Access and Flow | Timely | Custom Indicator

Indicator #2

Median Wait Time from Referral to First Offered Consult Appointment. (Centre for Addiction and Mental Health)

Last Year		This Year		
64.00	**51**	**49.00**	**--**	**NA**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Sustaining wait time reductions from year 2 and monitoring data quality within pilot clinics to ensure every clinic is reporting accurate wait times

Process measure

- By year end wait time reductions systematically occurring and progressing positively across pilot clinics

Target for process measure

- By year end wait time reductions systematically occurring and progressing positively across all pilot clinical programs

Lessons Learned

There was significant improvement to data capture across the board for wait times this past year. Through standardized scheduling practices, opportunities for data automation, staff education for wait time and co-design workflow improvements, the team was able to maintain a wait time below our target for Q1-Q3.

Quarterly data for wait times:

Q1 – April – June: 42 days

Q2 – July – September: 38 days

Q3 – October – December: 49 days

The Wait Time Strategy was recalibrated to refine vision, strengthen governance, and establish a clear and cohesive communication approach through ongoing engagement and iterative feedback cycles.

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

Scale and spread wait time reduction approach to an additional clinic within CAMH

Process measure

- Evaluate wait time reduction within additional clinic site

Target for process measure

- 30-50% of wait times reduced within additional clinic site

Lessons Learned

The team was able to onboard 2 new clinics during the year so far with significant improvement to their wait times.

Adult Neurodevelopment Services (ANS) was onboarded and saw data capture improve from 46% to 92%, and wait times dropped by 36% from Q1 to Q2.

Child and Adolescent Psychiatric Assessment Clinic (FAST) was onboarded as well and achieved an 11.36% decrease in wait times.

Change Idea #3 ☑ Implemented ☐ Not Implemented ☐ In Progress

Develop a plan to support other components of access and clinic sites at CAMH

Process measure

- Sustainability plan developed

Target for process measure

- Sustainability plan developed (y/n)

Lessons Learned

A sustainability plan was developed and includes a current state analysis, standardization of key processes, and a deliberate shift toward more agile and lean operating models.

Comment

Continue to include this indicator on next QIP with progression in change ideas.

Experience | Patient-centred | Custom Indicator

	Last Year		This Year		
Indicator #3 Real Time Patient Experience (Centre for Addiction and Mental Health)	**CB** Performance (2025/26)	**CB** Target (2025/26)	**CB** Performance (2026/27)	**--** Percentage Improvement (2026/27)	**NA** Target (2026/27)

Change Idea #1 ☑ **Implemented** ☐ **Not Implemented** ☐ **In Progress**

Implement real-time mechanisms for patient and family experience feedback

Process measure

- 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

Target for process measure

- 1) % of patients who complete the experience surveys (CB) 2) Dedicated family experience tool to be deployed by December 2025

Lessons Learned

Patient Experience surveys were implemented this year through an Emergency Department Short form, an Inpatient Mental Health & Addictions Short form, and an Outpatient Mental Health & Addictions Short form survey. Leader resources, as well as drop in sessions, posters and targeted communications in patient areas assisted with the awareness of this survey and subsequent survey responses.

One challenge in implementing this work was evidenced by the longer timeline than initially thought. The successes we achieved were a high response rate to the Emergency Department survey and we developed a new survey for Youth and Pediatric in partnership with other health care and mental health organizations.

Comment

Continue to include this as an area on next QIP with progression in change ideas.

Indicator #5

Total number of patients connected with research staff to hear about research opportunities in Child, Youth, and Family Services (FAST and Slaight Centre). (Centre for Addiction and Mental Health)

Last Year		This Year		
CB	**CB**	**CB**	**--**	**NA**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

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.

Process measure

- 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

Target for process measure

- 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

Lessons Learned

Continuous involvement of patients and families within research this past year has been a successful endeavor. A total of over 500 patients and families were connected with research staff to hear about opportunities during their clinical appointment.

To assist staff in this new process, an alert was created within the Electronic Medical Record to prompt staff to engage their patients and families about these opportunities. The alert was developed and implemented as of October 2025.

Comment

Continue to implement and advance opportunities for our patients to participate in research opportunities.

