ACCREDITATION CANADA



Driving Quality Health Services

Accreditation Report

St. Thomas-Elgin General Hospital

St. Thomas, ON

On-site survey dates: May 31, 2015 - June 4, 2015

Report issued: June 18, 2015

ACCREDITATION CANADA
AGRÉMENT CANADA

Driving Quality Health Services
Force motrice de la qualité des services de santé

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About the Accreditation Report

St. Thomas-Elgin General Hospital (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. As part of this ongoing process of quality improvement, an on-site survey was conducted in May 2015. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

Accreditation results are based on information provided by the organization. Accreditation Canada relies on the accuracy of this information to plan and conduct the on-site survey and produce the Accreditation Report.

Confidentiality

This report is confidential and is provided by Accreditation Canada to the organization only. Accreditation Canada does not release the report to any other parties.

In the interests of transparency and accountability, Accreditation Canada encourages the organization to disseminate its Accreditation Report to staff, board members, clients, the community, and other stakeholders.

Any alteration of this Accreditation Report compromises the integrity of the accreditation process and is strictly prohibited.

A Message from Accreditation Canada's President and CEO

On behalf of Accreditation Canada's board and staff, I extend my sincerest congratulations to your board, your leadership team, and everyone at your organization on your participation in the Qmentum accreditation program. Qmentum is designed to integrate with your quality improvement program. By using Qmentum to support and enable your quality improvement activities, its full value is realized.

This Accreditation Report includes your accreditation decision, the final results from your recent on-site survey, and the instrument data that your organization has submitted. Please use the information in this report and in your online Quality Performance Roadmap to guide your quality improvement activities.

Your Accreditation Specialist is available if you have questions or need guidance.

Thank you for your leadership and for demonstrating your ongoing commitment to quality by integrating accreditation into your improvement program. We welcome your feedback about how we can continue to strengthen the program to ensure it remains relevant to you and your services.

We look forward to our continued partnership.

Sincerely,

Wendy Nicklin
President and Chief Executive Officer

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Section 1 Executive Summary

St. Thomas-Elgin General Hospital (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. Accreditation Canada is an independent, not-for-profit organization that sets standards for quality and safety in health care and accredits health organizations in Canada and around the world.

As part of the Qmentum accreditation program, the organization has undergone a rigorous evaluation process. Following a comprehensive self-assessment, external peer surveyors conducted an on-site survey during which they assessed this organization's leadership, governance, clinical programs and services against Accreditation Canada requirements for quality and safety. These requirements include national standards of excellence; required safety practices to reduce potential harm; and questionnaires to assess the work environment, patient safety culture, governance functioning and client experience. Results from all of these components are included in this report and were considered in the accreditation decision.

This report shows the results to date and is provided to guide the organization as it continues to incorporate the principles of accreditation and quality improvement into its programs, policies, and practices.

The organization is commended on its commitment to using accreditation to improve the quality and safety of the services it offers to its clients and its community.

1.1 Accreditation Decision

St. Thomas-Elgin General Hospital's accreditation decision is:

Accredited with Commendation (Report)

The organization has surpassed the fundamental requirements of the accreditation program.

1.2 About the On-site Survey

- **On-site survey dates: May 31, 2015 to June 4, 2015**

- **Location**

  The following location was assessed during the on-site survey.

  1 St Thomas Elgin General Hospital

- **Standards**

  The following sets of standards were used to assess the organization's programs and services during the on-site survey.

  System-Wide Standards

  1 Leadership
  2 Governance
  3 Medication Management Standards
  4 Infection Prevention and Control Standards

  Service Excellence Standards

  5 Reprocessing and Sterilization of Reusable Medical Devices
  6 Critical Care
  7 Point-of-Care Testing
  8 Diagnostic Imaging Services
  9 Medicine Services
  10 Rehabilitation Services
  11 Ambulatory Systemic Cancer Therapy Services
  12 Obstetrics Services
  13 Mental Health Services
  14 Transfusion Services
  15 Biomedical Laboratory Services
  16 Perioperative Services and Invasive Procedures Standards
  17 Emergency Department

- **Instruments**

  The organization administered:

  1 Governance Functioning Tool
  2 Canadian Patient Safety Culture Survey Tool
  3 Worklife Pulse
  4 Client Experience Tool

1.3 Overview by Quality Dimensions

Accreditation Canada defines quality in health care using eight dimensions that represent key service elements. Each criterion in the standards is associated with a quality dimension. This table shows the number of criteria related to each dimension that were rated as met, unmet, or not applicable.

Quality Dimension	Met	Unmet	N/A	Total
 Population Focus (Work with my community to anticipate and meet our needs)	64	0	0	64
 Accessibility (Give me timely and equitable services)	86	0	1	87
 Safety (Keep me safe)	625	10	12	647
 Worklife (Take care of those who take care of me)	141	2	0	143
 Client-centred Services (Partner with me and my family in our care)	182	1	7	190
 Continuity of Services (Coordinate my care across the continuum)	64	0	0	64
 Appropriateness (Do the right thing to achieve the best results)	933	3	21	957
 Efficiency (Make the best use of resources)	65	0	1	66
Total	**2160**	**16**	**42**	**2218**

1.4 Overview by Standards

The Qmentum standards identify policies and practices that contribute to high quality, safe, and effectively managed care. Each standard has associated criteria that are used to measure the organization's compliance with the standard.

System-wide standards address quality and safety at the organizational level in areas such as governance and leadership. Population-specific and service excellence standards address specific populations, sectors, and services. The standards used to assess an organization's programs are based on the type of services it provides.

This table shows the sets of standards used to evaluate the organization's programs and services, and the number and percentage of criteria that were rated met, unmet, or not applicable during the on-site survey.

Accreditation decisions are based on compliance with standards. Percent compliance is calculated to the decimal and not rounded.

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	42 (100.0%)	0 (0.0%)	0	32 (100.0%)	0 (0.0%)	0	74 (100.0%)	0 (0.0%)	0
Leadership	46 (100.0%)	0 (0.0%)	0	85 (100.0%)	0 (0.0%)	0	131 (100.0%)	0 (0.0%)	0
Infection Prevention and Control Standards	40 (100.0%)	0 (0.0%)	1	30 (100.0%)	0 (0.0%)	1	70 (100.0%)	0 (0.0%)	2
Medication Management Standards	73 (96.1%)	3 (3.9%)	2	57 (96.6%)	2 (3.4%)	5	130 (96.3%)	5 (3.7%)	7
Ambulatory Systemic Cancer Therapy Services	49 (100.0%)	0 (0.0%)	1	97 (100.0%)	0 (0.0%)	2	146 (100.0%)	0 (0.0%)	3
Biomedical Laboratory Services **	71 (100.0%)	0 (0.0%)	0	103 (100.0%)	0 (0.0%)	0	174 (100.0%)	0 (0.0%)	0
Critical Care	33 (100.0%)	0 (0.0%)	1	82 (98.8%)	1 (1.2%)	12	115 (99.1%)	1 (0.9%)	13
Diagnostic Imaging Services	64 (97.0%)	2 (3.0%)	1	66 (98.5%)	1 (1.5%)	1	130 (97.7%)	3 (2.3%)	2
Emergency Department	46 (100.0%)	0 (0.0%)	1	76 (100.0%)	0 (0.0%)	4	122 (100.0%)	0 (0.0%)	5

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Medicine Services	31 (100.0%)	0 (0.0%)	0	71 (100.0%)	0 (0.0%)	0	102 (100.0%)	0 (0.0%)	0
Mental Health Services	36 (100.0%)	0 (0.0%)	0	88 (100.0%)	0 (0.0%)	0	124 (100.0%)	0 (0.0%)	0
Obstetrics Services	60 (100.0%)	0 (0.0%)	4	78 (98.7%)	1 (1.3%)	1	138 (99.3%)	1 (0.7%)	5
Perioperative Services and Invasive Procedures Standards	100 (100.0%)	0 (0.0%)	0	88 (100.0%)	0 (0.0%)	0	188 (100.0%)	0 (0.0%)	0
Point-of-Care Testing **	38 (100.0%)	0 (0.0%)	0	48 (100.0%)	0 (0.0%)	0	86 (100.0%)	0 (0.0%)	0
Rehabilitation Services	31 (100.0%)	0 (0.0%)	0	70 (100.0%)	0 (0.0%)	0	101 (100.0%)	0 (0.0%)	0
Reprocessing and Sterilization of Reusable Medical Devices	49 (98.0%)	1 (2.0%)	3	61 (100.0%)	0 (0.0%)	2	110 (99.1%)	1 (0.9%)	5
Transfusion Services **	75 (100.0%)	0 (0.0%)	0	67 (100.0%)	0 (0.0%)	0	142 (100.0%)	0 (0.0%)	0
Total	**884 (99.3%)**	6 (0.7%)	14	1199 (99.6%)	5 (0.4%)	28	2083 (99.5%)	11 (0.5%)	42

* Does not includes ROP (Required Organizational Practices)
** Some criteria within this standards set were pre-rated based on the organization's accreditation through the Ontario Laboratory Accreditation Quality Management Program-Laboratory Services (QMP-LS).

1.5 Overview by Required Organizational Practices

A Required Organizational Practice (ROP) is an essential practice that an organization must have in place to enhance client safety and minimize risk. Each ROP has associated tests for compliance, categorized as major and minor. All tests for compliance must be met for the ROP as a whole to be rated as met.

This table shows the ratings of the applicable ROPs.

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Safety Culture			
Accountability for Quality (Governance)	Met	4 of 4	2 of 2
Adverse Events Disclosure (Leadership)	Met	3 of 3	0 of 0
Adverse Events Reporting (Leadership)	Met	1 of 1	1 of 1
Client Safety Quarterly Reports (Leadership)	Met	1 of 1	2 of 2
Client Safety Related Prospective Analysis (Leadership)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Communication			
Client And Family Role In Safety (Ambulatory Systemic Cancer Therapy Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Critical Care)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Diagnostic Imaging Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Medicine Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Mental Health Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Obstetrics Services)	Met	2 of 2	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client And Family Role In Safety (Perioperative Services and Invasive Procedures Standards)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Rehabilitation Services)	Met	2 of 2	0 of 0
Dangerous Abbreviations (Medication Management Standards)	Met	4 of 4	3 of 3
Information Transfer (Ambulatory Systemic Cancer Therapy Services)	Met	2 of 2	0 of 0
Information Transfer (Critical Care)	Met	2 of 2	0 of 0
Information Transfer (Emergency Department)	Met	2 of 2	0 of 0
Information Transfer (Medicine Services)	Met	2 of 2	0 of 0
Information Transfer (Mental Health Services)	Met	2 of 2	0 of 0
Information Transfer (Obstetrics Services)	Met	2 of 2	0 of 0
Information Transfer (Perioperative Services and Invasive Procedures Standards)	Met	2 of 2	0 of 0
Information Transfer (Rehabilitation Services)	Met	2 of 2	0 of 0
Medication reconciliation as a strategic priority (Leadership)	Met	4 of 4	2 of 2
Medication reconciliation at care transitions (Ambulatory Systemic Cancer Therapy Services)	Met	7 of 7	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Critical Care)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Emergency Department)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Medicine Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Mental Health Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures Standards)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Rehabilitation Services)	Met	5 of 5	0 of 0
Safe Surgery Checklist (Obstetrics Services)	Met	3 of 3	2 of 2
Safe Surgery Checklist (Perioperative Services and Invasive Procedures Standards)	Met	3 of 3	2 of 2
Two Client Identifiers (Ambulatory Systemic Cancer Therapy Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Biomedical Laboratory Services)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Two Client Identifiers (Critical Care)	Met	1 of 1	0 of 0
Two Client Identifiers (Diagnostic Imaging Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Emergency Department)	Met	1 of 1	0 of 0
Two Client Identifiers (Medicine Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Mental Health Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Obstetrics Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Perioperative Services and Invasive Procedures Standards)	Met	1 of 1	0 of 0
Two Client Identifiers (Point-of-Care Testing)	Met	1 of 1	0 of 0
Two Client Identifiers (Rehabilitation Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Transfusion Services)	Met	1 of 1	0 of 0
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management Standards)	Unmet	4 of 4	0 of 1
Concentrated Electrolytes (Medication Management Standards)	Met	3 of 3	0 of 0
Heparin Safety (Medication Management Standards)	Met	4 of 4	0 of 0
High-Alert Medications (Medication Management Standards)	Met	5 of 5	3 of 3

