## Access and Flow | Efficient | Optional Indicator

| Indicator #1 | Last Year | | This Year | | |
|---|---|---|---|---|---|
| Alternate level of care (ALC) throughput ratio (Waypoint Centre For Mental Health Care) | **0.68** Performance (2024/25) | **1** Target (2024/25) | **0.71** Performance (2025/26) | **4.41%** Percentage Improvement (2025/26) | **NA** Target (2025/26) |

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

Continue implementation of ALC leading practices

**Process measure**

- Number of implemented leading practices

**Target for process measure**

- 11 by end of December 2024

**Lessons Learned**

The socializing of leading practices internally has led to better processes and discharge planning.

**Change Idea #2** ☑ Implemented ☐ Not Implemented

Expand on ALC leading practice # 11 - Build relationships & seek funding to increase available access to alternate discharge options

**Process measure**

- Number of formal partnerships created

**Target for process measure**

- Dec 2024 - 1 Partnership Empower Simcoe - MOU

### Lessons Learned

Added ALC ROUNDS for greater visibility, to leverage all opportunities, increase situational awareness (internal/external) and improve collaboration inside and outside our walls.

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

Expand on ALC leading practice # 4 Survey internal program staff regarding early identification and assessment practices of all inpatients.

**Process measure**

- % of those patient charts audited which had fulsome early identification and assessments prior to ALC designation

**Target for process measure**

- Gathering baseline - process not in place yet

### Lessons Learned

Challenges were faced with the manual reporting of this data. New reporting strategies allow for the manual auditing process to be discontinued.
Collaboration is underway with Data Analytics to ensure more accurate data capture and reporting.

## Comment

While not meeting target in Q3, this indicator demonstrates normal variation.

14/32 or 44% of our ALC patients are on Forensic programs, essentially homeless within our walls, with no housing options – this negatively impacts our throughput rate.

Advocacy continues across multiple ministries, with partners and housing organizations/agencies.

Rebooking a postponed tour of CAMH/LOFT partnership which houses 22 male forensic patients in the GTA in Q4. The tour will also include several supportive housing programs supporting different patient populations.

**Equity | Equitable | Custom Indicator**

| Indicator #4 | Last Year Performance (2024/25) | Last Year Target (2024/25) | This Year Performance (2025/26) | This Year Percentage Improvement (2025/26) | This Year Target (2025/26) |
|---|---|---|---|---|---|
| Percentage of audited Recovery Plans that include person centered culturally relevant goals and interventions (Waypoint Centre For Mental Health Care) | 65.00 | 95 | 81.00 | -- | NA |

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

Develop and release an eLearning on anti-black racism across the organization

**Process measure**

- Percentage of staff who have completed the anti-black racism eLearning module

**Target for process measure**

- 90% - Based on entire staff population

**Lessons Learned**

Target exceeded with over 90% of staff completed the Intro to Anti-Black Racism module.

**Change Idea #2** ☑ Implemented ☐ Not Implemented

Engage staff around the "Human Library Experience" and provide library cards to some staff.

**Process measure**

- Number of staff who participated in a "Human Library Experience"

**Target for process measure**

- 300 - Based on entire hospital staff population

### Lessons Learned

The number of registrants in the Human Library event was lower than expected. This initiative will be carried forward onto next year's QIP with.

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

Develop an EDI committee and review Policies and Procedures with an equity lens; make updates and/or develop new Policies and Procedures to support equitable practices.

**Process measure**

- Number of policies and procedures reviewed with an equity lens

**Target for process measure**

- 5 Policies and/or procedures

### Lessons Learned

Target exceeded with six policies and procedures reviewed. The EDI working group work efficiently utilizing small sub-working to provide feedback ahead of scheduled policy updates.

### Comment

While not at target yet, significant improvement over previous performance is demonstrated.

Q3 23/24 = 65%
Q3 24/25 = 81%

**Experience | Patient-centred | Custom Indicator**

**Indicator #3**

Percent positive responses to the annual OPOC survey question "Staff understood and responded to my needs and concerns." (Survey Question # 21)
Inpatient Population Only
2024 Annual OPOC Survey (Waypoint Centre For Mental Health Care)

| Last Year | | This Year | | |
|---|---|---|---|---|
| **80.00** | **88** | **78.00** | **--** | **NA** |
| Performance (2024/25) | Target (2024/25) | Performance (2025/26) | Percentage Improvement (2025/26) | Target (2025/26) |

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

Expand the utilization of the patient portal at Waypoint

**Process measure**

- Number of in-patient programs to implement the patient portal

**Target for process measure**

- 1 Additional IP program by end of 24-25 (2 cumulative total)

**Lessons Learned**

Work is underway to implement the Patient Portal with a subset of Outpatient clients (those enrolled in DBT program) with a targeted launch in January 2025. Inpatient expansion is paused at this time due to resource constraints.

