### Theme 1: Timely and Efficient Transitions

#### Timely

<table>
<thead>
<tr>
<th>Year</th>
<th>Issue Description</th>
<th>Measure/Indicator</th>
<th>Unit/Population</th>
<th>Source/Period</th>
<th>Current Performance</th>
<th>Target Justification</th>
<th>Target for Process Measure</th>
<th>Target for Process Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>2023</td>
<td>Develop a strategy to address data quality issues across CAMH (e.g., non-compliance with Wait Time PowerForm completion in I-CARE) to ensure every outpatient clinic is reporting accurate wait times.</td>
<td>Standardize mechanisms for measuring wait time data across CAMH (new clinic referrals)</td>
<td>NA</td>
<td>CB</td>
<td>New indicator</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Method:**
- **Process Measures:**
  - (1) General and local barriers identified to wait time data completion
  - (2) General and local barriers identified to reduce wait times
  - (3) % of Wait Time PowerForm completion rates across all programs

**Outcome:**
- (1) MD and non-MD level sponsor leaders identified
- (2) Pilots designed and initiated
- (3) MD and non-MD level sponsor leaders identified by end of March 2023
- (4) Pilot designed by end of Q2 2023 and initiated by Q3 2023

### Year 2 (2014)

<table>
<thead>
<tr>
<th>Year</th>
<th>Issue Description</th>
<th>Measure/Indicator</th>
<th>Unit/Population</th>
<th>Source/Period</th>
<th>Current Performance</th>
<th>Target Justification</th>
<th>Target for Process Measure</th>
<th>Target for Process Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>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.</td>
<td>Analyze, validate and disseminate Wait Time data results (e.g., highest/lowest)</td>
<td>NA</td>
<td>CB</td>
<td>New indicator</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Method:**
- **Process Measures:**
  - (1) % of Wait Time PowerForm completion rates across all programs
  - (2) Wait times in key priority dashboard will be monitored by outpatient clinical services weekly

**Outcome:**
- (1) MD and non-MD level sponsor leaders identified
- (2) % of Wait Time PowerForms completed by Q3 2024
- (3) MD and non-MD level sponsor leaders identified by end of March 2023
- (4) Pilot designed by end of Q2 2023 and initiated by Q3 2023

### Year 3 (2015)

<table>
<thead>
<tr>
<th>Year</th>
<th>Issue Description</th>
<th>Measure/Indicator</th>
<th>Unit/Population</th>
<th>Source/Period</th>
<th>Current Performance</th>
<th>Target Justification</th>
<th>Target for Process Measure</th>
<th>Target for Process Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>Set the conditions for scale and spread of the pilot projects to other outpatient clinics within each program.</td>
<td>Evaluate the three pilots and month-to-month reductions in wait times (I-CRA, Acute and CCR)</td>
<td>NA</td>
<td>CB</td>
<td>New indicator</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Method:**
- **Process Measures:**
  - (1) Evaluation of the three pilots
  - (2) Wait time reduction in all three pilot areas

**Outcome:**
- (1) MD and non-MD level sponsor leaders identified by end of March 2023
- (2) 30-50% of wait times reduced in all three pilot areas
- (3) MD and non-MD level sponsor leader identified by end of March 2023

### Year 4 (2016)

<table>
<thead>
<tr>
<th>Year</th>
<th>Issue Description</th>
<th>Measure/Indicator</th>
<th>Unit/Population</th>
<th>Source/Period</th>
<th>Current Performance</th>
<th>Target Justification</th>
<th>Target for Process Measure</th>
<th>Target for Process Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>Long-term evaluation related to Emergency Department volumes, inpatient admissions related to outpatient wait times controlling for key confounding variables and develop sustainability plan.</td>
<td>By year end, begin to determine whether reductions across clinics in wait times are being achieved</td>
<td>NA</td>
<td>CB</td>
<td>New indicator</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Method:**
- **Process Measures:**
  - (1) Wait time reductions systematically occurring and progressing positively across all clinical programs
  - (2) Sustainability plan developed