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Infusion Pumps Training (Ambulatory Systemic Cancer Therapy Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Critical Care)	Met	1 of 1	0 of 0
Infusion Pumps Training (Emergency Department)	Met	1 of 1	0 of 0
Infusion Pumps Training (Medicine Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Mental Health Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Obstetrics Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Perioperative Services and Invasive Procedures Standards)	Met	1 of 1	0 of 0
Infusion Pumps Training (Rehabilitation Services)	Met	1 of 1	0 of 0
Narcotics Safety (Medication Management Standards)	Met	3 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Client Flow (Leadership)	Met	7 of 7	1 of 1
Client Safety Plan (Leadership)	Met	2 of 2	2 of 2
Client Safety: Education And Training (Leadership)	Met	1 of 1	0 of 0
Preventive Maintenance Program (Leadership)	Met	3 of 3	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Worklife/Workforce			
Workplace Violence Prevention (Leadership)	Met	5 of 5	3 of 3
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Compliance (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Hand-Hygiene Education and Training (Infection Prevention and Control Standards)	Met	1 of 1	0 of 0
Infection Rates (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Patient Safety Goal Area: Falls Prevention			
Falls Prevention Strategy (Ambulatory Systemic Cancer Therapy Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Diagnostic Imaging Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Emergency Department)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Medicine Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Mental Health Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Obstetrics Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Perioperative Services and Invasive Procedures Standards)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Rehabilitation Services)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Pressure Ulcer Prevention (Critical Care)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Medicine Services)	Unmet	3 of 3	1 of 2
Pressure Ulcer Prevention (Perioperative Services and Invasive Procedures Standards)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Rehabilitation Services)	Met	3 of 3	2 of 2
Suicide Prevention (Mental Health Services)	Met	5 of 5	0 of 0
Venous Thromboembolism Prophylaxis (Critical Care)	Unmet	3 of 3	1 of 2
Venous Thromboembolism Prophylaxis (Medicine Services)	Unmet	3 of 3	1 of 2
Venous Thromboembolism Prophylaxis (Perioperative Services and Invasive Procedures Standards)	Unmet	3 of 3	1 of 2

1.6 Summary of Surveyor Team Observations

The surveyor team made the following observations about the organization's overall strengths, opportunities for improvement, and challenges.

The organization St. Thomas-Elgin General Hospital is commended on preparing for and participating in the Qmentum survey program. The board of directors is acknowledged for its service to the community with such involvement. Board members are informed and demonstrate an ongoing commitment to ensuring that the organization's programs and services meet the needs of the population of the area. There has been some recent turnover on the board but it is now reaching a full complement. The board works to ensure that there is a mix of backgrounds in the current composition, and this has been achieved. It suggested that consideration be given to expanding the diversity of the board.

Board members are open-minded and engaged. They receive appropriate orientation and perform their roles using a policy governance model. The committee structure is well-established and works efficiently. The board processes cover fiduciary responsibilities, policy development and strategic planning, quality, safety and risk management. The board is also accountable for the recruitment and evaluation of the organization's chief executive officer (CEO) and chief of staff. The board is encouraged to consider having a deeper involvement in the credentialing process of medical staff.

The board is thoroughly engaged in the strategic deployment of the St. Thomas-Elgin General Hospital, especially the current focus on Lean. This initiative has brought forth the concept of continuous improvement from: "Board to Bedside". The organization is applauded for maintaining its position as the top performer for provincial wait times in the emergency department (ED). The board receives scorecard data appropriate to their governance role. The data are collected from the daily front-line huddles, via the weekly leadership huddles prior to data presentation.

The board has a duty to provide annual performance evaluations of the chief executive officer (CEO). This performance review is based on predetermined goals and objectives. It is suggested that the board utilize behavioural elements in that CEO evaluation, and that it include these elements in the succession planning process.

A board is integral to the ethics framework of an organization. It is suggested that the board consider applying the existing framework to their decision-making process.

There are good relationships between the community partners and the organization. During the on-site meeting partners gave acknowledgement to multiple examples of specific initiatives generated at St. Thomas-Elgin General Hospital (hospital). The Community Care Access Centre (CCAC) has been actively involved in planning initiatives relative to home care and discharge planning. The hospital is also engaged with several partners of the South West Local Health Integrated Network (SW LHIN) around developing holistic approaches for addressing patient needs. The organization is actively involved in the Elgin Health Service Providers Committee to inform resource planning and quality initiatives. The communication channels using all multi-media parameters have vastly enhanced the organization's identity and transparency. This two-way communication has augmented the relationship between the community partners and the hospital. The establishment of patient experience partners has enhanced positive relationships and increased understanding of hospital functioning. These partners commend the commitment of staff members where patient safety is obvious to them. Suggestions made include creating a more senior-friendly environment and program focus. Partner comments include enhancements to patient pre-discharge education, particularly in diabetes. They noted that the positive change in culture, efficiency and effectiveness of the organization could be leveraged as a major factor in economic development for the area.

The leadership is commended for its steadfast approach to bringing the Lean Management System to the entire organization. The leadership is committed to the growing expansion of the "Patient Experience" model. This focus has already demonstrated significant achievements in the area of patient care and safety. Culture change is often prolonged and difficult. This leadership group's approach has demonstrated early "wins" in staff engagement and client-focused outcomes. The flatter hierarchy promotes leadership development at all levels of the organization in that 'leaders' are encouraged from any staff member that participates in the huddles, and this is evidence of system effectiveness.

The approach to quality improvement, risk management and safety is also embedded across the organization and supports the patient-centred approach. These elements are integrated into the reporting structure of the organization and the overall strategic framework. The strategic framework for 2015-2016 is also a significant achievement in that it captures existing strategic directions and develops specific plans under the areas of: Patient Experience, Safety, Quality, People and Financial Stewardship. This framework 'cascades' to all clinical and support areas, in concert with the overall plan and promotes staff engagement via the daily huddles.

Internal communication initiatives are comprehensively and effective. The leadership team is diligent in its management of fiscal resources. There is an annual planning cycle that reflects input from all departments and services. The human resources (HR) plan is reflective of the directions set in the overall strategic framework. It is comprehensive and addresses the human capital needs for the immediate future and as the organization expands. The HR plan addresses the non-physician component only. It is noted that each physician department has a recruitment plan that is based on succession, expansion and speciality development. These recruitment plans must fit with the strategic direction of the organization and also where possible, be cost and resource neutral.

All new hires undergo a rigorous orientation program that is aimed initially at the organization level and then at the work-space level, either unit or department. All staff members have regular performance evaluations and are able to "plot" career development in tandem with a myriad of educational opportunities, both internal and external. There are reward systems in place such as the service rewards and individual recognition for employees that go beyond the ordinary. Also, patient feedback is brought back verbatim to staff. There are excellent communication avenues between staff members and leadership and the implementation of the "huddle" phenomenon has empowered front-line workers to express their opinions and ideas, and to benefit from timely feedback. There is a general feeling of enthusiasm amongst staff members particularly in the expectation of new construction, but also in the sense of 'team' in the building.

The interdisciplinary care teams are knowledgeable and committed to the services they provide to patients and clients in this region. Population health data are used to facilitate both current and future care requirements. There are numerous examples of new programs and expanded services that have been put in place to enhance care provided closer to home. Regular "bullet rounds" occur in all patient care areas, with engagement of all members of the team. The goal of ensuring safe and effective discharges is evident from the discussion. Plus, the "daily huddles" in all patient care and support service areas provide an opportunity to discuss patient risk, safety and quality metrics at the unit level. Numerous examples were provided during this survey of improvement opportunities that were developed and implemented at the unit level. Metrics are regularly reviewed to monitor success of the initiatives regardless of the scope of the project. Lean management principles are embedded in the huddle boards to facilitate a structured and fulsome discussion. Safety prevention programs are comprehensive. Other projects are developing a focus on the optimization of transitions of care, both internally and externally.

The implementation of transfer of accountability (bedside accountability report) has been embraced by staff. It also allows patients and families to be involved and engaged in this process. The patient whiteboards provide opportunity to openly communicate patient goals, expected date of discharge and discharge destination to both

the patients and their families. At this time, team members document their findings in various places. There is a combination of paper charts, bedside charts and electronic charts. This means that all the information cannot be viewed comprehensively and in continuity by any team member.

The involvement of the patients and families in their care places them at the forefront of services provision. Patients report that they are involved in care decisions and feel that they are part of the process. The patients are engaged in evaluating service quality and the organization has initiated a hospital-wide patient satisfaction survey. The feedback received is used verbatim to acknowledge services and personnel inclusive of physicians, volunteers and staff. In addition, the data collected from patient surveys are used for developing quality-based patient centric goals and objectives. The patients that were interviewed during the survey reported that bedside reporting does make them feel safe and secure. The patient, families and their care givers are updated by way of this process. Patients reported that the inclusion of pharmacy ensures that their medication record is up to date. The patients are pleased with the quality of the team.

Section 2 Detailed Required Organizational Practices Results

Each ROP is associated with one of the following patient safety goal areas: safety culture, communication, medication use, worklife/workforce, infection control, or risk assessment.

This table shows each unmet ROP, the associated patient safety goal, and the set of standards where it appears.

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Medication Use	
Antimicrobial Stewardship The organization has a program for antimicrobial stewardship to optimize antimicrobial use. Note: Beginning in January 2013, this ROP will only apply to organizations that provide inpatient acute care services. For organizations that provide inpatient cancer, inpatient rehab, and complex continuing care services, evaluation of this ROP will begin in January 2014.	· Medication Management Standards 2.3
Patient Safety Goal Area: Risk Assessment	
Pressure Ulcer Prevention The team assesses each client's risk for developing a pressure ulcer and implements interventions to prevent pressure ulcer development.	· Medicine Services 9.4
Venous Thromboembolism Prophylaxis The team identifies clients at risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) and provides appropriate thromboprophylaxis.	· Medicine Services 7.4 · Critical Care 7.5 · Perioperative Services and Invasive Procedures Standards 8.9

Section 3 Detailed On-site Survey Results

This section provides the detailed results of the on-site survey. When reviewing these results, it is important to review the service excellence and the system-wide results together, as they are complementary. Results are presented in two ways: first by priority process and then by standards sets.

Accreditation Canada defines priority processes as critical areas and systems that have a significant impact on the quality and safety of care and services. Priority processes provide a different perspective from that offered by the standards, organizing the results into themes that cut across departments, services, and teams.

For instance, the patient flow priority process includes criteria from a number of sets of standards that address various aspects of patient flow, from preventing infections to providing timely diagnostic or surgical services. This provides a comprehensive picture of how patients move through the organization and how services are delivered to them, regardless of the department they are in or the specific services they receive.

During the on-site survey, surveyors rate compliance with the criteria, provide a rationale for their rating, and comment on each priority process.

Priority process comments are shown in this report. The rationale for unmet criteria can be found in the organization's online Quality Performance Roadmap.

See Appendix B for a list of priority processes.

INTERPRETING THE TABLES IN THIS SECTION: The tables show all unmet criteria from each set of standards, identify high priority criteria (which include ROPs), and list surveyor comments related to each priority process.

High priority criteria and ROP tests for compliance are identified by the following symbols:

!	High priority criterion
ROP	Required Organizational Practice
MAJOR	Major ROP Test for Compliance
MINOR	Minor ROP Test for Compliance

3.1 Priority Process Results for System-wide Standards

The results in this section are presented first by priority process and then by standards set.

Some priority processes in this section also apply to the service excellence standards. Results of unmet criteria that also relate to services should be shared with the relevant team.

3.1.1 Priority Process: Governance

Meeting the demands for excellence in governance practice.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Members of the board of directors are engaged in performing their role in the governance of the St. Thomas-Elgin General Hospital (hospital). They are open, engaged and knowledgeable of their role and function. The board has adopted a policy governance model and is diligent in performing their oversight role as opposed to being engaged in operations. All board members receive a thorough orientation. They also receive ongoing education. There are well-established policies and bylaws governing board functioning. The board is supportive of and integrated into the Lean initiatives for instance, board members are invited to attend huddles. Lean initiatives continue to be developed across the organization.

Board members are selected using an established process and in addition to regular board election and appointments, there is also one person appointed by the county and another appointed by the city. There is a significant effort to ensure a diversity of skill sets around the board table, which has proven successful from the perspective of professional backgrounds. Nevertheless it is suggested that the board consider reviewing their selection process, and look at further diversity; for example, socio-economic and ethnic backgrounds. The board may possibly also think of other diversity "lenses."

The board performs its duty of evaluating the performance of chief executive officer (CEO) on a regular basis. Performance review is mainly based on the achievement of set objectives. It is suggested that the board review the current process of evaluating the CEO, and consider also behavioural elements. This could be achieved in several ways including a 360-degree review. This will be important to address given that the board is in the process of implementing the succession plan for a new CEO once the current CEO retires.

The board ensures that there is an ethics framework in place in the organization as well as a code of conduct. It is suggested that the board consider ways to implement a process that would make sure the ethics framework is used to assist in making key decisions.