**Change Idea #2** ☐ Implemented ☑ Not Implemented

Expand the utilization of the patient portal at Waypoint

**Process measure**

- Percent of eligible patients that are registered to the patient portal and there is evidence of them using the portal

**Target for process measure**

- 90% 10% buffer to allow for patients who decline use of portal

### Lessons Learned

At this time we are only able to measure patients registered to use the Patient Portal. We are working with Data Analytics on better metrics to demonstrate patient use of the Portal.

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

Strengthen utilization of the Recovery plan of care (RPOC) and the client assessment protocols(CAPS)

**Process measure**

- Percentage of patients with at least one CAPS updated in the last 28 days

**Target for process measure**

- 90% as per CNE Dashboard

### Lessons Learned

To support clinicians, a Business Intelligence Portal was developed to allow for easier visibility of outstanding work on the patient's Recovery Plan of Care (RPOC). The report displays all CAPS requiring attention.

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

Strengthen utilization of the Recovery plan of care (RPOC) and the client assessment protocols(CAPS)

**Process measure**

- Percentage of patients with all CAPS updated

**Target for process measure**

- 90% as per CNE Dashboard

### Lessons Learned

To support clinicians, a Business Intelligence Portal was developed to allow for easier visibility of outstanding work on the patient's Recovery Plan of Care (RPOC). The report displays all CAPS requiring attention.

**Comment**

A new survey tool was implemented in 24/25 to allow for more frequent data capture of the patient experience. The Patient Experience Pulse (PEP) survey is a shortened monthly survey with questions aligned to the OPOC survey. More frequent surveying has led to expanded data sets (larger sample size) allowing for deeper analysis of the results.
Discussions with peer hospitals are underway to explore the option of discontinuing with the annual OPOC survey and continuing with monthly PEP surveying.

Current performance results are inclusive of both OPOC and PEP surveying results.

Target not yet met.

## Safety | Safe | Custom Indicator

**Indicator #2**

Number of incidents of Violence and Aggression (severity level 2 - 4) (Waypoint Centre For Mental Health Care)

| Last Year | | This Year | | |
|---|---|---|---|---|
| **822.00** | **740** | **512.00** | **--** | **NA** |
| Performance (2024/25) | Target (2024/25) | Performance (2025/26) | Percentage Improvement (2025/26) | Target (2025/26) |

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

Explore opportunities to minimize the requirement to utilize Code Whites across the organization

**Process measure**

- Number of "true" code whites called per quarter

**Target for process measure**

- 37 per quarter Approx 15% reduction

**Lessons Learned**

The debriefing process is being evaluated to improve communication and support staff and patient following code white events. performance for this measure has continued to achieve target each quarter.

**Change Idea #2** ☑ Implemented ☐ Not Implemented

Implement Safewards on all inpatient programs

**Process measure**

- Number of programs with safewards implemented

**Target for process measure**

- 2 Programs (3 were previously completed)

**Lessons Learned**

Safewards has been implemented on 4 out of 5 targeted in-patient programs. The 5th program has begun implementation in January 2025. Further expansion of this program will be to incorporate Safewards training into Core Curriculum training and staff onboarding.

**Change Idea #3** ☐ Implemented ☑ Not Implemented

Implement training of clinical staff specific to the provision of mental health care

**Process measure**

- % of Inpatient Clinical Staff trained in specific module of the Waypoint Core Curriculum: Intro to Mental Health

**Target for process measure**

- 85% (Casual staff and various leaves are a barrier to 100% compliance)

**Lessons Learned**

This initiative was not executed due to resource challenges delaying the implementation of the Core Curriculum which supported this work.

**Change Idea #4** ☑ Implemented ☐ Not Implemented

Implement standardized daily Safety Huddles on on clinical programs

**Process measure**

- No process measure entered

**Target for process measure**

- No target entered

**Lessons Learned**

Standardized daily safety huddles provide a structured forum for team members to communicate potential risks, share concerns, and reinforce protocols, fostering proactive strategies to prevent violence and aggression. This consistent dialogue helps identify early warning signs and ensures that everyone is aligned on safety practices, reducing the likelihood of incidents. Daily Safety Huddles have been implemented on 5 out of 8 clinical forensic programs.
Daily Safety Huddles will continue to be implemented on all clinical programs in alignment with the Waypoint's rollout of the new Model of Care/ 6 Core Strategies.

**Comment**

Performance on this measure is meeting target and on track to achieve QIP cycle target of <740

| | Last Year | | This Year | | |
|---|---|---|---|---|---|
| **Indicator #5**<br>Workplace Violence Frequency<br>(Waypoint Centre For Mental Health Care) | **3.90**<br>Performance (2024/25) | **1.20**<br>Target (2024/25) | **2.80**<br>Performance (2025/26) | **--**<br>Percentage Improvement (2025/26) | **NA**<br>Target (2025/26) |

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

Improve our staff competency in Therapeutic Intervention training

**Process measure**

- % of staff with current Therapeutic Interventions training (within the 18 month renewal time frame)

**Target for process measure**

- 85% (Casual staff and various leaves are a barrier to 100% compliance)

### Lessons Learned

Staff Competency has increased, supporting reduced incidents at all severity levels, and ultimately reduced in injuries and lost time. The following initiatives have led to improved staff training and preparedness:
•resumption of in-person Therapeutic Interventions (TI) and Planned Room Extraction (PRE) training
•expansion of TI curriculum to include enhanced environmental awareness and inclusion of seated interventions
•sustained increase in TI and PRE training rates.