**Outcome:**
- (1) MD and non-MD level sponsor leaders identified by end of March 2023
- (2) Sustainability plan developed (Y/N)
- (3) 30-50% of wait times reduced across all major outpatient services

### Year 5 (2017)

<table>
<thead>
<tr>
<th>Year</th>
<th>Issue Description</th>
<th>Measure/Indicator</th>
<th>Unit/Population</th>
<th>Source/Period</th>
<th>Current Performance</th>
<th>Target Justification</th>
<th>Target for Process Measure</th>
<th>Target for Process Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>Scale and spread wait time reduction approach across larger number of clinics cutting across all major outpatient services at CAMH.</td>
<td>Launch wait time reduction approach across larger number of clinics cutting across all major outpatient services at CAMH</td>
<td>NA</td>
<td>CB</td>
<td>New indicator</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Method:**
- **Process Measures:**
  - (1) Wait time reduction across all major outpatient services

**Outcome:**
- (1) MD and non-MD level sponsor leaders identified by end of March 2023
- (2) 30-50% of wait times reduced across all major outpatient services

### Year 6 (2018)

<table>
<thead>
<tr>
<th>Year</th>
<th>Issue Description</th>
<th>Measure/Indicator</th>
<th>Unit/Population</th>
<th>Source/Period</th>
<th>Current Performance</th>
<th>Target Justification</th>
<th>Target for Process Measure</th>
<th>Target for Process Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>Develop a plan to support other components of access (e.g., on discharge and with community partners, or across the health system, for instance, our role in Early Psychosis Intervention (EPI) wait times across the province).</td>
<td>Begin planning for access 2.0 initiative (e.g., peer clinics in the system)</td>
<td>NA</td>
<td>CB</td>
<td>New indicator</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Method:**
- **Process Measures:**
  - (1) Factors related to access to care beyond year 3 at CAMH and across the health system identified
  - (2) Plan developed (target: TBD)
### Purpose

**2023-2024 Quality Improvement Plan**

**“Improvement Targets and Initiatives”**

The document provides a detailed improvement plan focusing on various dimensions and initiatives aimed at enhancing performance and retention rates. It outlines specific targets, methods, and processes for improvement, as well as the implementation strategies for achieving these goals.

### Dimensions

**Turnover**
- **Vacancy Rate**
  - Percentage/workers: 9.8% (FY 2022 Q4)
  - Target: 8.8% (CB)
- **Percentage/workers**
  - Source: Local data collection January – December
  - Period: 2023

**Voluntary Turnover**
- **Percentage/workers**
  - Source: Local data collection January – December
  - Period: 2023

### Targets

1. **New Indicator - Turnover**
   - Target is set as a significant improvement compared to the average of the past 8 quarters (lower 99% confidence limit). The target is comparable to pre-pandemic averages.

2. **New Indicator - Vacancy Rate**
   - Target: 8.8% (CB)

### Methods

1. **Conduct exit interviews for all permanent 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 to identify drivers of retention.

2. **Develop and implement a communication plan for managers and leadership** to ensure that exiting staff are asked to participate in exit interviews.

3. **Continue Nursing Referral Program (NRP)** with incentive payment for staff who make a referral that leads to a successful external nurse hire.

### Process Measures

1. **Engage nurses in workforce and system process improvements**

2. **Identify and track measures relating to staff and physician wellness**

3. **Collect reliable data on drivers that positively enhance retention and recruitment**.

### Change Ideas

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.

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 date and for all physicians who leave CAMH to identify drivers of retention.

3. **Develop and implement a communication plan for managers and leadership** to ensure that exiting staff are asked to participate in exit interviews.

4. **Continue Nursing Referral Program (NRP)** with incentive payment for staff who make a referral that leads to a successful external nurse hire.