The board has established regular communications with its Local Health Integrated Network (LHIN), and also ensures there is communications with elected officials.

There are established committees of the board including quality improvement and finance and audit. These committees are engaged in fulfilling the board's responsibilities for financial stewardship and ensuring that patient safety and quality care is delivered. These committees complete a lot of work and make sure that the board is not only well-informed, but committees ensure good financial management of the organization and that care is delivered in an environment where quality and safety are paramount. The board receives

detailed information which facilitates the thorough analysis required for making informed decisions. This information is provided to the board on a timely basis.

The board members are fully engaged appropriately in developing the mission, vision, values and strategic directions of the organization, last developed in 2009. However, instead of developing a new strategic plan in the past two to three years, they felt that the elements developed in 2009 were still relevant and as a result, adopted a process of strategic deployment. This is working well in that they were able to break down the existing plan into annual goals that were achievable and measurable. This process, along with the development of the clinical services plan and the proliferation of Lean management across the organization has served them well in achieving the strategies outlined in the original plan.

The community needs assessment conducted by the LHIN is informative in terms of ensuring there is a clear understanding of the population needs of the county. The board is encouraged to conduct a thorough review of the mission, vision, values and the strategic directions of the organization in the not too distant further as the original plan is now six years old.

3.1.2 Priority Process: Planning and Service Design

Developing and implementing infrastructure, programs, and services to meet the needs of the populations and communities served

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

There is a well-established process for developing the vision and strategic plan for the organization. The last plan was developed in 2009. While there has been no new development of a strategic plan during the past three years, it has been recognized that the strategic directions from the 2009 report are still relevant and are still being implemented. There has been instead a focus on implementing strategic deployment and making sure the original directions are broken down to measurable actions with established time lines. This is augmented by the establishment of a clinical services plan and the continued implementation of the Lean system so that it is prevalent in all areas of the organization. The organization is encouraged to ensure that there is focused strategic planning within the next two years.

The needs of the community are understood via several ways including a careful analysis of the community needs assessment conducted by the Local Health Integrated Network (LHIN) which informs on the community's health status, capacities and health care needs. In addition, there is significant involvement with the health services network in the area. Understanding and responding to the needs of patients/clients is also achieved with Lean implementation which places the patient at the centre of all improvement activities.

There are annual operational plans which reflect the strategic goals and are implemented within the overall financial targets.

The focus on the implementation of the Lean philosophy throughout the entire organization is a valuable process in assisting the organization in managing the change required to achieve its goals in quality improvement, risk management and overall organizational direction.

Several partnerships help support the organization in its delivery and coordination of efficient and effective services. These partners include the LHIN, Mental Health Association, Emergency Medical Services (EMS), and police, colleges and universities. There are also several areas where community engagement partners are highly involved. For example these individuals are involved in clinical service groups, Kaizen events and recruitment. The involvement of community partners across the organization will increase as the organization continues to develop new roles for community engagement partners.

The organization is spending a considerable amount of time and effort in the development of the expansion, which is the largest development since the 1950s. This expansion has been the result of several years of careful planning. There will be space improvements in several areas including a mental health unit, emergency department and surgical suite. At this time the project is on target to finish in 2017. There is currently a project manager to oversee the development of this expansion, which is now out to tender. The team works closely with the provincial government and there is a well-established process to ensure a careful evaluation of the tenders. There are also efforts at ensuring the move from existing space to new space is well planned to ensure improved flow and smooth transition for patients, physicians and staff.

3.1.3 Priority Process: Resource Management

Monitoring, administration, and integration of activities involved with the appropriate allocation and use of resources.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

There is a well-established and executed process for planning capital and operating budgets. This includes a thorough process where managers are gathered for an all-day session. At this session each of the managers submits their upcoming annual requirements. These management groups then have the opportunity to compare their needs to others in the group. This serves as an opportunity to find savings as well as to introduce additional expenses for the coming year. The aim of the exercise is to create an overall savings target. There is also a benchmarking exercise with other organizations. This planning session and the benchmarking exercise helps in the creation of a proposed budget for the coming year. The proposed budget is eventually brought to senior management and then to the board for approval. The budget is expected to achieve an annual savings of 2%.

For capital equipment budget planning, every manager submits their requirements by a specified time frame and the prioritization decisions are made during the planning meetings. It is suggested that the team establish criteria to assist in the decision-making process.

There is a regular reporting process and variance analysis that is provided to all managers. A financial analyst is assigned to each manager for the purpose of analyzing variances and taking corrective measures to address 'over' expenditures. Financial statements are released to the management team on the seventh day of the following month. Regular training in the budgeting process is provided to new and existing managers.

There is an established process to move resources to where they are needed most within and across operational and service or program areas. This decision usually rests at the vice president (VP) level.

The organization follows the criteria established in the Hospital Service Accountability Agreement (HSAA) for the receipt and expenditure of funds from government via the Local Health Integration Network (LHIN). Internal auditing is completed to a degree. For example last year, two areas were audited. There is also an annual “Attestation” prepared and submitted in accordance with section 15 of the Broader Public Sector Accountability Act. 2010 (BPSAA). This attestation addresses compliance to spending criteria for areas such as expense claims and procurement directives. There is an annual external audit.

The team members are commended for their many achievements including the achievement of the 2% reduction and the methods used to achieve this including the reduction of sick leave and the reduction of overtime. The team has also brought the working capital from a significant deficit to a surplus. There has also been significant improvements in the monthly financial process.

3.1.4 Priority Process: Human Capital

Developing the human resource capacity to deliver safe, high quality services

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization has a focus on ensuring a healthy workplace. This is supported by policies and actual programs such as smoking cessation, in-house blood pressure clinic, waist-watchers, health pregnancy program and other programs, some of which are in partnership with public health.The flu vaccine campaign is active, occurs on an annual basis and is supported by an appropriate policy. The organization achieved 80% compliance during the last season.

There is a comprehensive strategy for workplace violence and the matter is addressed in a comprehensive manner. This is supported by a risk management process. The occupational health and safety committee had a major role in the development and evaluation of the policy.

The team has addressed recruitment and retention issues and used several methods to increase success in both areas. The organization has completed the Picker Employee Engagement survey and is monitoring the results.

Annual client safety training is conducted and covers multiple topics, and attendance is monitored.

There is a performance appraisal system in place for all staff members and physicians. At the time of this survey a 40% completion rate is noted. The organization is encouraged to increase this rate as soon as possible. There is a new process being developed to replace the existing system. This new version is in a simpler format and it is hoped that this will encourage greater participation in meeting the requirement for completion of performance appraisals.

The filing system for staff records is well maintained but needs to follow policy in a consistent way. For example, there are inconsistencies in what is contained in the file. In some files there are records of employee credentials, education sessions attended and the related certificates. In other files these are not present. The team is encouraged to decide what elements need to be contained in the employee file and then ensure that there is compliance in that regard.

The human resources (HR) plan has been developed and it is aligned with the organization’s strategic framework for 2015-2016. There are multiple planned tasks under the categories of: Patient Experience, Safety, Quality, People and Financial Stewardship.

The human resources team is high functioning and delivering effective programs to support the organization's employees.

3.1.5 Priority Process: Integrated Quality Management

Using a proactive, systematic, and ongoing process to manage and integrate quality and achieve organizational goals and objectives

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Leaders have identified safety and quality improvement as a strategic priority for the organization and have provided appropriate resources to support these initiatives. In particular, they have staffed a Transforming Care Office which has Lean improvement specialists that provide support and education to enable the teams to implement Lean initiatives in their respective areas. There has also been a risk management specialist and a patient and family engagement leader appointed within the past two years. The group is commended for the successful design and implementation of the elements to support quality improvement, risk management and safety throughout all departments and services in the organization. The group has done a great job of doing this and continues to provide support for all the departments and services regarding their Lean initiatives.

Leaders are highly involved in the implementation of quality improvement across the organization. This is particularly evident in the implementation and sustainability of the Lean management process. The aim is to ensure that Lean is a part of the culture of the organization so that the unit or service area is "Lean versus doing Lean activities." Embracing this philosophy and directing it by leaders sets the foundation for successful implementation and sustainability of Lean in all areas of the organization.

There has been significant work in the promotion and support of the consistent use of standardized processes, protocols or best practice guidelines to reduce variation in and between services. For example, there are standardized care sets, and a move to care maps and clinical pathways. Also, falls and wound management, standard operating practices (SOPs) and the Mosby's nursing standards are all evidence based.

Contingency plans are developed for many scenarios including loss of electricity, water and the telephone system.

There is good integration of risk management, quality improvement and safety, and risk management and safety. The reporting structure supports this integration because the leaders of these areas report to the same vice president (VP). In addition, in terms of day-to-day operations, the Lean system, particularly the huddles, integrates these elements as a matter of doing daily business.

There are established policies and procedures for selecting and negotiating contract services. These contracts are written to ensure that the needs of the organization from a safety and quality patient care perspective are integrated in the contract.

Patient safety is a written strategic goal, and this is articulated in the executive plans and is integrated across the entire organization. Daily huddles in all clinical and services areas reflect the departmental scorecard which reflects the leadership weekly scorecard which, in turn, is integrated into the board scorecard.

There is an established reporting policy and process for adverse events, sentinel events and near misses. The Risk Management Pro system is used to report these events and it supplies the data for investigation and follow-up.

A client safety-related prospective analysis was completed in November 2014 and involved the monitoring of bed alarms. This process was chosen due to the team's identification of the need to reduce the number of falls. Staff members were trained in use of the failure effects modes analysis (FEMA) process and the project was executed using this method.

The client safety culture has been monitored using the Patient Safety Culture Tool. The team has analyzed the results collected and is reviewing to determine the areas where attention is needed. Leaders found the results telling and they will develop ways to address the concerns raised. The board scorecard addresses all elements contained in the St. Thomas-Elgin General Hospital (STEGH) strategic framework including safety which is presented to the board on a monthly basis.

Accurate and complete information about client/resident medications is collected and this information is used during transitions of care. There is considerable support to ensure that this process is conducted efficiently and safely. For example, all the best possible medication history (BPMH) lists are completed by pharmacists.

3.1.6 Priority Process: Principle-based Care and Decision Making

Identifying and decision making regarding ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

An ethics framework has been developed and it is user friendly. The framework covers the pertinent issues including accountability and the process for ethical decision making. There has also been a discussion as to who the contacts persons for staff members should be 24 hours a day seven days a week. This information is available on the intranet.

The “2015-16 Ethics Committee Work Plan” has been developed. This plan is comprehensive in its approach to next steps required to ensure increased capacity in use of the framework in the organization. For example, a communication plan will be developed and education of staff members and managers will be addressed. The work plan demonstrates that the organization is focusing on building sustainability of the program and expanding its role in the organization.

The team has developed an “Ethics Pocket Tool” which provides a synthesized approach to addressing ethics issues. The patient experience council is also included in the target audience for ethics education and one of their members sits on the ethics committee.

The organization participates in sessions entitled: “Lunch and Learn Ethics in Healthcare” on a regular basis.

The organization has a consultant ethicist that provides valuable services for the organization. The ethicist is available to provide consultation on ethics issues as well as to provide education to the local team.

The chair of the local ethics committee is also a member of the South West Health Ethics Network. This group is made up of representatives of the many hospitals in this and neighbouring counties. This will provide the opportunity for information exchange amongst the different organizations and will also act as a forum for other collaborative activities.

The organization is not actively involved with research at this time. If research is conducted it is usually by Western University and its process for the review of the ethical implications of research serves this purpose for the organization. It is suggested that the ethics committee develop and implement a process to supplement this review to ensure that the interests of the organization and its patients are reflected in the ethics review process for research conducted at the hospital.

3.1.7 Priority Process: Communication

Communicating effectively at all levels of the organization and with external stakeholders

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization has a communications office which is robust and has the responsibility for all internal and external communications. This office also is the repository for patient complaints and the patient experience initiative.

The communication strategy utilizes all available communication tools for external contact --Twitter, Facebook, You-tube, print and television and radio. There are also weekly E-Blasts and intranet messaging for internal stakeholders. All of these communication techniques are regularly monitored and there are indicators chosen to measure their effectiveness. Some of this feedback has resulted in modifications to the corporate communication plan, which is now revised yearly with weekly monitoring. This has resulted in a growing sense both internally and externally that the organization is becoming more and more transparent and communicative.

The organization has developed excellent communication channels at all levels namely: staff, community, healthcare partners, Local Health Integrated Network and Ministry of Health and Long-term Care.

There is a mechanism for policy and procedure review which is orchestrated by the communications office. It is suggested that the policy manual be organized to make it a little more user friendly.

