Quality Improvement Plan (QIP): 2023/2024 Progress Report
Centre for Addiction and Mental Health, 1001 Queen Street West

Measure/ Indicator from 2023/24 (Unit; Population; Period; Data Source)	Current Performance as stated on QIP 2023/24	Target as stated on the QIP 2023/24	Current Performance 2024	Change Idea from Last Year's QIP (2023/24)	Methods	Was the change idea implemented as intended Y/N)	Comments The following questions were considered: • What is the status of the proposed change idea? • Has the proposed change idea(s) been implemented? If no, why? • If implemented, to what degree (e.g. is the change idea(s) on track for completion)?
Median Wait Time from Referral to Consult	N/A	CB	48 days	1) Develop a strategy to address data quality issues across CAMH (e.g. noncompliance with Wait Times PowerForm completion in I-CARE) to ensure every outpatient clinic is reporting accurate wait times Standardize mechanisms for measuring wait time data across CAMH (new clinic referrals)	1) Develop a strategy to address data quality issues across CAMH (e.g. noncompliance with Wait Times PowerForm completion in I-CARE) to ensure every outpatient clinic is reporting accurate wait times Standardize mechanisms for measuring wait time data across CAMH (new clinic referrals)	Y	Local barriers to wait time data completion and reducing wait times in the pilot clinic areas have been identified and strategies to address data quality issues are underway. Work is in progress in partnership with IMG and Reporting and Analytics, to explore improvements to the Wait Times PowerForm. Wait time forecasting and planning tool is in development to improve wait time oversight and management. Wait Time Powerform completion rate across all programs is 53.4% which has exceeded the target. The '% of Wait Time PowerForm completion rates across all programs' metric includes patients that are referred both through Access CAMH and internally. However, due to gaps in documentation of the Wait Time PowerForms for internally-referred patients, the metric might be biased towards external referrals. To note, about 65.7% of all external referrals received in Q3 23/24 had a Wait Time PowerForm started under a respective encounter
				2) Develop and pilot change initiatives to decrease wait times for outpatient services across the three clinical programs Plan and initiate one pilot in each of the three clinical programs (CYEA, Acute and CCR) with high wait times. The pilots will have one MD and one non-MD level sponsor leader	2) Develop and pilot change initiatives to decrease wait times for outpatient services across the three clinical programs Plan and initiate one pilot in each of the three clinical programs (CYEA, Acute and CCR) with high wait times. The pilots will have one MD and one non-MD level sponsor leader	Y	MD and non-MD level sponsor leads have been identified in all three clinical programs. Pilot implementation was delayed in CCR due to resource however, pilot implementation in all three clinical programs is in progress. The Acute multi-disciplinary pilot achieved over 30% wait time reduction. Planning for the next PDSA cycle has begun. CYEA and CCR are approaching readiness to initiate multi-disciplinary assessments. Wait list management strategies have been implemented across each clinical program.
Vacancy Rate Voluntary Turnover	N/A 9.8% (FY 2022 Q2)	CB 8.8%	8.5% 9.5%	1) Collect reliable data on drivers that positively enhance retention and recruitment. Develop and pilot improvement initiatives in relation to manager, physician and nurse retention across all clinical programs	1)Conduct stay interviews with permanent managers and physicians to identify drivers for retention	Y	Process development for tracking all stay interviews and communication roll-out has been completed. Stay interviews are being tracked and follow up with Directors on the process of completing stay interviews with Managers will be completed. Physician stay interview process has been developed and articulated. The target has been exceeded for number of physicians who have completed a stay interview.
					2) Conduct exit interviews for all permanent full-time and part-time nurses (RNs and RPNs) who leave CAMH within 2 years of their start	Y	Exit interview survey was developed in an automated format. Testing phase was completed and launched in June 2023. Data collection is continual and analysis will follow. A reminder will be provided to Managers to ensure that exiting staff are asked to participate in exit interviews.

					date and for all physicians who leave CAMH to identify drivers of retention		Of 25 Nurses that experienced a voluntary turnover (any length of service), 94.4% were offered an exit interview. 18 Nurses with 2 or less years of service left and sent exit interviews, with 5 having completed the survey (20%). 100% of physicians who left received a stay interview.
					3) Continue Nursing Referral Program (NRP) with incentive payment for staff who make a referral that leads to a successful external nurse hire	Y	Ten nurses hired through the NRP program are still employed at CAMH six months following their probationary period. Overall summary of the program since January 1, 2023: • There are currently a total of 19 active referrals (employees that need to complete their probationary hours or were recently referred and are not in Lawson yet) • There were 21 ineligible referrals that have been submitted (mainly because the referral form was submitted months after the employee was hired and/or the employee was previously employed at CAMH and was not an external candidate, or the employee was terminated) • There have been 16 paid referees (they each received a $500 bonus)
				2) Nursing informatics Engagement Strategy aimed as sustaining and retaining nursing workforce by enhancing nursing engagement and leadership in informatics decision making; improving experiences with technology; leveraging data to identify opportunities to further streamline documentation and enhancing and optimizing informatics education/training and communication strategies	Engage nurses in workflow and system process improvements	Y	Nurses have been engaged in workflow and system process improvements throughout 2023 in the following ways: • 11 Nursing and Health Disciplines Think Tanks (NTT) were held which exceeded the target. Ten nurses or more participated in NTT each quarter. • Over 100 clinical IDEAS were submitted and implemented in I-CARE on nursing related topics • 239 nurses were engaged in information/digital health governance and related committees
				3) Identify and track measures relating to staff and physician wellness	1) Identify and track measures relating to CAMH staff and physician wellness [e.g., Wellness Centre usage numbers, Employee and Family Assistance Program [EFAP] utilization rates, Sunlife Financial (SLF) Lumino online tool usage, lost time (sick, WSIB, STD, LTD) and overtime data]	Y	990 wellness classes were offered to staff and physicians in 2023. 37.20% of physicians engaged with at least one wellness initiative in 2023 which has exceed the target set. 23.7% of staff used SLF Lumino online tool in 2023. The top three searches were massage, psychotherapist and psychologist.