###洗澡

The document includes a table summarizing the planned improvement initiatives, change ideas, and associated process measures, focusing on various dimensions such as turnover, vacancy rate, and voluntary turnover. This structured approach ensures that the improvement strategies are well-defined and measurable, allowing for effective monitoring and evaluation of progress towards the set targets.
<table>
<thead>
<tr>
<th>Aim</th>
<th>Measure</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>2023-2024 Quality Improvement Plan</td>
<td>&quot;Improvement Targets and Initiatives&quot;</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Planned improvement initiatives [Change ideas]</th>
<th>Methods</th>
<th>Process Measures</th>
<th>Target for Process Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>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</td>
<td>1) Identification of metrics related to physician burnout/wellness 2) Develop implementation plan for tracking metrics related to physician burnout/wellness 3) % of physicians who indicate via the Leadership and Management Program for Physicians (LAMP) evaluation survey that this professional development program is relevant to their work</td>
<td>1) Identification of wellness indicators by Q2 2) Implementation plan for wellness measures completed by Q3 3) 60% of physicians indicate on the LAMP evaluation survey that this is relevant to their work</td>
<td></td>
</tr>
<tr>
<td>4) Improve measurement and reporting to support recruitment and retention (development of data acquisition and measurement reporting)</td>
<td>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)</td>
<td>1) Business case approved 2) ELT approval obtained (Y/N) 2) Board approval obtained (Y/N)</td>
<td></td>
</tr>
<tr>
<td>1) Identification of metrics related to physician burnout/wellness</td>
<td>3) % of physicians who indicate via the Leadership and Management Program for Physicians (LAMP) evaluation survey that this professional development program is relevant to their work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) Build a reliable report framework for the current HRIS</td>
<td>1) Create a standardized report for vacancy and voluntary turnover rate and lost time data 2) Feedback obtained by clinical management</td>
<td>3) 4 reports (quarterly) 2) Obtain feedback from 50% clinical management on report by end of December 2023</td>
<td></td>
</tr>
<tr>
<td>3) % of physicians who indicate via the Leadership and Management Program for Physicians (LAMP) evaluation survey that this professional development program is relevant to their work</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5) Enhance psychological health, safety, and wellness of staff and physicians</td>
<td>Continued implementation of the CAMH Workplace Mental Health Strategy</td>
<td>1) Develop content to embed psychological health and safety in new hire orientation 2) Number of organization-wide events where staff can talk about workplace mental health, anti-racism and psychological safety 3) Physician Engagement, Wellness &amp; Excellence Committee (which includes divisional wellness leads, Peer Support lead, Mentorship lead, and LAMP lead) and conduct wellness forums for exploration of topics that impact physician engagement, wellness, and excellence 4) Number of enrollments in the automated text-based clinician mental health support, which aims to connect CAMH clinicians to mental health resources and discipline-specific resources and information</td>
<td>1) New hire orientation content developed by September 20, 2023 2) Host 2 organization-wide events 3) Physicians attend at least 1 quarterly wellness forum per year 4) # of enrollments (CB)</td>
</tr>
<tr>
<td>1) Develop content to embed psychological health and safety in new hire orientation</td>
<td>3) Physicians attend at least 1 quarterly wellness forum per year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) Number of organization-wide events where staff can talk about workplace mental health, anti-racism and psychological safety</td>
<td>4) Number of enrollments in the automated text-based clinician mental health support, which aims to connect CAMH clinicians to mental health resources and discipline-specific resources and information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3) Physician Engagement, Wellness &amp; Excellence Committee (which includes divisional wellness leads, Peer Support lead, Mentorship lead, and LAMP lead) and conduct wellness forums for exploration of topics that impact physician engagement, wellness, and excellence</td>
<td>5) Enhance diversity, equity and inclusion for staff and physicians</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4) Number of enrollments in the automated text-based clinician mental health support, which aims to connect CAMH clinicians to mental health resources and discipline-specific resources and information</td>
<td>1) Provide tools and supports for staff and physicians to foster a Fair &amp; Just CAMH for all</td>
<td>1) % of managers who have completed the mandatory training on Foundational Knowledge on Anti-Black Racism 2) Number of training sessions developed and launched for managers on leading discussions to create an inclusive environment for everyone at CAMH 3) Number of staff who have completed the San'yas training for staff</td>
<td>1) 70% of management have completed the mandatory training by December 2023 2) 5 sessions for managers developed and launched by end of Q2 3) 375 CAMH staff trained by the end of December 2023</td>
</tr>
<tr>
<td>1) Provide tools and supports for staff and physicians to foster a Fair &amp; Just CAMH for all</td>
<td>2) Re-launch updated CAMH Diversity Survey</td>
<td>1) Design and launch campaign for participation in Diversity Survey 2) % increase in response rate</td>
<td>1) Develop campaign and communication plan by end of March 2023 and launch surveys by April 2023 (Y/N) 2) Increase response rate by 10% by end of Q2</td>
</tr>
<tr>
<td>3) Number of staff who have completed the San’yas training for staff</td>
<td>4) Re-launch updated CAMH Diversity Survey</td>
<td>1) Design and launch campaign for participation in Diversity Survey 2) % increase in response rate</td>
<td>1) Develop campaign and communication plan by end of March 2023 and launch surveys by April 2023 (Y/N) 2) Increase response rate by 10% by end of Q2</td>
</tr>
</tbody>
</table>
Aim | Measure | Change |
--- | --- | ---
**Theme III: Safe and Effective Care**
Safe Workplace Violence Last Time Injury Frequency (IF of VW incidents/100 FTEs) | Count per FTE / Worker | Local data collection / January - December 2023 | 0.28 | 0.29 | Target is set as a significant improvement compared to the average of the past 8 quarters (lower 99% confidence level). The target is comparable to pre-pandemic averages.