3.1.8 Priority Process: Physical Environment

Providing appropriate and safe structures and facilities to achieve the organization's mission, vision, and goals

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization has made infrastructure changes as required, taking into consideration the upcoming renovations and capital project. Physical plant changes are part of the capital process every year and a five-year capital plan for the physical plant is developed. The most recent influx of infrastructure renewal funding has allowed for new generators and subsequent redundancy capability.

An electronic work order system ensures the tracking of work orders and prioritization. Systems are in place for urgent work order requests and maintenance staff members are available for on-call after hours.

The maintenance department has been an active participant in the Lean process changes in the organization and "huddle boards" monitor metrics in real time. This ensures staff engagement in quality improvements for the physical plant.

When external contractors are required site supervisors are provided orientation along with a comprehensive package that covers infection control requirements, policies and procedures and protocols.

The team is encouraged to continue to advocate externally for the infrastructure changes required in light of the new capital project and the age of the current buildings.

3.1.9 Priority Process: Emergency Preparedness

Planning for and managing emergencies, disasters, or other aspects of public safety

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The emergency preparedness plans are comprehensive and readily accessible to all staff. One page check lists have been developed for key codes especially for staff members to understand how to react in a code orange situation. Code orange has been practiced in 2013 with a county-wide disaster exercise involving the organization, paramedics and police. During the on-site survey examples were provided for the changes made based on this exercise.

There is an excellent working relationship between Emergency Medical Services (EMS), Fire and the police departments. Recently, the fire department did the annual inspection and recommendations have been implemented from this inspection. An evacuation exercise was conducted with involvement of both fire department and staff. A debrief was held and changes were made to the protocols where required.

The emergency department is appreciative of the support it receives from the police especially as it pertains to mental health patients and challenging patient situations.

Code drills for other situations are practiced regularly and there is evidence of staff participation from all areas of the organization. The recent Ebola global situation has provided opportunity for emergency staff members to practice donning and doffing of essential equipment, along with reviewing processes for future care. One example is the triage process has changed to meet the changing electronic chart at St. Thomas-Elgin General Hospital.

The internal emergency planning team meets monthly and is encouraged to continue to focus on regular code reviews with changes and planning educational opportunities in all areas of the hospital for all staff.

3.1.10 Priority Process: Patient Flow

Assessing the smooth and timely movement of clients and families through service settings

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Patient flow is a major component of the function of this organization. Although there is a dedicated patient flow team, there is also participation by all levels of staff.

There are established protocols for emergency department (ED) activities and because of changes that have occurred these have not had to be implemented. There are excellent relationships with Emergency Medical Services (EMS) and other collaborating agencies and there are no apparent bottle necks to ED admission. The ED has a 60-minute expected stay for admitted patients and this indicator is monitored daily.

A bed management group meets everyday and reviews the capacity of the organization for the day. These deliberations are reviewed again later in the day and there is overall monitoring of the effectiveness of this process. The details of this monitoring is also presented to the front-line via the unit huddles.

There is block booking in the operating room (OR) with regular review of utilization and capacity. There is a plan to move to electronic booking with the information coming from the surgeon's office.

The organization has done a great deal of work and is innovative in its approach to patient flow. These processes have resulted in no surgical cancellations, no patient transfers (within scope)and smooth transitions of care across the organization.

3.1.11 Priority Process: Medical Devices and Equipment

Obtaining and maintaining machinery and technologies used to diagnose and treat health problems

Unmet Criteria		High Priority Criteria
Standards Set: Diagnostic Imaging Services		
8.12	The individual responsible for the overall coordination of reprocessing and sterilization activities within the organization oversees the team's compliance with the organization's policies and procedures on cleaning and reprocessing.	
Standards Set: Reprocessing and Sterilization of Reusable Medical Devices		
5.2	The medical device reprocessing department's hand hygiene facilities are equipped with faucets supplied with foot-, wrist-, or knee-operated handles, or electric eye controls.	!

Surveyor comments on the priority process(es)

The team responsible for reprocessing has representatives from infection prevention and control (IPAC), Bio-medical, medical devices reprocessing (MDR) and management in its membership. The team meets regularly and has had a significant role in the selection and purchase of new and replacement equipment. The team also has been fully involved in the design of the proposed new area.

Bio-medical services is responsible for most preventive maintenance (warranty and vendor oversight). There are records kept of these interventions and there are tracking mechanisms for repaired and broken instrumentation. There is a solid succession plan for the replacement of equipment that is based in part on volumes, use and user.

The MDR area is well-located with appropriate barriers to personnel and with appropriate flow in the department. All staff members are certified and they receive regular updating and ongoing training. The 'supervisor' has the overall on-site responsibility for this area only and does not provide oversight elsewhere in the organization.

There is an excellent standard operating procedures (SOP) manual, available online and in paper as well as laminated cards of SOPs specific to a particular phase of reprocessing, and which hang in immediate adjacent areas. These SOPs undergo regular review and updating in accordance with Canadian Standards Association (CSA) and infection prevention and control (IPAC) and industry standards.

There are daily huddles in the department where discussions occur regarding events, updates, quality improvements and safety issues. The staff members feel these are extremely beneficial to them and make them feel strong and valuable to the team.

All reprocessing events in the department comply with CSA standards and all events are recorded and monitored. The available sinks do not have "non-hand" mechanisms however, these will be in the new unit.

Endoscopes from the operating room (OR) are cleaned and checked in the MDR and the responsibility for leak testing, hanging and tagging rest with this department. It is suggested that MDR work with the OR to ensure that dental instruments brought into the organization are managed in a similar fashion as "loaners", in that they are sterilized in the MDR to ensure institutional quality control.

3.2 Service Excellence Standards Results

The results in this section are grouped first by standards set and then by priority process.

Priority processes specific to service excellence standards are:

Episode of Care - Ambulatory Systemic Cancer Therapy

- Healthcare services provided for a health problem from the first encounter with a health care provider through the completion of the last encounter related to that problem.

Point-of-care Testing Services

- Using non-laboratory tests delivered at the point of care to determine the presence of health problems

Clinical Leadership

- Providing leadership and overall goals and direction to the team of people providing services.

Competency

- Developing a skilled, knowledgeable, interdisciplinary team that can manage and deliver effective programs and services

Episode of Care

- Providing clients with coordinated services from their first encounter with a health care provider through their last contact related to their health issue

Decision Support

- Using information, research, data, and technology to support management and clinical decision making

Impact on Outcomes

- Identifying and monitoring process and outcome measures to evaluate and improve service quality and client outcomes

Medication Management

- Using interdisciplinary teams to manage the provision of medication to clients

Organ and Tissue Donation

- Providing organ donation services for deceased donors and their families, including identifying potential donors, approaching families, and recovering organs

Infection Prevention and Control

- Implementing measures to prevent and reduce the acquisition and transmission of infection among staff, service providers, clients, and families

Surgical Procedures

- Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge

Diagnostic Services: Imaging

- Ensuring the availability of diagnostic imaging services to assist medical professionals in diagnosing and monitoring health conditions

Diagnostic Services: Laboratory

- Ensuring the availability of laboratory services to assist medical professionals in diagnosing and monitoring health conditions

Transfusion Services

- Transfusion Services

3.2.1 Standards Set: Ambulatory Systemic Cancer Therapy Services

Unmet Criteria	High Priority Criteria
Priority Process: Episode of Care - Ambulatory Systemic Cancer Therapy	
The organization has met all criteria for this priority process.	
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	
Priority Process: Medication Management	
The organization has met all criteria for this priority process.	
Surveyor comments on the priority process(es)	
Priority Process: Episode of Care - Ambulatory Systemic Cancer Therapy	
The systemic therapy team is knowledgeable and committed to excellence in improving the patient experience. Team members are passionate about making a difference for patients and families treated in this area. Staff members are proud of the care they deliver and understand the needs of this patient group.	

The team is committed to improving the patient experience and there are numerous examples of the personal care provided. Chimes are outside the department for patients to use as a celebration when treatment is completed. There are welcome packs donated by a family, and iPADs are available for patient use, and quilted blankets are provided to all new patients. The presence of volunteers provides support to patients and their families in their cancer journey.

The process of two client identifiers is well done even though the population is well known to the staff members working in this area. They do an excellent job of explaining why two client identifiers are required to ensure safe care for all patients. Patients are appreciative of the care and knowledge of the staff. They are well informed and have great support during their care and treatment.

Priority Process: Clinical Leadership

The systemic therapy care team is engaged and committed to the services it provides to patients in the region. The team has reviewed the needs of the population. As a result of this review the team has been planning and facilitating treatment for a higher percentage of systemic therapy patients to ensure appropriate care is provided closer to home.

Goals and objectives are clearly defined and visible to all staff members via the huddle boards.

Priority Process: Competency

The systemic therapy services are provided by registered nurses (RNs), pharmacy and a physician. There is an active volunteer presence on the unit that is providing comfort and support to this patient group. The team members understands their roles and responsibilities and are effective in the coordination of services for this patient group.

The RN staff members have all received training from the de Souza Institute and re-certification is done within the required time frames. The London Health Sciences Centre provides monthly education via the Telemedicine network and staff members actively participate in this education. They also have opportunity to request education on a particular topic.

Intravenous (IV) pump infusion training is provided during orientation and the learning management system (LNS) allows for tracking of compliance with ongoing education. The staff members were able to demonstrate the pump safety features.

Performance reviews are completed regularly, and staff members receive regular feedback from their patients as they often receive regular care for a long period of time.

Priority Process: Decision Support

Electronic charting is in development at St. Thomas-Elgin General Hospital. The computerized physician order entry (CPOE) links to the London Health Sciences Centre, which ensures that all safety components and checking systems are in place for chemotherapy administration.

There is separation of documentation on the unit, with electronic documentation and paper documentation to ensure information is accessible for all health care providers.

The team's documentation is comprehensive. Encouragement is offered to continue the current review of the documentation systems and update as planned.

Priority Process: Impact on Outcomes

The systemic therapy team has a clear understanding of the critical nature of the medications administered in this treatment area. All systems are in place to ensure safe administration of all chemotherapy medications. Double-checking systems are well established and the pharmacy department involvement in this process and the responsibilities are well-established also.

The staff members have excellent systems for ensuring that information is shared with patients and families.

The interdisciplinary team is committed to excellence in care and ensures safety is part of daily practice in this area.

The systemic therapy team is encouraged to continue to foster the excellent linkages with London Health Sciences to ensure that best practice and evidence-based guidelines and education are available for this specialized service.

Priority Process: Medication Management

The systemic therapy team has a clear understanding of the critical nature of the medications administered in this treatment area. All systems are in place to ensure safe administration of all chemotherapy medications. Double-checking systems are well established and the pharmacy department's involvement in this process and responsibilities are clearly understood by all care providers involved in treatment.

3.2.2 Standards Set: Biomedical Laboratory Services

Unmet Criteria	High Priority Criteria
Priority Process: Diagnostic Services: Laboratory	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)
Priority Process: Diagnostic Services: Laboratory
The laboratory has a laboratory manual which is current and readily available for staff. Screens are available to monitor turnaround time in the laboratory to provide laboratory staff members with real time information that constantly updates. Turn around times are monitored and discussed at the daily huddles, along with other important safety and quality information. The laboratory staff members are commended for their participation in all initiatives to improve emergency department wait times by improvement of their turnaround times. Care teams appreciate the responsive nature of this department to the patient needs in all of their areas.

3.2.3 Standards Set: Critical Care

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
7.5 The team identifies medical and surgical clients at risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) and provides appropriate thromboprophylaxis.	ROP
7.5.3 The team establishes measures for appropriate thromboprophylaxis, audits implementation of appropriate thromboprophylaxis, and uses this information to make improvements to their services.	**MINOR**
12.7 Following transition or end of service, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	
Priority Process: Organ and Tissue Donation	
The organization has met all criteria for this priority process.	
Surveyor comments on the priority process(es)	
Priority Process: Clinical Leadership	

Goals and objectives are clearly defined and visible to staff members and the full team including the housekeeping services. Staff members able to provide suggestions, feedback and help with goal-setting at each of the daily huddles. The recent development of the closed unit for intensive care has enabled the team to set quality-based goals for improved patient care. These goals are aligned with the organization's strategic plan and are also in keeping with Critical Care Service Ontario guidelines for effective intensive care unit (ICU) teams.

There is a surge plan in place and the team participates fully with the: "No Refusal Life or Limb" policy. All team members participate in goal and objective setting the ICU. The team leadership is applauded for the inclusion of all staff members in this setting including non-clinical for their input to goals and patient care initiatives.