					2) Lead the TAHSN Measurement Working Group (part of the TAHSN Physician Wellness Working Group) to review and identify measures of burnout and ways to evaluate wellness initiatives	Y	Wellness indicators related to physician burnout/wellness have been identified and implementation plan for tracking indicators is complete. The survey will re-launch in January 2024. Eighty percent of physician respondents (via the Leadership and Management Program for Physicians evaluation survey) reported they agree that the workshop was relevant and useful, met expectations, organized and provided opportunities for engagement.
				4) Improve measurement and reporting to support recruitment and retention (development of data acquisition and measurement reporting)	1) Develop, support and receive approval for the implementation of a new Human Resources Information System (HRIS) as part of a larger Enterprise Resource Planning (ERP)	Y	On January 31, 2023 the Executive Leadership Team approved the implementation of a new Human Resources Information System. Board approval was also obtained on March 30, 2023.
					2) Build a reliable report framework for the current HRIS	Y	Voluntary turnover, vacancy rate and lost time data points have been determined. Voluntary turnover and vacancy rate report is being completed. A template report is developed and a meeting will be held with Directors in February/March for their feedback.
				5) Enhance psychological health, safety, and wellness of staff and physicians	Continued implementation of the CAMH Workplace Mental Health Strategy	Y	New hire orientation has been enhanced to include equity, diversity and inclusion and supports available for staff around psychological safety. Nineteen organization-wide events where staff can talk about workplace mental health, anti-racism and psychological safety have been hosted which has exceed the annual target. Physician wellness initiatives have also been offered on a quarterly basis with 86.6% of physicians having attended at least one wellness initiative over the course of 2023. BeWell app for CAMH Clinicians launched from May 2023 - October 2023. 58 Social Workers; 37 Occupational Therapists, 16 Registered Nurses and 51 other clinical staff participated. Evaluation of the program has been done and results reported.
				6) Enhance diversity, equity and inclusion for staff and physicians	1) Provide tools and supports for staff and physicians to foster a Fair & just CAMH for all	Y	The target has been exceeded for percent of managers who have completed the mandatory training on Foundational Knowledge on Anti-Black Racism. In addition, 372 managers completed the Anti-Racism, Harassment and Discrimination policy training.
					2) Re-launch updated CAMH Diversity Survey	Y	The CAMH Diversity Survey was delayed a month due to competing surveys and the desire to mitigate survey fatigue. The survey report was finalized by end of December and will be communicated/shared in Q1 2024. There has been a 10.8% increase participation rate in the survey from 2021.

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Workplace Violence (WPV) Lost Time Injury Frequency (# of WVP incidents/100FTEs)	0.28	0.29	0.37	1)Expand and enhance implementation of Safe & Well CAMH program, and Workplace Violence Prevention Committee recommendations and annual work plan	1) Implement revised Supervisor Competency Training	Y	The Supervisory Competency Training, "LEAD The Way to Health and Safety" was successfully delivered to 78 Managers in 2023.
					2) Continue implementation and adoption of the recommendations from the risk assessments completed on high-acuity units	Y	Implementation and adoption of the recommendations from the risk assessments completed on high-acuity units is in progress. 90% of recommendations are completed and 10% are in progress. Work is underway to evaluate previous implemented recommendations and creation of a sustainability plan.
					3) Urgent TIDES consultations to high acuity inpatient units	Y	TIDES exclusively offers consultation services in response to formal requests originating from designated units or groups. To date, 84 consultations have been completed on high acuity areas.
				2) 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)	Inpatient unit leadership teams: 1) To review workplace violence incident data and mitigation strategies, as well as 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	Y	Baseline compliance rates have been shared with all unit Managers starting in May, and is ongoing monthly to highlight units that are improving and encourage units that are not. The Managers are sharing compliance rates with the staff
				3) Plan, design and implement a simulation training on mitigating bad news, which is a TIDES practice enhancement. The goal of mitigating bad news is to ensure the care team works together to deliver bad news empathically, and provide support to the patient afterwards. Practice enhancements are aligned with interventions shown to reduce conflict	1) Understand gaps in knowledge, skills and attitudes related to the TIDES practice enhancement through staff feedback, and review evidence based practices in the literature to design a simulation training on mitigating bad news 2) Identify a working group to lead the design and implementation of	Y	A simulation training on delivering and mitigating bad news was developed and implemented in September 2023 as a part of the TIDES programming. 53 learners completed this training from September to December. TIDES renewed orientation program that contains a simulation with bad news mitigation will begin roll out in January 2024. In addition, it was determined that there was a need for a simulation training on disclosures of errors. Work has been initiated in the development of the simulation which is expected to launch in 2024.