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

Develop effective violence reduction strategies for the top 3 programs experiencing high staff incidents

**Process measure**

- Number of Clinical Programs with a Violent Incident Reduction strategy (A3)

**Target for process measure**

- 3 Programs (Based on most violent incidents)

### Lessons Learned

A continued focus on analytics via the Health & Safety Dashboard (implemented in Fall 2023) has supported continued incident reduction by effectively identifying areas of focus, measuring success of long term improvement initiatives, and quickly identifying emerging areas of concern.

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

Strengthen managers implementation of risk mitigation strategies for employee harm events within the required time frame

**Process measure**

- % of employee SPIRiT files completed with mitigation strategies within 72 hours of submission

**Target for process measure**

- 100% (100% mitigation rates last year, but not all within 72hr timeframe)

### Lessons Learned

We are achieving 100% of manager risk mitigation response each quarter with all employee Spirit files populated with mitigation strategies within 72 hours.

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

Improve supervisor engagement by sharing implemented mitigation strategies back with staff involved.

**Process measure**

- No process measure entered

**Target for process measure**

- No target entered

### Lessons Learned

Intentional focus on development of Manager risk mitigations skills has been effective. Enhancements to the SPIRiT incident reporting system will now allow us to measure the effectiveness of manager risk mitigations with staff. 2025/26 will see new Supervisor Competency measures - Debrief Rates and Staff Follow-up Rates - will allow identification of when/where post-incident debriefs are occurring, and will confirm that mitigations are being communicated to staff (we want to know that that a staff registering a SPIRiT report has had individual follow-up from the Manager regarding the mitigation strategy).

## Comment

Not meeting target.
Q3 2024/25 actually saw the lowest corporate violent incident totals since Q2 2020/21, representing the lowest quarterly incident totals in over 4 years.

**Indicator #6**

Workplace Violence Severity

(Waypoint Centre For Mental Health Care)

| Last Year | | This Year | | |
|---|---|---|---|---|
| **59.20** | **22** | **41.50** | **--** | **NA** |
| Performance (2024/25) | Target (2024/25) | Performance (2025/26) | Percentage Improvement (2025/26) | Target (2025/26) |

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

Develop effective violence reduction strategies for the top 3 programs experiencing high staff incidents

**Process measure**

- Number of Clinical Programs with a Violent Incident Reduction strategy (A3).

**Target for process measure**

- 3 Programs (Based on most violent incidents)

**Lessons Learned**

A continued focus on analytics via the Health & Safety Dashboard (implemented in Fall 2023) has supported continued incident reduction by effectively identifying areas of focus, measuring success of long term improvement initiatives, and quickly identifying emerging areas of concern.

**Change Idea #2** ☑ Implemented ☐ Not Implemented

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**Process measure**

- % of employee SPIRiT files completed with mitigation strategies within 72 hours of submission

**Target for process measure**

- 100% (100% mitigation rates last year, but not all within 72hr timeframe)

**Lessons Learned**

We are achieving 100% of manager risk mitigation response each quarter with all employee Spirit files populated with mitigation strategies within 72 hours.

**Change Idea #3** ☑ Implemented ☐ Not Implemented

Improve our staff competency in Therapeutic Intervention training

**Process measure**

- % of employee SPIRiT files completed with mitigation strategies within 72 hours of submission

**Target for process measure**

- 85% (Casual staff and various leaves are a barrier to 100% compliance)

**Lessons Learned**

Staff Competency has increased, supporting reduced incidents at all severity levels, and ultimately reduced in injuries and lost time. The following initiatives have led to improved staff training and preparedness:
•resumption of in-person Therapeutic Interventions (TI) and Planned Room Extraction (PRE) training
•expansion of TI curriculum to include enhanced environmental awareness and inclusion of seated interventions
•sustained increase in TI and PRE training rates.

**Change Idea #4** ☑ Implemented ☐ Not Implemented

Improve supervisor engagement by sharing implemented mitigation strategies back with staff involved.

**Process measure**

- No process measure entered

**Target for process measure**

- No target entered

**Lessons Learned**

Intentional focus on development of Manager risk mitigations skills has been effective. Enhancements to the SPIRiT incident reporting system will now allow us to measure the effectiveness of manager risk mitigations with staff. 2025/26 will see new Supervisor Competency measures - Debrief Rates and Staff Follow-up Rates - will allow identification of when/where post-incident debriefs are occurring, and will confirm that mitigations are being communicated to staff (we want to know that that a staff registering a SPIRiT report has had individual follow-up from the Manager regarding the mitigation strategy)

**Comment**

Not meeting target