**Year 1: (2023)**
1) Expand and enhance implementation of Safe & Well CAMH program, and Workplace Violence Prevention Committee recommendations and annual work plan.
2) Implement reward Supervisor Competency Training.
3) Continue implementation and adoption of the recommendations from the risk assessments completed on high-acuity units.
4) Urgent TIDES consultations to high-acuity inpatient units.

**Planned Improvement Initiatives (Change Ideas)**
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).
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).
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 empathetically, and provide support to the patient afterwards. Practice enhancements are aligned with interventions shown to reduce conflict 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 empathically.
4) 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).

**Process Measures**
1) Implement reward Supervisor Competency Training.
2) Continue implementation and adoption of the recommendations from the risk assessments completed on high-acuity units.
3) Urgent TIDES consultations to high-acuity inpatient units.
4) 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 empathetically, and provide support to the patient afterwards. Practice enhancements are aligned with interventions shown to reduce conflict 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 empathically.

**Flawed Improvement Initiatives (Change Ideas)**
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.
2) 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.

**Justification**
1) Needs assessment and literature review completed.
2) Convene curriculum committee and draft learning objectives.
3) Scenario developed and faculty trained.
4) Number of staff who completed the simulation training.

**Target for Process Measure**
1) Number of Managers who have received the revised training.
2) % of recommendations in progress or completed.
3) % of recommendations in progress or completed.
4) % of recommendations in progress or completed.

**Process Measures**
1) Needs assessment and literature review completed.
2) Curriculum committee convened and learning objectives drafted by June 2023.
3) Scenario developed and faculty trained by August 2023.
4) 10 staff will complete the simulation training by December 2023.

**Theme III: Safe and Effective Care**
Safe % of patients physically restrained during inpatient stay (%) / All inpatients | Hospital collected data / Q4 22-23 through Q4 23-24 | 5.4% | 4.8% | Target is set as a significant improvement compared to the average of the past 8 quarters (lower 99% confidence level). The target is comparable to pre-pandemic averages.

**Year 1: (2023)**
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).
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).
3) Convene curriculum committee and draft learning objectives.
4) Number of staff who completed the simulation training.

**Justification**
1) Needs assessment and literature review completed.
2) Curriculum committee convened and learning objectives drafted by June 2023.
3) Scenario developed and faculty trained by August 2023.
4) 10 staff will complete the simulation training by December 2023.

**Process Measures**
1) Needs assessment and literature review completed.
2) Curriculum committee convened and learning objectives drafted by June 2023.
3) Scenario developed and faculty trained by August 2023.
4) 10 staff will complete the simulation training by December 2023.

**Target for Process Measure**
1) % of recommendations in progress or completed.
2) % of recommendations in progress or completed.
3) % of recommendations in progress or completed.
4) % of recommendations in progress or completed.

**Process Measures**
1) Needs assessment and literature review completed.
2) Curriculum committee convened and learning objectives drafted by June 2023.
3) Scenario developed and faculty trained by August 2023.
4) 10 staff will complete the simulation training by December 2023.

**Flawed Improvement Initiatives (Change Ideas)**
1) Convene curriculum committee and draft learning objectives.
2) Scenario developed and faculty trained.
3) Number of staff who completed the simulation training.

**Process Measures**
1) Needs assessment and literature review completed.
2) Curriculum committee convened and learning objectives drafted by June 2023.
3) Scenario developed and faculty trained by August 2023.
4) 10 staff will complete the simulation training by December 2023.

**Target for Process Measure**
1) % of recommendations in progress or completed.
2) % of recommendations in progress or completed.
3) % of recommendations in progress or completed.
4) % of recommendations in progress or completed.
<table>
<thead>
<tr>
<th>Issue</th>
<th>Quality Dimension</th>
<th>Measure/ Indicator</th>
<th>Unit/ Population</th>
<th>Source/ Period</th>
<th>Current Performance</th>
<th>Target Justification</th>
<th>Planned improvement initiatives/Change ideas</th>
<th>Methods</th>
<th>Process Measures</th>
<th>Target for Process Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aim</td>
<td>Measure</td>
<td>Change</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>e.g. enhancing skills and building confidence through team-based learning</td>
<td>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)</td>
<td>1) % of policies reviewed and updated to align with RNAO BPG</td>
<td>1) 75% of policies reviewed and updated by December 2023</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>e.g. driving fundamental day to day processes proven to keep everyone safe</td>
<td>2) Review, update, align and implement documentation standards related to restraint use, de-escalation, and crisis management in alignment with RNAO BPG</td>
<td>2) % of clinical documentation standards reviewed, updated and implemented to align with RNAO BPG</td>
<td>2) 75% of clinical documentation standards related to restraint use, de-escalation and crisis management will be reviewed, updated and implemented by December 2023</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>e.g. bringing learning to the point of care</td>
<td>3) # of decision-making algorithms and assessment tools; prevention and safety strategies reviewed, updated and implemented to align with RNAO BPG (e.g. Mutual Action Plan behavior profile, (MAP), alternative to restraints decision tree, behavior monitoring log, patient and family education)</td>
<td>3) % of documented evidence of the use of alternative strategies used prior to the use of physical restraints (CB)</td>
<td>3) # of decision making algorithms and assessment tools: prevention and safety strategies reviewed, updated and implemented by December 2023 (CB)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3) 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</td>
<td>4) % of documented evidence of the use of assessment and prevention strategies, alternative strategies to physical restraints use</td>
<td>4) % documented evidence of the use of the alternative strategies used prior to the use of physical restraints (CB)</td>
<td>4) % documented evidence of the use of the alternative strategies used prior to the use of physical restraints (CB)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5) Work with Reporting and Analytics to monitor CAMH-wide physical restraint use</td>
<td>5) % of physical restraints used across CAMH (CB)</td>
<td>5) % decrease in the use of physical restraints at CAMH (CB)</td>
<td>5) % decrease in the use of physical restraints at CAMH (CB)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4) Work with physicians to understand current state of pharmacotherapy order data including challenges with use</td>
<td>Identify a working group to develop and implement a strategy to address data quality issues across CAMH (chart audits and current state analysis)</td>
<td>Develop pharmacotherapy indicators associated with mechanical restraint reduction</td>
<td>Indicators developed by December 2023</td>
</tr>
</tbody>
</table>