Safety | Effective | Custom Indicator

	Last Year		This Year		
Indicator #6 Workplace Violence Lost Time Injury Frequency (# of WPV incidents/100 FTEs) (Centre for Addiction and Mental Health)	**0.18** Performance (2025/26)	**0.28** Target (2025/26)	**0.31** Performance (2026/27)	**--** Percentage Improvement (2026/27)	**NA** Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Evaluating and maintaining TIDES education for clinical spaces.

Process measure

- 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

Target for process measure

- 1) 80% of applicable learners who reported an increase in knowledge 2) 80% of applicable learners who reported an increase in confidence

Lessons Learned

Through our consistent TIDES training the staff continued to show a marked increase in both knowledge and confidence after their training session. Since April, the team has received 1,150 evaluations with positive results.

Reported an increase in knowledge – range between 80-88%

Reported an increase in confidence – range between 76-77%

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

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

Process measure

- 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

Target for process measure

- 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

Lessons Learned

CAMH is a Best Practice Spotlight Organization (BPSO) that works towards becoming a global leader in advancing mental health and addictions care through evidenced-based practices. To reduce the amount of workplace violence incidents towards our staff, the team focused on improving the completion rates of documentation that would assist the staff in caring for their patients.

Completion Rates:

This is Me – range between 60-82%

Safety and Comfort – range between 57-64%

Client/Patient Debriefs – range between 45-50%

One challenge the team faced was low completion rates. These were addressed through consultations and work with multistakeholder engagement. Continuous work is also being done with the clinical teams, Informatics, and the Patient and Family Experience team to continue identifying opportunities for improvement.

Change Idea #3 ☑ Implemented ☐ Not Implemented ☐ In Progress

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. ®.

Process measure

- 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

Target for process measure

- 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

Lessons Learned

CAMH's Simulation team worked to deliver this important work and improve patient care after a safety incident. A pilot clinic was identified to begin this work, and work continued with the disclosure policy review working group to ensure alignment with larger organizational goals.

Challenges for this team were around recruiting facilitators and target learner groups/clinical spaces, but successes were found on expanding the stakeholders engaged for this work to ensure adequate resources

Change Idea #4 ☑ Implemented ☐ Not Implemented ☐ In Progress

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. ®.

Process measure

- 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

Target for process measure

- Evaluate and modify the simulation or additional scenarios as necessary, and provide recommendations for integration by December

Lessons Learned

In the teams work with the pilot clinic, this work was able to begin. Similar challenges and successes were met with this initiative as well.

Change Idea #5 ☑ **Implemented** ☐ **Not Implemented** ☐ **In Progress**

Evaluating and maintaining TIDES education for clinical spaces.

Process measure

- Number of active POCFs in inpatient and outpatient services

Target for process measure

- Increase from 40 POCFs to 60 POCFs by December 2025.

Lessons Learned

The team increased their complement of trainers from 55 in April to 89 in December, a 61% increase. They continuously train and assess their need for trainers to ensure adequate resources.

Comment

Continue to include this indicator on next QIP with progression in change ideas.

	Last Year		This Year		
Indicator #1	**3.10**	**4.10**	**3.80**	**--**	**NA**
% emergency use of physical restraints during inpatient stay (excludes the Emergency Department) (Centre for Addiction and Mental Health)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

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

Process measure

- % of staff who completed each module by inpatient and outpatient clinical staff

Target for process measure

- 80% completion for each of the four modules that are projected to be delivered by December 2025

Lessons Learned

Our TIDES team worked to deliver the Trauma-Informed De-Escalation Education for Safety and Self-Protection through modules for both Inpatient and Outpatient staff to complete. 70 facilitators were trained to deliver the training. Over 30 sessions were delivered to Inpatient units, and over 20 were delivered to Outpatient with a total of over 350 staff trained.

Some challenges with this work was the low completion rates for staff completion. The team worked to do engagement to identify the pain points and opportunities for these sessions.

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

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

Process measure

- 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

Target for process measure

- 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

Lessons Learned

CAMH is a Best Practice Spotlight Organization (BPSO) that works towards becoming a global leader in advancing mental health and addictions care through evidenced-based practices. To reduce the amount of workplace violence incidents towards our staff, the team focused on improving the completion rates of documentation that would assist the staff in caring for their patients.