Priority Process: Competency

Leadership is working diligently with clinical staff members to ensure that team members can work to full scope of competency and education is provided, tracked and encouraged by leadership for ongoing professional development. In-service and online education are regularly provided to help maintain quality of skills. Further professional development has been arranged for the team to enhance critical care skills and external education is encouraged. Physician competencies are met by the College of Physicians and Surgeons of Ontario (CPSO) qualifications for critical care categorization

Priority Process: Episode of Care

The critical care department now has a closed unit to create an entirely intensivist provision of care 24/7 for patients.

The team has developed a rapid response team and these charts have an audit process to ensure appropriate use and efficacy. There is active participation with Critical Care Services Ontario and Criti call.

At this time the team does not contact the patient directly to ensure optimal transition to the community however, a plan is in place to ensure appropriate follow-up appointment with primary care, and to ensure optimal patient transition back to the community for the next year.

The team reviews the advance care directives with the patient and their family to ensure patient needs are being met. The team is mindful of ethical practices recognizing deaths, and has appropriate inclusion of the ethicists in the team during difficult situations and debriefs. In addition, there are regular manual chart audits performed by the manager regarding code blue, rapid response team and seven-day readmits.

The team conducts an extensive discharge education to patients and their families regarding medication prior to discharge to ensure that patients have a clear understanding of discharge medications. Discharge notes are reviewed by team members to ensure accuracy prior to release to primary care.

As mentioned above, the team does not contact the patient directly to ensure optimal transition back home and to evaluate the effectiveness of the transition to the community. There is a plan to adopt this into work flow of the team in the next year.

Priority Process: Decision Support

The critical care service has recently closed the intensive care unit (ICU) to create an entirely Intensivist-led model of care consistent with Critical Care Service Ontario. A number of best-practice protocols are embedded in the electronic chart. There is also a paper-based inter-professional flow sheet used in the paper-based chart.

There is coordination of information between team members via bullet rounds and face-to-face handover for shift change or transitions between departments. Critical Care Service Ontario (CCSO) data are used to measure quality-based initiatives in the closed ICU. Adoption of evidence-based guidelines for critically ill patients is underway and the unit is well-positioned for full adoption of the CCSO guidelines.

There are electronic modules for: venous thrombo embolism (VTE) prophylaxis, amiodarone, sedation protocols and ventilation protocols. This eliminates unnecessary duplication of blood work. The notes from the emergency department are not available in the current electronic medical record (EMR) system for ICU.

Priority Process: Impact on Outcomes

Intensive care-specific standards are being developed by the clinical care team as part of quality-based initiatives for improved patient outcomes. The goals of the teams are clearly identified to enhance patient safety and improved patient outcomes. Standardized tools for central line insertion are currently implemented. The team uses quality-based metrics from Critical Care Service Ontario (CCSO) to ensure that goals are set to improve patient care. Indicator data are tracked as part of CCSO data sets, and the information is used to set quality-based goals and objectives for the team. The team's commitment to daily huddles is effective in ensuring quality- based activities.

Priority Process: Organ and Tissue Donation

The critical intensive care unit (CICU) team is an active participant with the Trillium Gift of Life program. An intensivist in the CICU is an appointed representative in the hospital for the Trillium Gift of Life program. The intensivists appropriately identify patients and inform the Trillium network in a timely manner. They are using the organ procurement guidelines set forth by Trillium Gift of Life Network (TGLN). The TGLN provides all the information and approach and all aspects of organ procurement to the patient and families.

3.2.4 Standards Set: Diagnostic Imaging Services

Unmet Criteria		High Priority Criteria
Priority Process: Diagnostic Services: Imaging		
4.3	For nuclear medicine, the team designates separate waiting areas to segregate clients who have been injected with radioactive substances from other clients.	!
4.4	The client service area includes a space for screening clients which respects confidentiality issues prior to their diagnostic imaging examination.	!
Surveyor comments on the priority process(es)		
Priority Process: Diagnostic Services: Imaging		

The diagnostic imaging (DI) team is enthusiastic and has an obvious focus on patient-centred care. A comprehensive service is provided to meet the needs of the patients in this region. Service includes bone density, mammography, computerized tomography (CT) scanning and interventional radiology where appropriate.

Quality indicators are monitored and are posted on the huddle boards in the department. The team members provided examples of the improvements that have been implemented as a result of their quality monitoring processes. Formal and informal evaluation of wait-lists are done regularly and additional days are added when required in both efficient and effective ways.

The team's turnaround times(TAT) are excellent. The radiologists use voice recognition software to dictate and finalize their reports which results in impressive report times. The DI team collaborates and communicates with internal and external partners regularly to ensure that report times continue to meet customer expectations.

The presence of volunteers in the unit provides support to the patients and assists flow to the various areas of the department seamlessly.

The DI staff members are commended for their participation in all initiatives to improve emergency department wait times by improvement of their turnaround times. The DI team's efforts to ensure timely access to DI services has been noted by other clinical service units as improving the in-patient experience.

Privacy and confidentiality are a challenge in the current environment however, the team has been reviewing this with the opportunity to make improvements in the upcoming capital expansion.

3.2.5 Standards Set: Emergency Department

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	
Priority Process: Organ and Tissue Donation	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The emergency department (ED) has a volume of about 52,000 visits per year. This is a large increase from previous years of between 12 and 17%, and it is attributed to some demographic change, but more due to repatriation/attraction of patients from outside the catchment area and precipitated by the large reduction in wait times. As noted previously in the report, this ED is number one in the province for having the shortest wait times for all Canadian Triage Acuity Scale (CTAS) classifications.

The scope of services has been defined in part by the organization in conjunction with the community and by the Local Health Integrated Network (LHIN). Patients requiring services beyond the scope are readily referred to London or to other facilities via Criti-Call. There has been minimal delay for these services.

The space in the ED is antiquated and not conducive to the volumes seen. Confidentiality and privacy are compromised but all possible efforts have been taken to minimize these complications. It is suggested that some screening at the registration desk could be implemented now. There are plans for ED redevelopment in the new infrastructure plans and there will be some changes in the ED as the new construction begins. Attention will have to be paid in the interim to confidentiality and access issues during this time.

Priority Process: Competency

The emergency department (ED) has a sufficient complement of physicians and nurses that work on a shift basis to provide appropriate care to the patients. There are data available that have permitted changes in shift /personnel allocations to manage high volume periods. Physician coverage for the full operation of the "fast track" area is a must. There is specialist coverage always available in house or on call. Laboratory and imaging investigations are available 24/7.

The team has access to ongoing educational opportunities both internal and external. The daily team huddles also offer an opportunity for information exchange and review and revision of service parameters. Here there is often recognition of staff members that have excelled however, most see this as team effort and prefer not to be singled out. The staff members have all had training in cultural, workplace and specific medical issues. This is a general ED and pediatrics and mental health are significant components of the expected care.

All new staff members working in ED undergo a rigorous orientation program that is both organizational and ED specific. There is a buddy system and new hires may spend between three and six months in this probationary period.

Priority Process: Episode of Care

The emergency department is well-signed and access is quite reasonable however, there may be some problems when the new infrastructure construction begins. The unit is open 24/7 with appropriate staffing levels and access to all diagnostic and specialist support. All arriving patients undergo early triage where communicable disease and safety risks are identified and remedial measures implemented. Consents for treatment are obtained at this point.

Following triage, patients are directed to the waiting area, and the Canadian Triage Acuity Scale 3, 4 and 5 patients are directed to the fast-track area. The nurses complete the admitting history and vital signs. Allergies and best possible medication history (BPMH) are recorded here.

Upon transfer of care, discharge or admission, there is a record available to the referring family physician, or for situation background assessment recommendation (SBAR) and face-to-face transfer for inpatient admissions.

Priority Process: Decision Support

The emergency department (ED) team has access to electronic mechanisms of charting as well as some paper remnants. All diagnostic results are relayed via the computer and if the patient is to be admitted then an electronic health record (EHR) is constructed. All other ED patients have a paper chart upon which all care giver documentation is recorded. There is a plan to become totally electronic but this is not likely to be a reality for some time.

The ED uses clinical practice guidelines that have been developed by ED experts. However, the team does have the ability to review and revise, where appropriate, to fit there particular circumstances.

Priority Process: Impact on Outcomes

This team has implemented measures that are designed to enhance patient safety. These measures are reviewed regularly during the daily huddles. There is evidence of a falls prevention strategy and all patients are assessed and classified accordingly.

The unit and team members are involved in quality improvement measures both at the organizational and unit level. There are indicators that are measured and the data are shared with the team and the community where necessary. The emergency department (ED) wait time strategy and the results have placed this ED at number one in the province and it had maintained this rating despite significant increases in patient visits.

Priority Process: Organ and Tissue Donation

The organization does not do organ transplantation. However, it is involved in harvesting corneas. The emergency department (ED) staff members do have a role in the identification of potential donors and will contact the Trillium Gift of Life Network. That organization then takes over the responsibility for all discussions with families and the coordination for transfer-harvesting and transplantation.
Potential donors are admitted to the intensive care unit ICU for organ support pending completion of the donor consent, transfer and harvesting.

3.2.6 Standards Set: Infection Prevention and Control Standards

Unmet Criteria	High Priority Criteria
Priority Process: Infection Prevention and Control	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)
Priority Process: Infection Prevention and Control

The infection prevention and control (IPAC) service has qualified IPAC practitioners that support the program. There are four main components: targeted surveillance, audit, policy development and education including consultation.

There is an established IPAC committee with broad representation from various clinical and service areas. The IPAC program is comprehensive in its approach. The staff members are available to provide consultation to the organization as required. They are consulted when there is renovation or new construction. They are consulted regarding environmental conditions, medical devices and equipment and laundry areas.

Policies are established and available to all staff. These policies are regularly reviewed and revised based on best practice and changes to applicable regulations.

The IPAC staff members provide significant education which is reflective of its priorities. There is orientation of new hires on multiple topics. There is education to all staff members on hand hygiene, use of personal protective equipment (PPE) and many other regular topics or specific ones on a just-in-time basis. Clients and families are also informed using appropriate methods including pamphlets and signs. Appropriate PPE and hand-hygiene resources are available to them as well.

The organization measures its compliance with accepted hand-hygiene practices on a regular basis. These results are shared using many methods including huddles and directly to the individual or group concerned. Point-of-care education is provided when an individual is observed as being non-compliant to the accepted hand-hygiene practice.

The targeted surveillance produces indicators for regular monitoring in areas such as nosocomial infections, ventilator associated pneumonia (VAP), surgical sight infections, central line infections and a few others.

There are well-established communication protocols developed and followed when there is a confirmed or suspected case of health care associated infection. These infections are tracked and analysis is conducted to prevent recurrence. The information is shared, internally and externally, as per established protocol.

There are good collaborative relationships with public health, the London Health Sciences Centre and others when necessary.

There is a quality improvement plan for IPAC which is fully reflective of the organization’s plan.

There is a strong and competent presence by infection control professionals in this organization. This is complemented by staff and physicians that support IPAC activities and continually learn new and different responses to IPAC initiatives.

The housekeeping department staff members are commended for the good work in maintaining the organization in a clean state. The knowledge regarding the IPAC implications in their work is quite notable.

3.2.7 Standards Set: Medication Management Standards

Unmet Criteria		High Priority Criteria
Priority Process: Medication Management		
2.3	The organization has a program for antimicrobial stewardship to optimize antimicrobial use. Note: Beginning in January 2013, this ROP will only apply to organizations that provide inpatient acute care services. For organizations that provide inpatient cancer, inpatient rehab, and complex continuing care services, evaluation of this ROP will begin in January 2014.	ROP
2.3.5	The organization establishes mechanisms to evaluate the program on an ongoing basis, and shares results with stakeholders in the organization.	**MINOR**
13.3	The organization stores chemotherapy medications in a separate negative pressure room with adequate ventilation segregated from other supplies.	!
16.2	The organization maintains appropriate ventilation, temperature, and lighting in the medication preparation areas.	
16.3	The organization has a separate negative pressure area with a 100 percent externally-vented biohazard hood for preparing chemotherapy medications.	!
16.4	The organization has a separate area with a certified laminar air flow hood for preparing sterile products and intravenous admixtures.	!
27.8	The interdisciplinary committee shares evaluation results with staff and service providers.	
Surveyor comments on the priority process(es)		
Priority Process: Medication Management		

The pharmacy and therapeutics committee is well-established and agenda items are pertinent to the accreditation standards and best practices. There is active participation from all disciplines and minutes are brought forward to the medical advisory committee.

The pharmacy department has led numerous changes and process improvements to improve patient safety related to medication administration.The pharmacy department at St. Thomas-Elgin General Hospital has been involved at the regional level in the implementation of computerized prescriber order entry (CPOE). This is well-established and 'power' plans are used extensively for a variety of conditions. The implementation of automated dispensing cabinets has improved safety and compliance with numerous medication standards including the unit dose medication administration systems.

