Develop and implement change ideas to address gaps by December 2024 3) Communicate to staff best practice indicator and change ideas by December 2024
									5)Further understand and address observed differences in the use of restraints for specific populations in the Emergency Department	Establish consistent process to debrief on situations requiring restraints as a team and when feasible, with patient. Understand systemic factors and where feasible, address systemic factors that may influence how/when restraints are used. Research is underway to understand patient perspectives to use that can inform these approaches.	Routine review of quarterly data related to restraint use, including by population	Consistent use of debrief that is documented in the ED.
Theme IIII: Service Excellence	**Patient-centred**	Real Time Patient Satisfaction	All patients	Local data collection/ January – December 2024	N/A	CB	New Indicator	**Year 2 (2024)**	Explore and develop real time mechanisms for patient experience feedback	Develop tools for CAMH surveying patient experience at CAMH.	1)Add patient experience survey questions to MyCAMH 2)determine baseline response rate for patients who complete the experience survey 3)Evaluate patient feedback from the survey in comparison to other patient experience data (OPOC, CRO, FRC) identify common trends and themes	1)Patient experience survey added to MyCAMH by June 2024 2)%of patients who complete the experience survey (CB) 3) Establish a regular report back to clinical units, CAMH Leadership, Family and Patient Advisory councils findings to identify opportunities for improvement