camh

2024 - 2025 Progress Report

Measure/ Indicator from the 2024/25 QIP	Current Performance as stated on the 2024/25 QIP	Target as stated on the QIP 2024/25	Current Performance 2025	Change Idea from Last Year's QIP (2024/25)	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? • Lessons Learned: What were you successes and/or challenges?
Median Wait Time from Referral to First Offered Consult Appointment	48 days	51.5 days	64 days	1) Strategy implemented to address data quality across CAMH (e.g. noncompliance with Wait Times PowerForm completion in I-CARE) to ensure every outpatient clinic is reporting accurate wait times	Analyze, validate and disseminate Wait Time data results (e.g. highest/lowest	Y	The Pilot Clinics worked on a strategy to reduce wait times. All teams continue conducting PDSA (Plan-Do-Study-Act) cycles of the pilot. The Data & Insights Team has a standardized process for collecting wait time data, including updating the wait time methodology, are currently being addressed. Accomplishments and Successes Across Pilot Sites 2024-25 Q3 data: • 85.1% of all external referrals have wait time data collection initiated • 67.1% of all externally referred patients who were seen at CAMH had all required data for Wait time calculation • Completion rate of initiated Wait Time forms in pilot units: o Child, Youth and Family Services (CYFS): 80.5% o General Assessment Clinic (GAC): 94.0% o Late Life Anxiety and Mood Disorder Clinic (LLAMD): 67.3% Key challenges at pilot sites include data standardization, process optimization, and resource allocation.
				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)	Y	Teams are in the process of evaluating wait times based on PDSA pilots. CYFS wait time is now 3 months, compared to 7 months in 2023. GAC wait time is now 3 months, compared to 9-10 months in 2023. LLMAD wait time is now 3 months, compared to 13 months in 2023.
				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.	Y	We have identified an additional pilot clinic for next year's QIP. The initial pilots have helped identify barriers, which has helped us focus on understanding and addressing these barriers before we can effectively spread and scale our efforts. Based on the project's current state and resourcing barriers identified, recommendations for 2025 have been established. **For 2025 the recommendations have been to:** **Scale and Spread** • Scale and spread wait time reduction approach to CCR and CYEAP clinics • Identifying other clinics within / across programs that would be suitable for scale and spread • Utilize key learnings and changes from pilots that can be leveraged for scale / spread **Build Team Based Models of Care** • Continue to build models of team based care • Optimize models of team based care based on resources, patient population and model of care • Maximize full scope of practice for all health care staff • Matched team based care **Build Organizational Capabilities** • Explore mechanisms to make scheduling more efficient for stakeholders • Weekly reporting and monitoring of wait times • Planning and projection of clinic operations to ensure number of assessments is matched to waiting patients

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Vacancy Rate Voluntary Turnover	8.5% 9.5%	8% 9.2%	1.5%* 8.0%	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 (RNs and RPNs) who leave CAMH within 2 years of their start date and for all physicians who leave CAMH	Y	*The 2024 vacancy rate of 1.5% is calculated using a new methodology known as the budgeted vacancy FTE rate, which differs from the previous target-setting approach. This new method provides a more accurate result. Based on the revised methodology, the vacancy rate for 2023 was 2.4%. A process improvement to automate the exit interview survey was implemented in 2023. This improved the overall delivery and completion rate of exit interviews. We saw an increase in the exit interviews completed by nurses. The Medical Affairs office offers exit interviews for Physicians working full-time holding active primary status. Two additional process improvements were made to the tool. The first, sending the interview tool to personal email addresses available in the system, increased the overall response rate from 35.5% to 47.4%. The second is a communication and education plan for managers to submit the Employee Status Change (ESC) forms earlier than the effective date. The People & Experience Department conducted an analysis of the exit interview responses, focusing on key factors such as the primary reasons for leaving, job satisfaction, training and development opportunities, workload distribution, work-life balance, and job security.
				2) Improve measurement and reporting to support recruitment and retention	1) Design and launch P&E dashboard across all programs	Y	We have received feedback regarding data points that would be beneficial to Clinical Directors. We are currently assessing the feasibility of producing this data while ensuring its quality and validity. We will incorporate these data points into future reports when possible. Additionally, initiatives and process changes have been implemented to support recruitment efforts.
					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]	Y	We have been collecting and comparing measures relating to staff and physician wellness on a quarterly basis and identified the top 5 programs/units with the highest leave average in 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	Y	The integration of development goals into evaluations was completed in May 2024. Managers are now expected to finalize Performance Evaluations. Beginning in June 2024, psychological safety training for leaders became a regular component of Organizational Development, in partnership with Workplace Mental Health. Leaders will receive support in conducting psychological safety assessments with their teams and in action planning, using the Leaders Psychological Safety toolkit developed in Spring 2024. Numerous sessions will be available through the Workplace Mental Health Team to enhance skill-building and knowledge in promoting psychological safety within teams. In December 2024, we offered a psychological safety session for Physician heads in collaboration with the Physician Wellness Lead. The employee and physician engagement survey conducted in October 2024 will guide the development of future training needs regarding psychological safety within the organization. This survey will also help shape focus groups and inform the next Workplace Mental Health and Wellness strategy, slated for 2025. We are continuing to track the completion rates for the mandatory manager training on the Anti-Racism, Harassment, and Discrimination (ARHD) Policy. This training is available to all managers and staff across the hospital. Additionally, the revamped training on navigating difficult questions, designed to support psychological safety, has been completed and is scheduled to be offered starting in April 2025.
					2) Provide tools and supports for staff and physicians to foster a Fair & just CAMH for all	Y	This work is well underway. A toolkit for leaders on Psychological Safety in teams was launched in the first week of May 2024. There is good uptake with teams and managers reaching out for support for these trainings and integrating this support into team discussions. Psychological Safety related trainings include Psychologically Safe Conversations, Burnout and Compassion Fatigue, Giving and Receiving Feedback, Team Resilience, Nurturing Psychological Safety (Teams that Talk for Physicians and Leaders. We continue to track the completion rate for mandatory manager training on the Anti-Racism, Harassment, and Discrimination (ARHD) Policy. The focus on psychological safety is an important aspect of fostering inclusion in the workplace. We have developed a Difficult conversations training for leaders to facilitate discussions aimed at creating an inclusive environment, which was completed in December 2024 and launched in early 2025. However, elements of inclusivity are also incorporated into the previously mentioned trainings.

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Workplace Violence (WPV) Lost Time Injury Frequency (# of WVP incidents/100FTEs)	0.40	0.29	0.18	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	Y	95% of recommendations completed. There is only one outstanding recommendation to be completed. Implementation is planned for 2025.
					2) Urgent TIDES education consultations	Y	The TIDES team responds to consultation requests, including those deemed urgent. This year, we implemented process improvements such as updating the consultation tracker to better reflect the urgency of requests and enhance the detail and availability of information. Additionally, we ensured that requests are sent directly to the area manager. In FYQ3, the response time to urgent requests was 17 hours (equivalent to 2.5 work hours), which is within our target of less than 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	Y	The completion rates for This is Me and the Safety and Comfort Plans are above target. We are just below target for the Patient/Client Debrief forms, but have seen an increase since FYQ3. Initiatives to sustain and increase completion include: - The of Registered Nurses' Association of Ontario (RNAO), Best Practice Guideline (BPG): *Promoting Safety: Alternative approaches to the use of Restraints* Interdisciplinary Champions have implemented customized, local-level strategies to increase the completion of each form.. Examples of these strategies include identifying local needs and gaps, developing tailored projects, including a visual representation of safety and comfort items to support discussions with patients, and the "all about me in CCC" initiative. - Managers and BPG Champions share compliance rates with staff to motivate unit teams to improve/sustain their completion rates. - The "This is Me with the CNE" initiative is an engaging approach designed to increase completion rates across units. We are focusing on improving the completion rates of Client/Patient Debrief forms. This includes understanding unique contributing factors and workflows and providing support to units with lower completion rates.
				3) Deliver and evaluate a simulation training on disclosure of errors.	Deliver and evaluate the disclosure simulation to clinical staff every month.	Y	A total of twenty-four staff members completed the disclosure simulation in 2024. Evaluation results from 16 participants show a confidence increase of 1.5 points, or 39%, from pre-training to post-training assessments. This represents a 64% gain from the baseline scores. Additionally, 100% of participants expressed an intention to change their practice following the training. Furthermore, 94% of learners reported being satisfied with the training, and all participants (100%) would recommend it to others.