Numerous improvements have been completed in the pharmacy processes including re-organization of pill shelves and medication cabinet review.

During the survey physicians and nursing staff members commented on the professional and excellent support provided with the pharmacy presence at "bullet" rounds. Pharmacists are also available to consult on complex patients and provide teaching to patients related to medications when required.

The best possible medication history (BPMH) is well done at St. Thomas Elgin General Hospital. The leadership and involvement of pharmacy technicians in this initiative has led to the success of medication reconciliation in all areas of the organization.

The antimicrobial stewardship committee has been established and has made changes and improvements. The audit process is in early stages and the team is encouraged to continue the work to evaluate the program on an ongoing basis.

The pharmacy department is encouraged to continue the work to review medication incidents and identify potential areas of risk and to ensure there are formal mechanisms established to bring forward the pharmacy perspective related to these incidents.

3.2.8 Standards Set: Medicine Services

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
7.4 The team identifies medical and surgical clients at risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) and provides appropriate thromboprophylaxis. 7.4.3 The team establishes measures for appropriate thromboprophylaxis, audits implementation of appropriate thromboprophylaxis, and uses this information to make improvements to their services.	ROP **MINOR**
9.4 The team assesses each client's risk for developing a pressure ulcer and implements interventions to prevent pressure ulcer development. 9.4.5 The team has a system in place to measure the effectiveness of pressure ulcer prevention strategies, and uses results to make improvements.	ROP **MINOR**
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The medicine team members are engaged and committed to the services they provide to patients in the region. The team has reviewed the needs of the population, and the planning for the stroke unit is an example of determining future needs for this population.

Goals and objectives are clearly defined and visible to all staff members via the huddle boards displayed on both medical units.

Priority Process: Competency

The interdisciplinary team is made up of a variety of disciplines including occupational therapy and physiotherapy to enhance the care of the elderly. The team members understands their roles and responsibilities and are effective in the coordination of services for this patient group.

The interdisciplinary team is well-established and engaged in the daily bullet rounds with a comprehensive goal to ensure effective and safe discharge of this patient group.

Intravenous (IV) pump infusion training is provided during orientation and the learning management system (LMS) allows for tracking of compliance with provision of ongoing education.

Performance reviews are completed regularly with input from the clinical resource nurses. Clinical resource nurses provide consistency for both staff members and physicians on the unit.

Priority Process: Episode of Care

The medicine team is knowledgeable and committed to excellence in improving the patient experience. Staff members are proud of the care they deliver and work extremely well as an interdisciplinary team. This is evidenced in the commitment to attend daily bullet rounds on both medical units. The presence of volunteers on the unit provides support and additional help for patients and families.

The interdisciplinary team is committed to daily huddles where important safety, quality and risk information is discussed. Indicators are altered based on the importance for the patient population and staff ideas for improvement. There is real-time data and this is meaningful to all staff members that work in the area.

Fall prevention programs are ingrained into daily practice and changes have been made based on improving this metric significantly on both medical units. The IDEAS project to sustain the optimization of transitions of care for acute medical patients to primary care providers ensures that transitions from hospital to home are successful. Metrics are reviewed regularly to monitor the success of this initiative.

Use of the patient whiteboards ensures that information is shared with patients and families. Laminated patient information sheets are available beside the whiteboards to encourage patients and families to read this information regularly. The implementation of transfer of accountability at bedside shift report in March 2015 has been embraced by staff. This practice also allows the patients and families to feel more involved in their care planning.

There are policies and procedures in place to screen patients at risk of venous thrombo-embolism and the electronic environment ensures that reasons are listed when treatment is not required. The team is encouraged to set up a system to audit implementation of appropriate thrombo prophylaxis, and use this information to make improvements to services.

The team members document their findings in various places. Currently, there are paper charts, beside charts and electronic charts which means that all information cannot be viewed in a continuous way. Therefore, the team is encouraged to work towards interdisciplinary documentation that allows for a comprehensive overview of the patient, in one place.

Priority Process: Decision Support

Electronic charting is in development on the medicine unit. The physician order entry is well-developed with triggers for required organizational practices such as venous thrombo embolism (VTE) prophylaxis to ensure this is considered for every patient. Medication administration records are electronic with systems to support electronic implementation.

There is separation of documentation on the unit, with electronic documentation and paper documentation thus, creating challenges to access the full patient chart when required. The team's documentation is well done and extensive. Fall prevention programs and pressure ulcer programs are part of the practice with interventions that can easily implemented.

The medicine team is encouraged to continue to explore opportunities to further expand electronic documentation and to include all components of healthcare discipline charting.

Priority Process: Impact on Outcomes

Fall prevention programs are ingrained into daily practice and changes have been made based on improving this metric significantly on both medical units. Bed and chair alarms are used appropriately with recent education provided to staff. Purple arm bracelets ensure that patients at fall risk are identified to all health care providers.

Patient whiteboards ensure that information is shared with patients and families. Laminated patient information sheets are available at the bedside whiteboards to encourage patients and families to read this information regularly.

The interdisciplinary team is committed to daily huddles where important safety, quality and risk information is discussed. Indicators are altered based on their importance for the patient population and staff ideas for improvement. Real-time data are meaningful to all staff members working in the area.

The medicine team is encouraged to continue to develop written safety information that patients can take with them following discharge from hospital.

3.2.9 Standards Set: Mental Health Services

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	
Surveyor comments on the priority process(es)	
Priority Process: Clinical Leadership	

The team receive socio-demographic information about the client population served and it uses this information to define its scope of services. The organization takes a strengths-based and client directed approach to service provision and supports. The services offered are recovery oriented, and focused on well-being.

There are goals and objectives developed for the provision of mental health services and these are reflected in the: “Work Plan to Support Organizational Objectives: April 1 2015 – March 31 2015”.

Positive relationships exist with partners in the community and police services is one example. The team has ongoing contact and has held meetings to address mutual concerns. The mental health team has prepared educational information which has been provided to the police in one of these meetings.

The team has taken active steps to reduce stigma of mental illness amongst staff members and service providers. For example, there was a full page dedicated to this matter in the spring 2015 issue of: “Community Connections”, which is published by the organization and distributed widely in the community. The theme was: “Opening Hearts, Opening Minds” and it outlined the things one can do to stamp out stigma.

Team members have access to the employee assistance program.

Priority Process: Competency

The mental health team members are competent individuals and committed to their established role in the provision of mental health services. There are position profiles in place, and performance evaluations are performed on a regular basis.

Education and training is provided on a regular basis. There is an emphasis on training for staff members on how to prevent and manage violent or aggressive behaviour using de-escalation techniques. An assessment of education needs in this area has led to the change from the management of aggressive behaviour program to the safe management program.

There is an established process for the equitable division of responsibilities amongst service providers and staff.

Priority Process: Episode of Care

The mental health unit is situated in an area newly renovated during the past two years. It is nicely appointed and quite functional and safe, supporting care needs of the target population, with a 15-bed inpatient program and an out-patient program. There are a few areas that need minor correction; however, the team is in the enviable position of planning to move to the new addition to the hospital which is scheduled for completion in 2017. This provides the team with the opportunity to ensure that any deficient areas at the current time are corrected in the new construction.

The team members are qualified and committed to the provision of excellent care. The commitment and support of the psychiatrists is apparent. The team has developed good response times for requests for care. The team monitors this and regularly reviews wait times to identify any deficiency in targets. The team has also addressed barriers to care in the service and access to community supports.

There is good communication between the team and patients/clients. Service information is provided verbally and in writing with the in-patient or out-patient handbook. Assessments are completed within 12 hours of admission and an holistic approach is taken in the assessment and development of care planning. The assessment process is inclusive of the patient and family and considers all elements necessary for the development of care plans. It is inclusive of the specific client safety risks.

The team is encouraged to address the assessment and care planning process. At this time, while the team communicates well amongst each other, there is still individual assessment and care planning by the various professionals. It is suggested that the team complete the assessment in a way that reflects the interdisciplinary care model so that there is one set of care goals and subsequent care plan established between the team and the client/family. Each professional can then develop their own individual treatment plan that is focused on the common established care goals. This review and subsequent enhancement will also reinforce the strengths-based and client-directed approach to services and supports. The huddles and bullet rounds support the communication requirements of the interdisciplinary model.

The charting process requires review to ensure that it is fully supportive of the interdisciplinary process. For example, the care plan needs to be reflective of the development of common goals.

The team has an established process to address suicide prevention and there is an individual assessment and monitoring process completed on clients that may be at risk. The manager has developed a teaching tool on suicide prevention. The tool outlines all elements of Accreditation Canada's Required Organizational Practices on suicide assessment and prevention.

There is an established process for clients and families to be fully integrated into the assessment, care planning and regular monitoring of care including a process for receiving and addressing complaints. There is a policy to provide the least intrusive and least restrictive care possible. Careful assessment is conducted regarding the use of restraints and seclusion. All other methods are discussed and ruled out before restraints or seclusion is used.

There is an excellent process established to generate and record the best possible medication history (BPMH) and the information collected is used to reconcile the medications at transitions of care. The history is collected and electronically recorded by a pharmacist for the use of the psychiatrist when creating new medication orders. The process established by the team for the completion of the BPMH and the administration of medication has several safeguards to prevent error. This is evidenced by the low number of medication errors.

Care transitions are carefully addressed by the team so that the client has appropriate follow-up and supports in the community following discharge from the in-patient unit. This is addressed by the provision of appropriate and timely information to agencies that provide mental health service in the community. For example, the team will often refer the patient to its own out-patient program or to the local office of the Canadian Mental Health Association (CMHA) or other providers of mental health in the community. The mental health program has a long list of community partners with which it can interact to ensure there is continuity between the in-patient and out-patient services of the organization and other elements of the continuum of mental health care in the community.

The one client interviewed during the survey expressed satisfaction with the care and services offered here. All aspects of the admission, including safety, were thoroughly addressed. Two identifiers were used, handwashing by staff members was noted and the overall demeanour of staff was noted as positive. The patient noted that safety was incorporated in the physical design of the facility. In addition, the food choices and quality of the food was noted as excellent.

Priority Process: Decision Support

The team maintains an accurate and up-to-date chart for every patient/client. The progress notes are all in one area and all disciplines record sequentially instead of in separate areas. This practice supports the provision of interdisciplinary care. However, there are two areas that need to be addressed in order to further support the interdisciplinary care model and address safety. First, the team is encouraged to review the structure of the chart. For example, the care planning process, which is meant to be fully interdisciplinary, is not reflected in the current care planning process. The chart should reflect the setting of common goals derived by the team as a whole, fully inclusive of the client and family input. Instead, in this instance each professional completes an individual assessment and this is reflected in the charting process.

The second area of concern is that the chart is partially electronic and partially hard copy. Any time there is two charting sources, there is room for error. Consequently, the team is encouraged to move toward one charting system.

There is good information sharing amongst team members especially during the huddles and bullet rounds.

The team has several examples of using evidence-based guidelines including the use of standard order sets and evidence-based treatment groups.

Priority Process: Impact on Outcomes

There is quite an emphasis on safety for team members and there are many safe guards implemented. The team is also trained to identify, reduce and manage risks to client family and staff. There are regular safety briefings. There is also written information developed for clients and families which is included in the patient handbooks for in-patient and out-patient services.

There is an established process for the identification, reporting and monitoring of sentinel events, adverse events and near misses. There is also an established policy for the disclosure of adverse events.

There are established objectives for quality improvement which are monitored on a regular basis and which are discussed with staff members during the huddles.

3.2.10 Standards Set: Obstetrics Services

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
12.5 Following transition or end of service, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end-of-service planning.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The obstetrics service receives approximately 700 newborn deliveries per year by way of midwives and obstetricians. The team hopes to grow this program by implementing a variety of initiatives to address the population needs in terms of maternal and fetal care. The team has a partnership with Public Health and uses Better Outcomes Registry Network (BORN) data in addition to other sources to determine the needs of the patient community.

In addition, the team has a close partnership with Public Health (PH) nursing to identify high-risk patients for PH community follow up. These PH nurses are able to communicate patient needs to the program to align educational services as part of quality improvement goals. The team is committed to daily huddles that enable alignment of goals to the organization's strategic plan. These goals and objectives are clearly defined and visible to all staff via the huddle boards. Staff members are able to comment on care goals in the labour and delivery, post-partum and pediatrics, as staff members work in all three areas thus, defining family oriented care.

Leadership is working diligently with clinical staff members to ensure that team members can work to full scope of competency, and education is provided, tracked and encouraged by leadership for ongoing professional development. In-service and online education are regularly provided to help maintain quality of skills.