Completion Rates:

This is Me – range between 60-82%

Safety and Comfort – range between 57-64%

Client/Patient Debriefs – range between 45-50%

One challenge the team faced was low completion rates. These were addressed through consultations and work with multistakeholder engagement. Continuous work is also being done with the clinical teams, Informatics, and the Patient and Family Experience team to continue identifying opportunities for improvement.

Of the 18 targeted units for champion identification, all 18 have at least 1 champion supporting this work.

Change Idea #3 ☑ Implemented ☐ Not Implemented ☐ In Progress

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

Process measure

- 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

Target for process measure

- 1) Hold consultation by August 2025 2) By December 2025

Lessons Learned

The team held consultations with patients, families, and support networks to assist in the development of the pamphlet. The pamphlet was completed, and the implementation and roll out is expected for March.

Change Idea #4 ☑ Implemented ☐ Not Implemented ☐ In Progress

Engage physicians in the development and implementation of change ideas for the effective use of Pharmacotherapy PRN (chemical restraint) order sets

Process measure

- % of new admissions using the optimized (or aggression) order set

Target for process measure

- 50 % by Dec 2025

Lessons Learned

Utilization of the optimized order set for patients at risk of aggressive behaviours has surpassed the target of 50% and is currently sitting at 68% utilization. A lot of work was done to engage physicians from a variety of programs, with oversight from the Order Set Committee and Pharmacy teams. Consultation was also completed with the teams responsible for the Electronic Health Record to ensure suitability and accessibility for clinicians.

Change Idea #5 ☑ Implemented ☐ Not Implemented ☐ In Progress

Engage physicians in the development and implementation of change ideas for the effective use of Pharmacotherapy PRN (chemical restraint) order sets.

Process measure

- 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

Target for process measure

- 1) Questions developed by July 2025 2) 50% of inpatient units trained by December 2025 3) Qualitative feedback collected by December 2025

Lessons Learned

Questions were generated in consultation with nursing leadership, and the initiative was presented to frontline nursing. A communication strategy and education materials were developed in partnership with nursing leadership and an initiative to standardize morning rounds PRN review process was developed collaboratively amongst the team.

Change Idea #6 ☑ Implemented ☐ Not Implemented ☐ In Progress

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.

Process measure

- Percentage of restraint events in the ED for which debrief forms are initiated within 72 hours

Target for process measure

- 27.3% of restraint events in the ED for which debrief forms are initiated within 72 hours

Lessons Learned

The Emergency Department worked diligently to support the completion of debrief events within 72 hours. Reminders are provided to the team to assist with compliance, and they continue to leverage their clinical scholars and social worker to support patient debriefing. Work was also done to include an automated visual prompt for staff within the Electronic Health Record to assist staff with compliance rates.

Successes were the team saw great improvement starting at 27% in June and increasing to 36% in December.

Change Idea #7 ☑ Implemented ☐ Not Implemented ☐ In Progress

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.

Process measure

- Toronto Police Services Pilot: Time for transfer of care and officers released from the ED.

Target for process measure

- Time for transfer of care and officers released from the ED is one hour.

Lessons Learned

Processes to prioritize transfer of care with Toronto Police Services have proved beneficial with Emergency Department staff and the relationship between the police, and the clients they are bringing in.

Success for this initiative is that time for transfer of care continues to be the lowest in the city at 51 mins.

Comment

Continue to include this indicator on next QIP with progression in change ideas.

	Last Year		This Year		
Indicator #4 Reduction of inpatient falls resulting in moderate to severe harm or death (Centre for Addiction and Mental Health)	**14.00** Performance (2025/26)	**8** Target (2025/26)	**13.00** Performance (2026/27)	**--** Percentage Improvement (2026/27)	**NA** Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Development and implementation of an evidence informed corporate falls prevention and management strategy aimed at reducing falls with harm (moderate/severe/death)

Process measure

- 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

Target for process measure

- Establishment of a Working Group (Steering Committee) 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 Analysis of existing falls harm data 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

Lessons Learned

The Falls Prevention working group was established this year and set out to determine how to best develop a Falls Prevention strategy at CAMH. The group meets to identify gaps and determine their next steps with strategy development.

A challenge with this work was evidenced by some personnel changes which delayed the start of this working group. Prioritizing this work and identifying staff responsible for the strategy development was ultimately helpful in getting the work off the ground.

Comment

Will continue to implement and advance the corporate falls prevention and management strategy.