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% of patients physically restrained during inpatient stay	4.2%	4.8%	3.1%	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.	Y	The completion rates for This is Me and the Safety and Comfort Plans are above target. We are just below target for the Patient/Client Debrief forms, but have seen an increase since FYQ3. Initiatives to sustain and increase completion include: - The of Registered Nurses' Association of Ontario (RNAO), Best Practice Guideline (BPG): *Promoting Safety: Alternative approaches to the use of Restraints* Interdisciplinary Champions have implemented customized, local-level strategies to increase the completion of each form.. Examples of these strategies include identifying local needs and gaps, developing tailored projects, including a visual representation of safety and comfort items to support discussions with patients, and the "all about me in CCC" initiative. - Managers and BPG Champions share compliance rates with staff to motivate unit teams to improve/sustain their completion rates. - The "This is Me with the CNE" initiative is an engaging approach designed to increase completion rates across units. We are focusing on improving the completion rates of Client/Patient Debrief forms. This includes understanding unique contributing factors and workflows and providing support to units with lower completion rates
				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.	Y	Over the course of the year, the number of POCF increased from 38 to 40. A refocus on outpatient and inpatient POCF programs will begin in 2025. TIDES administrative support in the latter third of the year impacted POCF scheduling. In the first three quarters, the rate of co-facilitation was 41%. The quarterly rate of on-unit facilitation dropped progressively over the year attendance reporting is a key factor, and we will be implementing a system to update the process and accountability in 2025.
				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, 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	Y	Successes: • We identified synergies with CAMH's ongoing work and aligned implementation accordingly. • This approach was grassroots and bottom-up, led by BPG champions in their respective areas. • Champions have been engaged and are very enthusiastic about providing input and shaping their practice locally. • Support from CAMH managers and directors Lessons learned: • Initially, we believed that we needed to implement new documentation tools. However, we found that we could build on our existing assessment processes and utilize the tools already available in our documentation system. This approach helped reduce the documentation burden on staff. • We recognized that implementation strategies needed to be tailored to the unique needs and differences within each clinical area. • Before the implementation, we thought we had to conduct manual audits of staff documentation, but we were able to leverage existing data collection methods at CAMH instead.

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% of patients physically restrained during inpatient stay	4.2%	4.8%	3.1%	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.	Y	We have developed an indicator for chemical restraint: the rates of high-risk patients with appropriately dosed pharmacotherapy PRN (chemical restraint) orders. We have collected and analyzed data on this measure for the inpatient units. We attempted to identify units with lower rates of chemical restraint orders for high-risk patients. Two units with lower rates of chemical restraint orders for high-risk patients were initially identified. As more data was collected for these two units, significant variability was noted across quarters. Upon review of longitudinal data and review with teams, we are then proposed identifying change ideas to be implemented on a hospital-wide rather than on a unit-specific basis related to chemical restraint data. New process measures will be focused on implementation of change ideas on a hospital-wide basis, focused on improving pharmacotherapy practices to reduce mechanical restraint use. Consequently, this work will carry forward to our 2025-26 QIP implementation of two change ideas is on track for completion by December 2025.
					2) Monitor chemical restraint indicator data (Year 1) linked to change ideas to inform improvement cycles and effectiveness on physical restraint reduction	Y	We continue to monitor chemical and restraint data for inpatient units. Due to variability in specific unit data across quarters, a decision has been made to focus on hospital-wide data. Two change ideas are now being proposed: 1. Optimization of ED admission order sets 2. Standardization of inpatient morning rounds to include review of PRN use in the previous 24 hours and anticipation of PRN use in the next 24 hours. Iterative development of change ideas through team and clinical leadership engagement is in-progress.
				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.	Y	Patient/Client Debrief Form completion: The completion rates for the Patient/Client debrief forms have shown success in establishing a process for ensuring that patients who have experienced a restraint event complete a debriefing form. The process improvements began to take hold with the involvement of Clinical Scholars, who reminded and coached staff on how to complete the debrief forms following a restraint event. However, challenges have been identified in completing the debrief forms; notably, some patients have left the emergency department (either discharged or transferred) before the forms could be completed. The insights gained from the identified challenges are guiding improvement initiatives for the 2025-26 QIP. Toronto Police Services (TPS) Pilot: This pilot is an initiative to reduce restraint used in the ED, informed by research to understand and address the clinical, systemic and structural factors contributing to restraint use amongst marginalized populations. The pilot has been successful, resulting in timely transfers of care and officers being released from the emergency department in just over an hour. This approach decreases the number of officers present in the department and minimizes potential trauma responses from patients. Ultimately, it leads to a reduction in agitation and escalation, as well as fewer instances of restraint.
Real Time Patient Experience	CB	CB		Explore and develop real time mechanisms for patient experience feedback	Develop tools for CAMH surveying patient experience at CAMH.	Y	We have explored and developed real time patient feedback mechanisms. We have faced technical issues in distributing the patient experience survey via MyCAMH. We continue to work to address these challenges and have deployed the survey through an alternate format in the meantime.