				and containment in inpatient mental health settings. The simulation will provide an opportunity for staff in the clinical areas to learn and practice delivering bad news as a care team emphatically	the simulation training (e.g. develop the simulation scenario and curriculum, assist with training faculty to facilitate the simulation etc.)		
% of patients physically restrained during inpatient stay	5.4%	4.8%	4.2%	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)	Inpatient unit leadership teams, in collaboration with Professional Practice and TIDES, to 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	Y	Baseline compliance rates have been shared with all unit Managers starting in May, and is ongoing monthly to highlight units that are improving and encourage units that are not. The Managers are sharing compliance rates with the staff.
				2) Advance our Trauma-Informed De-Escalation Education for Safety and Self Protection (TIDES) training implementation and sustainability, and the utilization of practice enhancements. The TIDES program strengthens the relationship underlying crisis prevention, de-escalation and physical intervention. To be flexible and responsive, the program considers the diverse needs of staff and patients across an array of interventions and treatment approaches including acute care, inpatient, outpatient and aftercare services. This is achieved through three key goals: 1) Enhancing skills and building confidence through team-based learning 2) Driving fundamental day to day processes proven to keep everyone safe 3) Bringing learning to the point of care	1) Offer train-the-trainer sessions to inpatient and outpatient clinical staff to become point-of-care facilitators (POCF) for their services. POCFs are direct care staff that receive additional training, mentorship and support to bring the knowledge and skills of TIDES to direct care teams across the organization. The role requires them to be content experts for their clinical teams around TIDES strategies and skills	Y	Overall there has been an 8% decrease in available POCFs. This was expected, as the TIDES team was engaged in planning a new approach to the POCF program to promote continuous engagement and mentoring, and thus did not offer onboarding opportunities in Q1.The renewal plan for the TIDES POCF program launched in Q2, with TIDES confirming and onboarding 35 inpatient POCFs. The renewed program is designed to promote continuous engagement and mentoring, and includes a commitment to on-unit and organizational facilitation. The TIDES team continue to onboard POCFs to this updated program, and expand the program to outpatient services.

				3) Implement the Registered Nurses' Association of Ontario (RNAO) Best Practice Guideline: Promoting Safety: Alternative approaches to the use of Restraints. This guideline assists staff to focus on evidence-based best practices for assessment, prevention and use of alternative practices (including de-escalation and crisis management techniques) to prevent the use of restraint.	1) Review and update the Emergency Use of Chemical Restraint, Seclusion and Mechanical Restraint Policy, and other associated policies, to ensure alignment with RNAO Best Practice Guidelines (BPG) 2) Review, update, align and implement documentation standards related to restraint use, de-escalation, and crisis management in alignment with RNAO BPG 3) Review, update, and implement decision-making algorithms and assessment tools; prevention and safety strategies to ensure alignment with RNAO BPG (e.g. Mutual Action Plan behavior profile (MAP), alternative to restraints decision tree, behavior monitoring log, assessment of pre-disposing factors, patient and family education tools) 4) Conduct documentation audits to establish baseline to identify gaps in the use of assessment and prevention strategies, alternative approaches, and assessment strategies for physical restraints and provide focused education to address identified gaps 5) Work with Reporting and Analytics to monitor CAMH-wide physical restraint use		RNAO BPG implementation launched in September following Accreditation. All relevant policies aligned with RNAO BPG were reviewed. Alternative approaches to restraints algorithm will be integrated into documentation standards instead of appended to policies. Documentation standards have been reviewed and opportunities for enhancements to the Safety and Comfort Plan, This is Me and Client Event Debrief Power Forms have been identified. The enhancements will improve documentation of restraint events, de-escalation and steps taken prior to a restraint event. Baseline data for This is Me, Safety and Comfort Plan and Client Event Debrief Power Forms will be tracked and presented next quarter. Documentation audits will be initiated next quarter and results will be shared to identify any opportunities for improvement.

				4) Work with physicians to understand current state of pharmacotherapy order data including challenges with use	Identify a working group to develop and implement a strategy to address data quality issues across CAMH (chart audits and current state analysis)	Y	The goal to define clear indicators for chemical restraint use was achieved in December 2023. The proposed definition of select chemical (PRN) orders for prevention of restraint within 24 hours of admission was reviewed by staff psychiatrists and feedback was incorporated in the final definition. The next steps for 2024/25 are monitoring chemical (PRN) order data and identifying gaps, developing change ideas and communicating best practice and change ideas with staff.