Priority Process: Competency

The organization has a team that provides care on the obstetrical service and which crosses to cover labour and delivery, postpartum and pediatrics. This creates a family-centric environment for patients. Commitment to team daily huddles improves process and services. Education is ongoing and documented for all team members. The team receives training and has access to ongoing educational opportunities, both internal and external. There is accommodation to debrief the team following adverse or sentinel events. Team huddles provide an opportunity for recognition of team members' contributions to service and quality improvement.

There is a plan to increase the number of obstetricians. There will be an expansion of scope for midwifery in keeping with provincial scope standards.

Priority Process: Episode of Care

There is a structured best practice approach to ensuring maternal and fetal health assessments from the time of admission through to labour and delivery. The labour and delivery rooms are well-quipped and there is an inter-professional team that supports care.
Mothers and families receive both verbal and written information regarding the care and the services available. There is a patient-centric approach to mother and child care that includes parents and family members as active participants in care.
Cesarean sections are performed in the operative suite, with one room dedicated for emergency cesarean section capacity. Cesarean sections follow the operating room (OR) procedural format for safety.

Currently, pharmacy delivers pre-mixed oxytocin to labour and delivery, which likely decreases dosing medication error. Medication orders are submitted to pharmacy via electronic order sets, and patients and medications are scanned via this system before the medication is dispensed to the patient. The Bishop score is used for induction.

The interdisciplinary team is committed to daily huddles where important safety, quality and risk information is discussed. Indicators are altered based on the importance for the patient population and ideas for improvement from staff. Real-time data are available and meaningful to all staff working in the area. Team members readily identify barriers for patients and make changes to improve patient care.

Discharge arrangements include Public Health to determine high risk or high needs patients for follow up. There is no follow-up contact with the patients after discharge. It is suggested that the team be willing to consider providing post-care contact, especially in the first few days of discharge post delivery. This would improve patient transition to community and also help to evaluate the effectiveness of end-of-service programs.

Priority Process: Decision Support

There are a number of best practice guideline used in protocols for ensuring mother and newborn health. The obstetrical charts continue to be a blend of paper-based charts and electronic order sets. The antenatal history is available prior to patient admission. Copies of the reports from diagnostic imaging are contained in the paper-based chart. The newborn record is kept in a separate section of the same chart as the mother. Laboratory results are available on the electronic chart.

There is a plan to progress to a full electronic chart but this will likely take some time. There is face-to-face transfer of care throughout the three units.

Priority Process: Impact on Outcomes

Team huddles are used to identify goals and objectives for the team. In addition, team members can suggest things.

Patients are assessed for falls risks and are identified for falls. This team has implemented measures that are designed to enhance patient safety. Both verbal and written information is provided to the patient to promote safety for a number of services. This team has implemented measures that are designed to enhance patient safety. These measures are reviewed regularly during the daily huddles. There is evidence of a falls prevention strategy and all patients are assessed and classified accordingly.

The unit and team members are involved in quality improvement measures both at the organization and unit level.

3.2.11 Standards Set: Point-of-Care Testing

Unmet Criteria	High Priority Criteria
Priority Process: Point-of-care Testing Services	

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)
Priority Process: Point-of-care Testing Services

The Point-of-Care Testing process is appropriate and monitoring systems are well established along with staff education.

3.2.12 Standards Set: Rehabilitation Services

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The rehabilitation team is engaged and committed to the services provided to patients in the region. The team has reviewed the needs of the population and bed distribution has been altered to provide timely care to those awaiting rehabilitation. The future planning for the stroke unit is an example of determining future needs for this population.

Goals and objectives are clearly defined and visible to all staff members via the huddle boards displayed on the unit.

Priority Process: Competency

The interdisciplinary team is made of a variety of disciplines including occupational therapy, recreation therapy and physiotherapy to enhance the care of this diverse population with a variety of needs. Team members understand their roles and responsibilities and are effective in the coordination of services for this patient group. Interdisciplinary rounds are well attended with active participation from all team members including the lead physician. The interdisciplinary team is established and engaged in rounds with a comprehensive goal to ensuring safe transition of this patient group to home, or other destinations as required.

Intravenous (IV) pump infusion training is provided during orientation and the learning management system (LNS) allows for tracking of compliance with ongoing education.

Performance reviews are completed regularly with input from the clinical resource nurses. Clinical resource nurses provide consistency for both staff members and physicians on the unit.

Priority Process: Episode of Care

The rehabilitation team is knowledgeable and committed to excellence in improving the patient experience. Staff members are proud of the care they deliver and work extremely well as an interdisciplinary team. This is evidenced in their commitment to attend interdisciplinary rounds on this unit.

The restorative philosophy implementation has enabled patients to better achieve independence from programs that enhance better outcomes for this patient group. The presence of volunteers on the unit provides support and additional help for patients and families.

The interdisciplinary team is committed to daily huddles where important safety, quality and risk information is discussed. Indicators are altered based on their importance for the patient population and ideas for improvement from staff. Real-time data are available and meaningful to all staff members working in the area.

Fall prevention programs are ingrained into daily practice and changes have been made to improve this metric significantly on both medical units.

Use of patient whiteboards ensures that information is shared with patients and families. Laminated patient information sheets are available at the beside whiteboards to encourage patients and families to read this information regularly. The implementation of transfer of accountability at bedside shift report in March 2015 has been embraced by staff. This practice also allows the patients and families to feel more involved in their care planning.

The team provides comprehensive information for patients at discharge, both verbal and written, to ensure understanding of medications and services that will be provided. Follow-up appointments are arranged as required.

There are policies and procedures in place to screen patients at risk of venous thrombo-embolism and the electronic environment ensures that reasons are listed when treatment is not required. The team is encouraged to set up a system to audit implementation of appropriate thrombo prophylaxis, and use this information to make improvements to services.

The team members document their findings in various places. Currently, there are paper charts, beside charts and electronic charts which means that all information cannot be viewed in a continuous way. Therefore, the team is encouraged to work towards interdisciplinary documentation that allows for a comprehensive overview of the patient, in one place.

Priority Process: Decision Support

Electronic charting is in development on the rehabilitative unit. The physician order entry is well-developed with triggers for required organizational practices such as venous thrombo embolism (VTE) prophylaxis to ensure this is considered for every patient. Medication administration records are electronic, with systems to support electronic implementation.

There is separation of documentation on the unit, with electronic documentation and paper documentation thus, creating challenges to access the full patient chart when required.

The team's documentation is well done and extensive. Fall prevention programs and pressure ulcer programs are part of the practice with interventions that can easily implemented.

The rehabilitative team is encouraged to continue to explore opportunities to further expand electronic documentation to include all components of healthcare discipline charting.

Priority Process: Impact on Outcomes

Fall prevention programs are ingrained into daily practice and changes have been made based on improving this metric significantly on the unit. Bed and chair alarms are used appropriately with recent education provided to staff. Purple arm bracelets ensure that patients at fall risk are identified to all health care providers.

Patient whiteboards ensure that information is shared with patients and families. Laminated patient information sheets are available at the bedside whiteboards to encourage patients and families to read this information regularly.

The rehabilitation team has led the work to improve the ulcer prevention program that is in place at this organization. There has been standardization of equipment, supplies and assessment tools. The team has recently participated in an ulcer prevention prevalence initiative to further understand next steps for program development.

The interdisciplinary team is committed to daily huddles where important safety, quality and risk information is discussed. Indicators are altered based on the importance for the patient population and ideas for improvement from staff. Real-time data are available and meaningful to all staff working in the area.

3.2.13 Standards Set: Transfusion Services

Unmet Criteria	High Priority Criteria
Priority Process: Transfusion Services	

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)
Priority Process: Transfusion Services

The laboratory offers twenty-four hour coverage every day. It has blood and blood products available whenever needed by the patients. There are appropriate procedures in place to obtain blood for testing from patients, and to select the appropriate blood product for the needs of the patient. Blood or blood products are verified with the health care professional that receives them according to protocol. Staff members in the blood bank have processes in place to minimize blood and blood product wastage.

3.2.14 Priority Process: Surgical Procedures

Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge

Unmet Criteria	High Priority Criteria
Standards Set: Perioperative Services and Invasive Procedures Standards	
8.9 The team identifies clients at risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) and provides appropriate thromboprophylaxis.	ROP
8.9.3 The team establishes measures for appropriate thromboprophylaxis, audits implementation of appropriate thromboprophylaxis, and uses this information to make improvements to their services.	**MINOR**

Surveyor comments on the priority process(es)

The surgical service is busy with a scope that has been designed to serve the community yet also stay within the scope defined by the Local Health Integrated Network (LIHN). There are four functioning rooms, one of which is used exclusively for endoscopy. Cesarean sections are performed in the operating room (OR) and there is always "reserved" capacity for emergency procedures.

The OR team has implemented the "safe surgical" bundle and it has been in place for a long time and there is good evidence of compliance. Patient safety is paramount and the interdisciplinary team reviews its policies and procedures on an ongoing basis to ensure relevance and continuity.

Between 90 and 95% of the elective surgery is done on an out-patient or same-day admit basis. Therefore, all patients have complete documentation, assessments and diagnostics pre-operatively. The admission process is viable and efficient and the patient flow is smooth.

The surgical service is coordinated and efficient with the staff members participating in regular safety huddles and review of quality improvement plans.

Patients participate in their well-being with education, reports and at bedside transfers of care. There is identification of high risk events such as falls, pressure ulcer formation and venous thrombo embolism (VTE). There does not appear to be any audit process for the appropriateness or effectiveness of thrombo-embolic prophylaxis and this should be implemented.

The team members document their findings in various places in that there is a paper chart that is kept at the main desk, and there is a bedside chart that contains bedside data. Plus, there is an electronic chart that contains other data. This dispersion of information invites error and is a risk to the patient. There needs to be "one patient-one chart" so that all information can be viewed in continuity for that patient. It is also suggested that the progress notes become multidisciplinary and continuous, as this not only reinforces the team concept it more importantly allows all care givers to have instant overview of the care progress.

At the discharge points all patients have follow-up appointments arranged and booked. It is suggested a 24-hour post discharge telephone call assessment of progress, especially for post-operative surgical day care patients, would be a welcome addition for patients and families. It would also provide the organization with data on the immediate surgical outcome.

Section 4 Instrument Results

As part of Qmentum, organizations administer instruments. Qmentum includes three instruments (or questionnaires) that measure governance functioning, patient safety culture, and quality of worklife. They are completed by a representative sample of clients, staff, senior leaders, board members, and other stakeholders.

4.1 Governance Functioning Tool

The Governance Functioning Tool enables members of the governing body to assess board structures and processes, provide their perceptions and opinions, and identify priorities for action. It does this by asking questions about:

- Board composition and membership
- Scope of authority (roles and responsibilities)
- Meeting processes
- Evaluation of performance

Accreditation Canada provided the organization with detailed results from its Governance Functioning Tool prior to the on-site survey through the client organization portal. The organization then had the opportunity to address challenging areas.

- **Data collection period: December 2, 2014 to December 23, 2014**
- **Number of responses: 12**

Governance Functioning Tool Results

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1 We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations.	8	0	92	93
2 Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	0	0	100	95
3 We have sub-committees that have clearly-defined roles and responsibilities.	0	0	100	97
4 Our roles and responsibilities are clearly identified and distinguished from those delegated to the CEO and/or senior management. We do not become overly involved in management issues.	0	0	100	95
5 We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decisionmaking.	0	0	100	92

		% Disagree	% Neutral	% Agree	%Agree * Canadian Average
		Organization	Organization	Organization	
6	Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	8	92	95
7	Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	8	92	98
8	Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	0	8	92	96
9	Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	0	8	92	94
10	Our governance processes make sure that everyone participates in decision-making.	0	17	83	94
11	Individual members are actively involved in policy-making and strategic planning.	8	17	75	89
12	The composition of our governing body contributes to high governance and leadership performance.	0	17	83	93
13	Our governing body’s dynamics enable group dialogue and discussion. Individual members ask for and listen to one another’s ideas and input.	0	0	100	96
14	Our ongoing education and professional development is encouraged.	0	8	92	88
15	Working relationships among individual members and committees are positive.	0	17	83	97
16	We have a process to set bylaws and corporate policies.	0	0	100	95
17	Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	97
18	We formally evaluate our own performance on a regular basis.	0	0	100	82
19	We benchmark our performance against other similar organizations and/or national standards.	9	18	73	72
20	Contributions of individual members are reviewed regularly.	0	25	75	64

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
21 As a team, we regularly review how we function together and how our governance processes could be improved.	0	25	75	81
22 There is a process for improving individual effectiveness when non-performance is an issue.	8	58	33	64
23 We regularly identify areas for improvement and engage in our own quality improvement activities.	0	50	50	80
24 As a governing body, we annually release a formal statement of our achievements that is shared with the organization's staff as well as external partners and the community.	17	25	58	84
25 As individual members, we receive adequate feedback about our contribution to the governing body.	8	50	42	69
26 Our chair has clear roles and responsibilities and runs the governing body effectively.	0	25	75	96
27 We receive ongoing education on how to interpret information on quality and patient safety performance.	0	8	92	84
28 As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	95
29 As a governing body, we hear stories about clients that experienced harm during care.	8	8	83	85
30 The performance measures we track as a governing body give us a good understanding of organizational performance.	0	0	100	92
31 We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	0	8	92	87
32 We have explicit criteria to recruit and select new members.	8	25	67	84
33 Our renewal cycle is appropriately managed to ensure continuity on the governing body.	0	8	92	90

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
34 The composition of our governing body allows us to meet stakeholder and community needs.	0	17	83	94
35 Clear written policies define term lengths and limits for individual members, as well as compensation.	8	0	92	94
36 We review our own structure, including size and subcommittee structure.	0	25	75	89
37 We have a process to elect or appoint our chair.	0	0	100	95

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2014 and agreed with the instrument items.

