camh

2025-2026 QIP Workplan

Aim	Measure						Change				
Quality Dimension	**Measure/ Indicator**	**Unit/ Population**	**Source/ Period**	**Current Performance**	**Target (2025/2026)**	**Target Justification**		**Planned Improvement Initiatives (Change Ideas)**	**Methods**	**Process Measures**	**Target for Process Measure**
Timely	Median Wait Time from Referral to First Offered Consult Appointment	Days /referred outpatients	Local data collection/ January – December 2025	64 days	51 days	Target is based on 2 standard deviations below the average of previous year's performance (2023-24 Q3 to 2024-25 Q2)	**Year 3**	1) Sustaining wait time reductions from year 2 and monitoring data quality within pilot clinics to ensure every clinic is reporting accurate wait times	Analyse, validate and disseminate Wait Time data results (e.g. highest/lowest) and evaluate wait time reductions across pilot clinics to ensure reductions have been sustained and maintained	By year end wait time reductions systematically occurring and progressing positively across pilot clinics	By year end wait time reductions systematically occurring and progressing positively across all pilot clinical programs
								2) Scale and spread wait time reduction approach to an additional clinic within CAMH	Launch wait time reduction approach to an additional clinic within CAMH	Evaluate wait time reduction within additional clinic site	30-50% of wait times reduced within additional clinic site
								3) Develop a plan to support other components of access and clinic sites at CAMH	Begin developing a sustainability plan for access 2.0 initiative	Sustainability plan developed	Sustainability plan developed (y/n)
Safety	Workplace Violence Lost Time Injury Frequency (# of WPV incidents/100 FTEs)	Count per FTE / Worker	Local data collection / January - December 2025	0.18	0.28	Target based on 95% CI	**Year 3**	1) Evaluating and maintaining TIDES education for clinical spaces	1) Staff to complete TIDES mandatory training with high rate of knowledge or intent to change practice	An increase in reported knowledge or confidence for learners on one or more content elements: 1) % of applicable learners who reported an increase in knowledge 2) % of applicable learners who reported an increase in confidence	1) 80% 2) 80%
									2) Implement train-the-trainer and mentorship programming to inpatient and outpatient clinical staff to become point-of-care facilitators (POCF) for their services	Number of active POCFs in inpatient and outpatient services	Increase from 40 POCFs to 60 POCFs by December 2025
								2) Sustained implementation of Registered Nurses' Association of Ontario (RNAO) Best Practice Guideline (BPG): *Promoting Safety: Alternative approaches to the use of Restraints*, on all inpatient units in each clinical program. This includes the evaluation and sustainability of initiatives to ensure compliance with: 1) This is Me, 2) Safety and Comfort Plan; and, 3) Client/Patient Debriefing	1) Continued implementation of local-level strategies and work of the interprofessional BPG champions, to increase completion of This is Me, Safety and Comfort Plan and Client/Patient Debriefing in compliance with CAMH documentation standards and policy 2) Inpatient unit leadership teams to continue to review workplace violence incident data, mitigation strategies and training requirements with teams	1) % of new admissions with "This is Me" initiated within 14 days of admission (in our EHR) 2) % of Safety and Comfort Plans initiated within 72 hours of admission 3) % of Client/Patient Debriefs initiated within 72 hours of the restraint event	1) 76 % of new admissions with "This is Me" initiated within 14 days of admission (in our EHR) 2) 71.4 % of Safety and Comfort Plans initiated within 72 hours of admission 3) 55.8 % of Client/Patient Debriefs initiated within 72 hours of the restraint event
								3) Sustained delivery and evaluation of a simulation training on the disclosure of a patient safety incident: A Disclosure Simulation: Practicing an apology using H.E.A.R.T. ®	1) Continue to provide disclosure simulation training by further integrating it into the practice setting and targeting specific learner groups	1) Train new instructors to deliver the simulation training on the disclosure of errors 2) Identify targeted learner groups 3) Deliver training sessions to targeted learner groups 4) Identify a pilot unit based on rates of lost time due to workplace violence incidents and pilot an on-unit training in collaboration with Nurse Educators	1) 4 new instructors trained 2) Learner groups identified by April 2025 3) 4 sessions delivered by December 2025 4) Pilot unit identified and training delivered by December 2025
									2) Continue to evaluate the simulation training and incorporate improvements recommended by the working group into future offerings. Use evaluation data to identify needs for additional scenarios or unit-specific training	Collect and analyze evaluation data to highlight commitment to practice change (e.g., change in confidence). Develop recommendations to further integrate the training into the practice setting	Evaluate and modify the simulation or additional scenarios as necessary, and provide recommendations for integration by December

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Safety	% emergency use of physical restraints during inpatient stay (excludes the Emergency Department)	% / All inpatients	Local data collection/ January – December 2025	3.1%	4.1%	Maintain target. Based on the average of last FY 4.1%	**Year 3**	1) Continue to advance our Trauma-Informed De-Escalation Education for Safety and Self- Protection (TIDES) training implementation and sustainability, and the utilization of practice enhancements	Delivery of the TIDES/BPSO Prevention modules and achieving high completion rate for staff in inpatient and outpatient areas	% of staff who completed each module by inpatient and outpatient clinical staff	80% completion for each of the four modules that are projected to be delivered by December 2025
								2) Sustained implementation of Registered Nurses' Association of Ontario (RNAO) Best Practice Guideline (BPG): *Promoting Safety: Alternative approaches to the use of Restraints* on all inpatient units in each clinical program. This includes the evaluation and sustainability of initiatives to ensure compliance with: 1) This is Me, 2) Safety and Comfort Plan; and, 3) Client/Patient Debriefing	1) Continue to reinforce alternative strategies for physical restraint use, focusing on de-escalation measures and crisis intervention strategies through the continued recruitment and engagement of Promoting Safety BPG Champions. These Champions play a crucial role in implementing best practice guidelines by providing unit-level education during huddles, facilitating reflective practices, and participating in events and unit projects	1) % of new admissions with "This is Me" initiated within 14 days of admission (in our EHR) 2) % of Safety and Comfort Plans initiated within 72 hours of admission 3) % of Client/Patient Debriefs initiated within 72 hours of the restraint event 4) One champion per unit within the PRT, CCC and Forensic Programs	1) 76% of new admissions with "This is Me" initiated within 14 days of admission (in our EHR) 2) 71.4% of Safety and Comfort Plans initiated within 72 hours of admission 3) 55.8% of Client/Patient Debriefs initiated within 72 hours of the restraint event 4) 18 units with at least one champion
									2) Develop an education pamphlet for patients and families on the use of restraints	1) Conduct a consultation with patients, families and support networks to better understand how to support patients and families regarding restraint use. 2) Develop the education pamphlet	1) Hold consultation by August 2025 2) By December 2025
								3) Engage physicians in the development and implementation of change ideas for the effective use of Pharmacotherapy PRN (chemical restraint) order sets	1) Optimization of emergency department (ED) admission order sets	% of new admissions using the optimized (or aggression) order set	50 % by Dec 2025
									2) Standardization of inpatient morning rounds to include review of pharmacotherapy PRN (chemical restraint) use in the previous 24 hours and anticipation of PRN use in the next 24 hours	1) Generate standardized questions and prompts for physicians and registered nurses (RNs) to be used during morning rounds 2) % of inpatient units trained on the standardized morning round PRN review process 3) Collect qualitative feedback on the standardized morning round PRN review process	1) Questions developed by July 2025 2) 50% of inpatient units trained by December 2025 3) Qualitative feedback collected by December 2025
								4) Ensure consistent debrief documentation in the Emergency Department (ED). Patients who had a restraint event in the ED are more likely to have a restraint in an inpatient unit. Effective debriefing after a restraint event in the ED can help reduce repeat restraints once admitted	1) Regular communication between ED leadership and the team, and leveraging of Clinical Scholars to provide coaching and education on completing the Client/Patient Debrief Form (e.g., huddles, morning rounds) 2) Implement an icon on the ED whiteboard that is linked to restraint orders to prompt the ED team that a Client/Patient Debrief Form requires completion	Percentage of restraint events in the ED for which debrief forms are initiated within 72 hours	27.3%
									2) Continue our ongoing qualitative research to gain insights into patient perspectives on clinical, systemic, and structural inequities that may affect the use of restraints. This research has highlighted several strategies for further reducing restraint use in the emergency department (ED), including Trauma-Informed Approaches, a pilot program with the Toronto Police Services, a Team-Based Approach, and enhancing diversity within the ED team. We will continue ongoing monitoring of these strategies	Toronto Police Services Pilot: Time for transfer of care and officers released from the ED	1) One hour

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Safety	Reduction of inpatient falls resulting in moderate to severe harm or death	All inpatients	Local data collection/ January – December 2025	14 falls with harm/ 1000 patient days 0.31	< =8 falls with harm / 1000 patient days 0.21	New Indicator	**Year 1**	Development and implementation of an evidence informed corporate falls prevention and management strategy aimed at reducing falls with harm (moderate/severe/death)	1) Analyze and validate baseline inpatient falls data across CAMH 2) Conduct a gap analysis of the current state of falls management assessment tools and resources across CAMH 3) Monitor falls associated with moderate/severe harm or death to inform the corporate falls strategy 4) Implement a CAMH-wide falls strategy	Establishment of a working group (steering committee) to develop corporate strategies to reduce falls with harm Implement evidence informed strategies to assist in the reduction of falls with harm. Including the analysis of existing falls with harm data - use of visual management tools for e.g. safety cross, dashboards - Enhancement of existing falls prevention policy - Staff education & training - Patient/client education Adapt existing practices and adopt new and emerging activities that contribute to reduction in falls with injury	**<u>Establishment of a Working Group (Steering Committee)</u>** **Working group formation: Establishment of the steering committee within 2 months** of project initiation **Initial action plan:** Development of the first draft of the falls prevention strategy within 6 months of committee formation **<u>Analysis of existing falls harm data</u>** **Data completeness:** Ensure 100% of reported fall incidents with harm are documented and accessible in the system **Data analysis frequency:** Conduct data analysis at least monthly **Identifying patterns:** Identify at least three recurring patterns (e.g., time of day, specific patient risk factors) within the first 3 months **Actionable insights:** Generate at least 3 actionable recommendations or strategies for improvement based on the data analysis within 3 months **Policy review completion:** Complete review of the existing policy within 2 months
Experience	Real Time Patient Experience	All patients	Local data collection/ January – December 2025	N/A	CB	New survey tool	**Year 2**	Implement real-time mechanisms for patient and family experience feedback	Implement tools for surveying patient and family experience at CAMH	1) Determine baseline response rate for patients who complete the experience surveys 2) Leverage patient experience survey platforms to develop and deploy a family experience survey	1) % of patients who complete the experience surveys (CB) 2) Dedicated family experience tool to be deployed by December 2025
Experience	Total number of patients connected with research staff to hear about research opportunities in Child, Youth, and Family Services (FAST and Slaight Centre).	Outpatients: Child Youth and Family Services (FAST and Slaight Centre)	Local data collection/ January – December 2025	N/A	CB	New Indicator	**Year 1**	Patients connected with research staff to hear about research opportunities during their clinical care appointment Promote clinical research integration into the patient's episode of care	1) Educate outpatients and clinical staff about research opportunities to enhance their knowledge and awareness 2) Assess the technical options available to document the introduction of research	1) Develop a draft strategy to increase awareness and education for clinical staff 2) Collect baseline for how many outpatients are informed about research in pilot areas within the FAST and Slaight Centre pilot sites 3) Determine the tool we will implement to track offers of participation as well as assess the adoption and usage of the tool	1) Draft research engagement plan developed by Q2 including current state data analysis from Child Youth and Family Services (FAST and Slaight Centre) 2) By Q2 finalize selection of tool to implement to capture data