4.2 Canadian Patient Safety Culture Survey Tool: Community Based Version

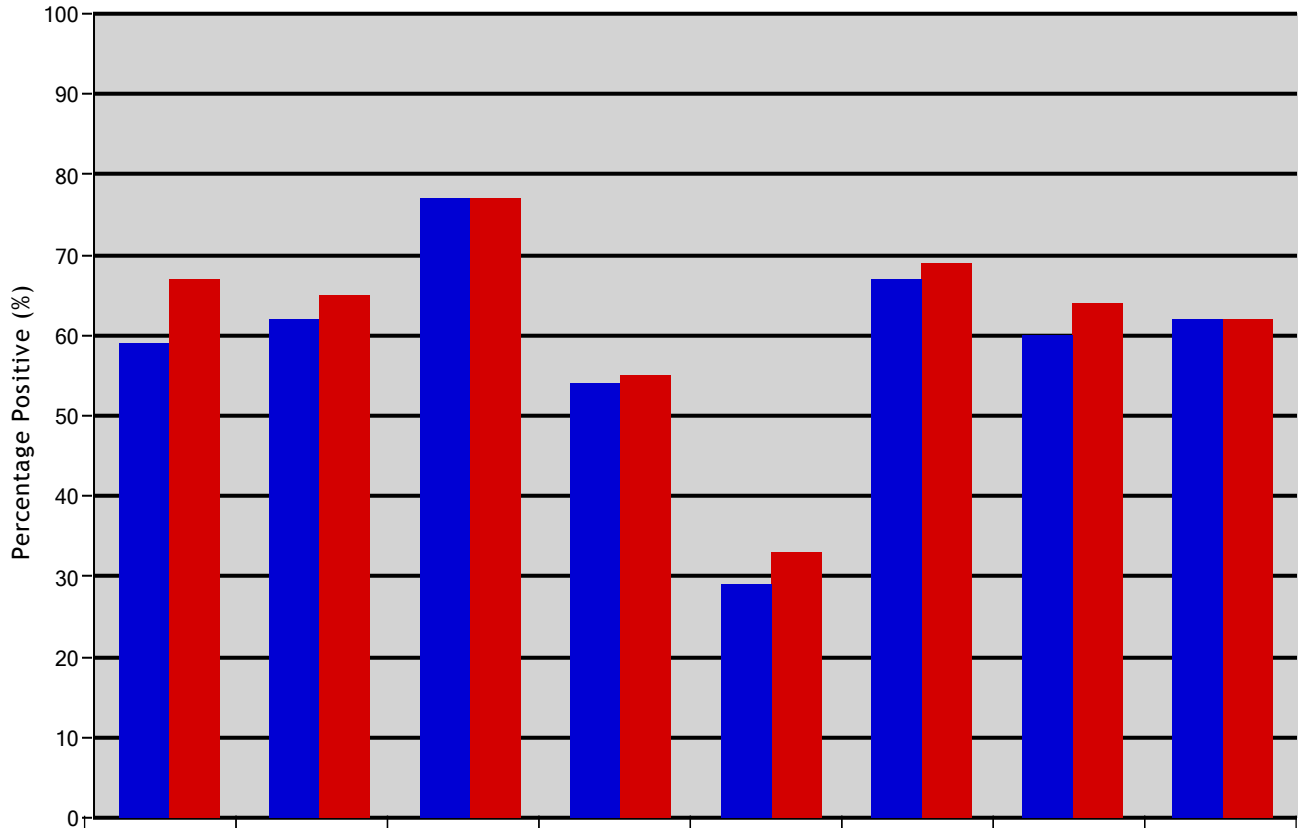
Organizational culture is widely recognized as a significant driver in changing behavior and expectations in order to increase safety within organizations. A key step in this process is the ability to measure the presence and degree of safety culture. This is why Accreditation Canada provides organizations with the Patient Safety Culture Tool, an evidence-informed questionnaire that provides insight into staff perceptions of patient safety. This tool gives organizations an overall patient safety grade and measures a number of dimensions of patient safety culture.

Results from the Patient Safety Culture Tool allow the organization to identify strengths and areas for improvement in a number of areas related to patient safety and worklife.

Accreditation Canada provided the organization with detailed results from its Patient Safety Culture Tool prior to the on-site survey through the client organization portal. The organization then had the opportunity to address areas for improvement. During the on-site survey, surveyors reviewed progress made in those areas.

- **Data collection period: October 30, 2014 to January 16, 2015**
- **Minimum responses rate (based on the number of eligible employees): 188**
- **Number of responses: 189**

Canadian Patient Safety Culture Survey Tool: Community Based Version: Results by Patient Safety Culture Dimension



	Organizational (senior) leadership support for safety	Supervisory leadership for safety	Unit learning culture	Enabling Open Communication I: judgment-free environment	Enabling Open Communication II: job repercussions of error	Incident follow up	Stand-alone items	Overall Perceptions of Client Safety
	59%	62%	77%	54%	29%	67%	60%	62%
	67%	65%	77%	55%	33%	69%	64%	62%

Legend

St. Thomas-Elgin General Hospital

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2014 and agreed with the instrument items.

4.3 Worklife Pulse

Accreditation Canada helps organizations create high quality workplaces that support workforce wellbeing and performance. This is why Accreditation Canada provides organizations with the Worklife Pulse Tool, an evidence-informed questionnaire that takes a snapshot of the quality of worklife.

Organizations can use results from the Worklife Pulse Tool to identify strengths and gaps in the quality of worklife, engage stakeholders in discussions of opportunities for improvement, plan interventions to improve the quality of worklife and develop a clearer understanding of how quality of worklife influences the organization's capacity to meet its strategic goals. By taking action to improve the determinants of worklife measured in the Worklife Pulse tool, organizations can improve outcomes.

The organization used an approved substitute tool for measuring the quality of worklife but did not provide Accreditation Canada with results.

4.4 Client Experience Tool

Measuring client experience in a consistent, formal way provides organizations with information they can use to enhance client-centred services, increase client engagement, and inform quality improvement initiatives.

Prior to the on-site survey, the organization conducted a client experience survey that addressed the following dimensions:

Respecting client values, expressed needs and preferences,including respecting client rights, cultural values, and preferences; ensuring informed consent and shared decision-making; and encouraging active participation in care planning and service delivery.

Sharing information, communication, and education,including providing the information that people want, ensuring open and transparent communication, and educating clients and their families about the health issues.

Coordinating and integrating services across boundaries,including accessing services, providing continuous service across the continuum, and preparing clients for discharge or transition.

Enhancing quality of life in the care environment and in activities of daily living,including providing physical comfort, pain management, and emotional and spiritual support and counselling.

The organization then had the chance to address opportunities for improvement and discuss related initiatives with surveyors during the on-site survey.

Client Experience Program Requirement	
Conducted a client experience survey using a survey tool and approach that meets accreditation program requirements	Met
Provided a client experience survey report(s) to Accreditation Canada	Met

Appendix A Qmentum

Health care accreditation contributes to quality improvement and patient safety by enabling a health organization to regularly and consistently assess and improve its services. Accreditation Canada's Qmentum accreditation program offers a customized process aligned with each client organization's needs and priorities.

As part of the Qmentum accreditation process, client organizations complete self-assessment questionnaires, submit performance measure data, and undergo an on-site survey during which trained peer surveyors assess their services against national standards. The surveyor team provides preliminary results to the organization at the end of the on-site survey. Accreditation Canada reviews these results and issues the Accreditation Report within 10 business days.

An important adjunct to the Accreditation Report is the online Quality Performance Roadmap, available to client organizations through their portal. The organization uses the information in the Roadmap in conjunction with the Accreditation Report to ensure that it develops comprehensive action plans.

Throughout the four-year cycle, Accreditation Canada provides ongoing liaison and support to help the organization address issues, develop action plans, and monitor progress.

Action Planning

Following the on-site survey, the organization uses the information in its Accreditation Report and Quality Performance Roadmap to develop action plans to address areas identified as needing improvement. The organization provides Accreditation Canada with evidence of the actions it has taken to address these required follow ups.

Evidence Review and Ongoing Improvement

Five months after the on-site survey, Accreditation Canada evaluates the evidence submitted by the organization. If the evidence shows that a sufficient percentage of previously unmet criteria are now met, a new accreditation decision that reflects the organization's progress may be issued.

Appendix B Priority Processes

Priority processes associated with system-wide standards

Priority Process	Description
Communication	Communicating effectively at all levels of the organization and with external stakeholders
Emergency Preparedness	Planning for and managing emergencies, disasters, or other aspects of public safety
Governance	Meeting the demands for excellence in governance practice.
Human Capital	Developing the human resource capacity to deliver safe, high quality services
Integrated Quality Management	Using a proactive, systematic, and ongoing process to manage and integrate quality and achieve organizational goals and objectives
Medical Devices and Equipment	Obtaining and maintaining machinery and technologies used to diagnose and treat health problems
Patient Flow	Assessing the smooth and timely movement of clients and families through service settings
Physical Environment	Providing appropriate and safe structures and facilities to achieve the organization's mission, vision, and goals
Planning and Service Design	Developing and implementing infrastructure, programs, and services to meet the needs of the populations and communities served
Principle-based Care and Decision Making	Identifying and decision making regarding ethical dilemmas and problems.
Resource Management	Monitoring, administration, and integration of activities involved with the appropriate allocation and use of resources.

Priority processes associated with population-specific standards

Priority Process	Description
Chronic Disease Management	Integrating and coordinating services across the continuum of care for populations with chronic conditions
Population Health and Wellness	Promoting and protecting the health of the populations and communities served, through leadership, partnership, innovation, and action.

Priority processes associated with service excellence standards

Priority Process	Description
Blood Services	Handling blood and blood components safely, including donor selection, blood collection, and transfusions
Clinical Leadership	Providing leadership and overall goals and direction to the team of people providing services.
Competency	Developing a skilled, knowledgeable, interdisciplinary team that can manage and deliver effective programs and services
Decision Support	Using information, research, data, and technology to support management and clinical decision making
Diagnostic Services: Imaging	Ensuring the availability of diagnostic imaging services to assist medical professionals in diagnosing and monitoring health conditions
Diagnostic Services: Laboratory	Ensuring the availability of laboratory services to assist medical professionals in diagnosing and monitoring health conditions
Episode of Care	Providing clients with coordinated services from their first encounter with a health care provider through their last contact related to their health issue
Impact on Outcomes	Identifying and monitoring process and outcome measures to evaluate and improve service quality and client outcomes
Infection Prevention and Control	Implementing measures to prevent and reduce the acquisition and transmission of infection among staff, service providers, clients, and families
Medication Management	Using interdisciplinary teams to manage the provision of medication to clients
Organ and Tissue Donation	Providing organ donation services for deceased donors and their families, including identifying potential donors, approaching families, and recovering organs
Organ and Tissue Transplant	Providing organ transplant services, from initial assessment of transplant candidates to providing follow-up care to recipients
Organ Donation (Living)	Providing organ donation services for living donors, including supporting potential donors to make informed decisions, conducting donor suitability testing, and carrying out donation procedures
Point-of-care Testing Services	Using non-laboratory tests delivered at the point of care to determine the presence of health problems

Priority Process	Description
Primary Care Clinical Encounter	Providing primary care in the clinical setting, including making primary care services accessible, completing the encounter, and coordinating services
Public Health	Maintaining and improving the health of the population by supporting and implementing policies and practices to prevent disease, and assess, protect, and promote health.
Surgical Procedures	Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge