ACCREDITATION CANADA



Driving Quality Health Services

Accreditation Report

Georgian Bay General Hospital

Midland, ON

On-site survey dates: November 30, 2015 - December 4, 2015

Report issued: December 23, 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

Georgian Bay 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 November 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

Georgian Bay 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

Georgian Bay General Hospital 's accreditation decision is:

Accredited (Report)

The organization has succeeded in meeting the fundamental requirements of the accreditation program.

1.2 About the On-site Survey

- **On-site survey dates: November 30, 2015 to December 4, 2015**

- **Locations**

  The following locations were assessed during the on-site survey. All sites and services offered by the organization are deemed accredited.

  1 Georgian Bay General Hospital
  2 Georgian Bay General Hospital - Penetanguishene

- **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 - Service Excellence Standards
  6 Critical Care - Service Excellence Standards
  7 Point-of-Care Testing - Service Excellence Standards
  8 Ambulatory Care Services - Service Excellence Standards
  9 Diagnostic Imaging Services - Service Excellence Standards
  10 Medicine Services - Service Excellence Standards
  11 Rehabilitation Services - Service Excellence Standards
  12 Obstetrics Services - Service Excellence Standards
  13 Transfusion Services - Service Excellence Standards
  14 Biomedical Laboratory Services - Service Excellence Standards
  15 Perioperative Services and Invasive Procedures Standards - Service Excellence Standards
  16 Emergency Department - Service Excellence Standards

- **Instruments**

  The organization administered:

  1 Governance Functioning Tool
  2 Canadian Patient Safety Culture Survey Tool: Community Based Version
  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)	61	1	0	62
 Accessibility (Give me timely and equitable services)	79	2	1	82
 Safety (Keep me safe)	551	17	29	597
 Worklife (Take care of those who take care of me)	126	4	1	131
 Client-centred Services (Partner with me and my family in our care)	153	1	1	155
 Continuity of Services (Coordinate my care across the continuum)	52	0	2	54
 Appropriateness (Do the right thing to achieve the best results)	882	18	8	908
 Efficiency (Make the best use of resources)	66	2	0	68
Total	**1970**	**45**	**42**	**2057**

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	39 (92.9%)	3 (7.1%)	0	31 (96.9%)	1 (3.1%)	0	70 (94.6%)	4 (5.4%)	0
Leadership	45 (97.8%)	1 (2.2%)	0	81 (95.3%)	4 (4.7%)	0	126 (96.2%)	5 (3.8%)	0
Infection Prevention and Control Standards	37 (92.5%)	3 (7.5%)	1	29 (93.5%)	2 (6.5%)	0	66 (93.0%)	5 (7.0%)	1
Medication Management Standards	67 (98.5%)	1 (1.5%)	10	61 (96.8%)	2 (3.2%)	1	128 (97.7%)	3 (2.3%)	11
Ambulatory Care Services	38 (97.4%)	1 (2.6%)	3	72 (96.0%)	3 (4.0%)	2	110 (96.5%)	4 (3.5%)	5
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	91 (97.8%)	2 (2.2%)	2	124 (98.4%)	2 (1.6%)	3
Diagnostic Imaging Services	59 (98.3%)	1 (1.7%)	7	67 (100.0%)	0 (0.0%)	1	126 (99.2%)	1 (0.8%)	8
Emergency Department	47 (100.0%)	0 (0.0%)	0	80 (100.0%)	0 (0.0%)	0	127 (100.0%)	0 (0.0%)	0

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	30 (100.0%)	0 (0.0%)	1	71 (100.0%)	0 (0.0%)	0	101 (100.0%)	0 (0.0%)	1
Obstetrics Services	62 (100.0%)	0 (0.0%)	2	80 (100.0%)	0 (0.0%)	0	142 (100.0%)	0 (0.0%)	2
Perioperative Services and Invasive Procedures Standards	96 (98.0%)	2 (2.0%)	2	88 (100.0%)	0 (0.0%)	0	184 (98.9%)	2 (1.1%)	2
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	30 (100.0%)	0 (0.0%)	1	70 (100.0%)	0 (0.0%)	0	100 (100.0%)	0 (0.0%)	1
Reprocessing and Sterilization of Reusable Medical Devices	46 (90.2%)	5 (9.8%)	2	56 (88.9%)	7 (11.1%)	0	102 (89.5%)	12 (10.5%)	2
Transfusion Services **	70 (100.0%)	0 (0.0%)	5	66 (100.0%)	0 (0.0%)	1	136 (100.0%)	0 (0.0%)	6
Total	**808 (97.9%)**	17 (2.1%)	35	1094 (98.1%)	21 (1.9%)	7	1902 (98.0%)	38 (2.0%)	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 Care Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Critical Care)	Unmet	1 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)	Unmet	1 of 2	0 of 0
Client And Family Role In Safety (Obstetrics Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Perioperative Services and Invasive Procedures Standards)	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 (Rehabilitation Services)	Unmet	1 of 2	0 of 0
Dangerous Abbreviations (Medication Management Standards)	Met	4 of 4	3 of 3
Information Transfer (Ambulatory Care 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 (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 Care Services)	Met	7 of 7	0 of 0
Medication reconciliation at care transitions (Critical Care)	Unmet	0 of 5	0 of 0
Medication reconciliation at care transitions (Emergency Department)	Unmet	1 of 5	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 (Medicine Services)	Unmet	0 of 5	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Unmet	1 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 Care Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Biomedical Laboratory Services)	Met	1 of 1	0 of 0
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 (Obstetrics 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 (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)	Met	4 of 4	1 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
Infusion Pumps Training (Ambulatory Care 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 (Obstetrics 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: Medication Use			
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
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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Ambulatory Care 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 (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
Pressure Ulcer Prevention (Critical Care)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Medicine Services)	Met	3 of 3	2 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
Venous Thromboembolism Prophylaxis (Critical Care)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Medicine Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Perioperative Services and Invasive Procedures Standards)	Met	3 of 3	2 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.

Georgian Bay General Hospital (GBGH) can celebrate many successes. The organization has carried out a strategic planning refresh process that is being used to lead strategic choices and operating decisions. Programs and services are working to align their annual work plans with key strategic directions through the identification of a key "Break Through" goal for each service and departmental level. They have developed working relationships with their key stakeholders to develop and deliver on this strategic plan and use a community advisory group of stakeholders for feedback and input on strategic and key operating decisions.

Regional planning is enhanced through involvement with the NSM-LHIN, involvement in joint planning committees and leadership roles it has taken with NSM-LHIN initiatives. The use of program work plans and quarterly reporting, etc. are tools and techniques that are demonstrating gains on their planning initiatives.

There is a dedicated Board and good governance practices in place, along with a strong Board orientation and evaluation process. The Board would benefit from the development of role descriptions for its various positions, to assist in role clarity. The organization is encouraged to develop an Enterprise Risk Management program that can be monitored by the Board in its entirety at the Board level. The Board is encouraged to use the organization's ethics framework to assist in making resource allocation decisions. The organization will benefit from a formalized CEO and senior management succession planning process. Given the recent enhancements to leadership and a refreshed Strategic Plan, the Board is encouraged to monitor the organization’s focus on its mission, vision, values, culture and strategy.
Positive relationships exist with their community partners who demonstrated an engagement and true partnership with the organization. The organization is challenged at times to find the balance between planning as it relates to its mission and partnering with its community stakeholders and meeting their expectations in service delivery and support (i.e., enhancing coordination with Huronia Hospice since the palliative beds were moved to the Midland site). There is an opportunity to better engage community partners around emergency response planning and the organization is encouraged to pursue this.
The community partners identified successful partnerships with public health in surveillance activities, engagement with the Community Health Link program, enhancing the culture of Aboriginal care and as a good partner in regional planning. The Board of Directors and senior leadership team seek input from their community through a standing Advisory Committee as well as through quarterly meetings with other key external stakeholders involved in the provision of health care in the community. Furthermore they have recently launched quarterly town hall meetings in each of the municipalities in their region to share information and respond to questions. In addition, GBGH leadership collaborates with their North Simcoe Muskoka Local Health Integration Network (NSM-LHIN) and other hospitals in their region to seek input on planning. The hospital has a good working relationship with its CCAC which facilitates discharge planning, with improved patient outcomes.

At the community partners' meeting, the surveyors heard that GBGH engages its partners and has a positive working relationship with the local Family Health Teams, public health and the long-term care sector. In addition, the work GBGH has done in joint planning with the local First Nations was recognized and the creation of the new First Nations Patient Navigator position was cited as a good example of a positive outcome in working together. The 2009 Board policy on community engagement is comprehensive and provides excellent direction to the Board and senior team.
The organization has made great efforts in the last year to develop an integrated quality plan. The various components have been recently implemented although staff are challenged to understand how the various components connect to an integrated plan. A good reporting system to the leadership group and the Board has been implemented and are standing items on their agendas. The organization may benefit from ensuring the

quality and transformation functions are well represented at the senior management committee to reinforce their strategic importance. Given the organization's current state of transformation, it would also benefit from the incorporation of a more robust change management framework for implementation of its strategic and transformational agenda.
The use of the "huddle" boards are very effective in translating strategy, quality and performance to the department and unit levels, with very good participation from and engagement with frontline staff. The skill set and commitment of the "Lean" transformation staff serves as solid resource for the training and implementation of quality initiatives. This has been demonstrated through the development of the organization's patient flow program.

The organization has made good progress in rebuilding its finance function and regaining Board and organizational confidence through its hiring of credentialed staff, improving reporting timelines and partnering with Shared Services West for supply chain management services. The organization has developed an appropriate capital and operating budget process to support the clinical and support programs in the delivery of their services, given their current fiscal position and MOHLTC timing requirements.

A multi-faceted comprehensive communication plan is refreshed annually and guides external and internal communication strategies for the organization. Elements of the communication plan include tactics for staff recognition, profile building and marketing, stakeholder relations and support, and issues or crisis management.

The human capital group has demonstrated adaptability through the amalgamation of services, staff and collective agreements. The organization's strong affiliation with its educational partners and the provision of on-site learning through student placements is a model to be shared with other organizations.

Improvements in the labour relations environment have been demonstrated through the quality and number of grievances is recognized as well as its mental health awareness program. There are numerous processes both formal and informal to recognize team members' contributions.

Each of the sites providing care within GBGH has identified specific program goals and objectives for its services. The physical environment is conducive to quality patient care and they have sufficient resources (supplies and equipment) to provide needed services. Both sites have embraced the falls prevention program and seek opportunities to enhance patient safety in their environments. Recognizing that melting snow increases the likelihood of slips and falls, the Midland site encourages patients and families to remove their winter boots and use slippers/booties, to mitigate this risk. In addition, in the endoscopy suite and operating room the clinical teams have adapted the surgical safety checklist and before each procedure they pause, identify the patient and confirm the procedure, and introduce team members. The patient passport tool developed and used by rehabilitation services ensures an exceptional discharge planning process and should be considered as a model for other service areas.

Break Through goals aligned with the organization's strategic plan have been established within services at both sites. Examples include the goal to reduce pre-appointment wait times at the Midland site; this will be re-activated in the new year. Data is being collected to better understand the causes of the delays, and then a quality improvement strategy will be developed. Continued efforts to incorporate SMART objectives into the goal setting, to enhance the ability to measure the progress being made, are encouraged.

The infection prevention and control staff have worked very hard on staff training on hand hygiene and personal protective equipment and should be commended for their good work. They have made great strides in infection prevention and control over the past year and should be supported in their endeavours.

GBGH uses numerous modalities to seek client feedback on the services it provides. The Board of Directors and the senior leadership team seek input from their community through a standing Advisory Committee as well as through quarterly meetings with other key external stakeholders involved in the provision of health care in the community. Furthermore they have recently launched quarterly town hall meetings in each of the municipalities in their region to share information and respond to questions.

Patients comment that the clinics respond in a timely manner. The families are informed of services and receive educational material. Documentation in the charts is clear and easily accessible.

The clients interviewed stated that they received excellent care and talked about how the interdisciplinary team helped them regain daily activities. The clients stated that the doctors and nurses are attentive to their specific needs.
Examples of patient- and family-centred care were observed within the organization. The organization is encouraged to continue to expand this philosophy of care through partnering with patients and families in the delivery of their care.

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: Communication	
Client And Family Role In Safety The team informs and educates clients and families in writing and verbally about the client and family's role in promoting safety.	· Medicine Services 15.4 · Rehabilitation Services 15.4 · Critical Care 16.3
Medication reconciliation at care transitions With the involvement of the client, family, or caregiver (as appropriate), the team generates a Best Possible Medication History (BPMH) and uses it to reconcile client medications at transitions of care.	· Medicine Services 7.6 · Critical Care 7.7 · Emergency Department 9.3 · Obstetrics Services 9.6

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.

Unmet Criteria		High Priority Criteria
Standards Set: Governance		
1.2	The governing body has written documentation that identifies its roles and responsibilities and how those roles and responsibilities are carried out.	!
2.6	Each member of the governing body signs a statement acknowledging his or her role and responsibilities, including expectations of the position and legal duties.	!
3.1	The governing body uses the ethics framework and evidence-informed criteria to guide decision making.	!
7.8	The governing body has a succession plan for the CEO.	

Surveyor comments on the priority process(es)

The organization has a dedicated Board and good governance practices in place, along with a strong Board orientation and evaluation process. The Board would benefit from the development of role descriptions for its various positions, to assist in role clarity. The organization is encouraged to develop an Enterprise Risk Management program that can be monitored by the Board in its entirety at the Board level. The Board is encouraged to use the organization's ethics framework to assist in making resource allocation decisions. The organization will benefit from a formalized CEO and senior management succession planning process. Given the recent enhancements to leadership and a refreshed Strategic Plan, the Board is encouraged to monitor the organization’s focus on its mission, vision, values, culture and strategy.

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
5.3	The organization's information about the community is maintained in a format that is up-to-date and easy to understand.	
6.5	The organization's leaders develop and implement a process to manage change.	

Surveyor comments on the priority process(es)

The organization has carried out a strategic planning refresh process that is being used to lead strategic choices and operating decisions. Programs and services are working to align their annual work plans with key strategic directions through the identification of a key "Break Through" goal for each service and department. They have developed working relationships with their key stakeholders to develop and deliver on this strategic plan and use a community advisory group of stakeholders for feedback and input on strategic and key operating decisions.

Regional planning is enhanced through their involvement with the North Simcoe Muskoka LHIN, involvement in joint planning committees and leadership roles it has taken with NSM LHIN initiatives.

The use of program work plans, quarterly reporting, etc. are tools and techniques that are demonstrating gains on their planning initiatives.

The organization is challenged at times to find the balance between planning as it relates to its mission, and partnering with its community stakeholders and meeting their expectations in service delivery and support (i.e., enhancing coordination with Huronia Hospice since the palliative beds were moved to the Midland site). The community partners identified successful partnerships with public health in surveillance activities, engagement with the Community Health Link program, enhancing the culture of Aboriginal care and as a good partner in regional planning.

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)

The organization has made good progress in rebuilding its finance function and regaining Board and organizational confidence through its hiring of credentialed staff, improving reporting timelines and partnering with Shared Services West for supply chain management services.

The organization has developed an appropriate capital and operating budget process to support the clinical and support programs in the delivery of their services, given their current fiscal position and MOHLTC timing requirements. It is encouraged to protect capital funds for major medical equipment replacement as good practice as opposed to relying solely on Foundation fundraising activities. The organization is encouraged to pursue its balanced budget objectives and resource allocation decisions within an ethics framework and established resource allocation criteria.

The organization is encouraged to pursue a long-term strategy to balance its operating budget to a GAAP bottom line to preserve capital for future capital and infrastructure needs.

3.1.4 Priority Process: Human Capital

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
10.4 The organization's leaders establish a talent management plan that includes strategies for developing leadership capacity and capabilities within the organization.	

Surveyor comments on the priority process(es)

The human capital group has demonstrated adaptability through the amalgamation of services, staff and collective agreements. The focus on its attendance management program to bring sick time within industry standards is encouraged.

The continued development of the foundational strength of its e-learning platform is encouraged. The organization's strong affiliation with its educational partners and the provision of on-site learning through student placements is a model to be shared with other organizations.

Improvements in the labour relations environment has been demonstrated through the quality and number of grievances being filed as well its mental health awareness program. There are numerous processes both formal and informal to recognize team members' contributions.

The organization may benefit from the presence of the human resources function at its senior management committee given the operational and strategic importance to the organization at this time in its redevelopment.

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
12.3	As part of the integrated risk management approach, the organization's leaders develop contingency plans.	!
12.5	The organization's leaders evaluate the effectiveness of the integrated risk management approach and make improvements as necessary.	

Surveyor comments on the priority process(es)

The organization has made great efforts in the last year to develop an integrated quality plan. The various components have been recently implemented although staff are challenged to connect the various components to an integrated plan. A good reporting system to the leadership group and the Board has been implemented and are standing items on their agendas. The organization may benefit from ensuring the quality function is well represented at the senior management committee to reinforce its strategic importance.

The use of the "huddle" boards are very effective in translating strategy, quality and performance to the department and unit levels, with very good participation from and engagement with frontline staff. The skill set and commitment of the "Lean" transformation staff serves as solid resource for the training and implementation of quality initiatives. This has been demonstrated through the development of the organization's highly successful patient flow program.

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)

The organization has a recently updated ethics policy and procedure that is thoughtful, clear, and concise. It appears to be well utilized throughout the hospital. Good evidence was found that frontline staff, senior management, and the hospital Board all embrace the ethics policy and procedure in their decision making.

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 Board of Directors and senior leadership team of the GBGH seek input from their community through a standing Advisory Committee as well as through quarterly meetings with other key external stakeholders involved in the provision of health care in the community. Furthermore they have recently launched quarterly townhall meetings in each of the municipalities in their region to share information and respond to questions. In addition, GBGH leadership collaborate with the North Simcoe Muskoka Local Health Integration Network (NSM-LHIN) and other hospitals in their region to seek input on planning.

At the community partners' meeting, the surveyors heard that GBGH engages its partners and has a positive working relationship with the local Family Health Teams, public health and the long-term care sector. In addition, the work GBGH has done in joint planning with the local First Nations was recognized and the creation of the new First Nations Patient Navigator position was cited as a good example of a positive outcome in working together. The 2009 Board policy on community engagement is comprehensive and provides excellent direction to the Board and senior team.

There is an opportunity to better engage community partners around emergency response planning and the organization is encouraged to pursue this opportunity.

A multi-faceted comprehensive communication plan is refreshed annually and guides external and internal communication strategies. Elements of the communication plan include tactics for staff recognition, profile building and marketing, stakeholder relations and support and issues or crisis management.

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 maintenance department should be commended for their excellent preventative program and tracking system.

The housekeeping training and orientation programs are excellent. Housekeeping staff feel part of patient safety and quality care as was demonstrated with them winning the award for their part in patient flow.

The hospital is very clean and housekeeping staff and management should be commended.

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)

Staff on 2 North should be commended on their handling of the code blue that occurred as all aspects were executed according to the plan.

The partnership with the LHIN acute sites on emergency preparedness is excellent. It is recommended that regular testing of code brown be performed. The back-up plant facilities are excellent and well maintained.

It is suggested that external community involvement in the emergency plan be improved.

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)

GBGH has made patient flow a strategic priority for the organization. The overarching goal is to achieve optimum movement of patients through the system and there is evidence of a hospital-wide commitment among all departments and services, with senior leadership direction and support.

There are a number of formal committees and working groups that meet to address patient flow. The GBGH Utilization Management Committee looks at clinical data from CIHI (Canadian Institute for Health Information), provincial QBP (Quality Based Procedures) reports and audits on compliance with order sets related to top diagnostic categories (CMGs) where the length of stay exceeds the benchmark. In addition to this strategic committee that guides and directs hospital efforts, there are daily bed meetings to look at patient flow across the system, daily rounding on each inpatient unit to review the status of each patient's admission (Rapid Rounds) and identify barriers to discharge, weekly alternate level of care meetings with community partners and weekly senior leadership team meetings to assess progress on agreed-upon strategies and tactics. These committees were observed in action and there is evidence of a strong commitment among participants to optimize patient flow through the system with good critical thinking and decision making.

The managers, discharge planners and social workers who work one-on-one with patients and their families to develop transition plans are supported by community workers through CCAC, hospice, retirement homes and other agencies. The local Community Health Links program has been very helpful in assisting patients and the care team to navigate through the system.

The overarching Patient Improvement Dashboard has 21 key performance indicators measuring patient flow and it profiles progress against targets on each clinical unit. The hospital may wish to consider posting unit-specific findings on each relevant unit to profile for the staff their results and the contribution they are making to the hospital's patient flow goals.

With regard to patient flow at GBGH, continued efforts are encouraged to move patient length of stay toward targeted benchmarks to free up capacity by reducing conservable bed days.

Surgical wait times are monitored at GBGH and they are not presently a bottleneck for access to care.

The organization is to be commended for its strong leadership support and commitment to optimizing patient flow. As one of the participants at the patient flow focus group expressed, one of the things she is most proud of in the hospital and the effort that has been put forth to improve patient flow is that "... the patient journey has been made better ... when we come up with a goal each department identifies what they can do to support it."

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: Perioperative Services and Invasive Procedures Standards		
22.7	When transporting contaminated equipment and devices, the organization complies with the applicable regulations, controls environmental conditions, and uses clean and appropriate bins, boxes, bags, and transport vehicles.	!
Standards Set: Reprocessing and Sterilization of Reusable Medical Devices		
2.4	Supervisors and staff members involved in reprocessing have completed a recognized course in reprocessing and sterilization.	
3.1	When planning and designing the layout of the medical device reprocessing department, the organization considers the volume and types of reprocessing and sterilization services, flow of devices and equipment, and traffic patterns.	
3.2	The organization limits access to the medical device reprocessing department to appropriate team members, and posts clear signage limiting access to all entry points.	!
3.5	The organization regulates the air quality, ventilation, temperature, and relative humidity, and lighting in decontamination, reprocessing, and storage areas.	
3.6	The organization selects materials for the floors, walls, ceilings, fixtures, pipes, and work surfaces that limit contamination, promote ease of washing and decontamination, and will not shed particles or fibres.	
5.1	The medical device reprocessing department is equipped with hand hygiene facilities at entrances to and exits from the reprocessing areas, including personnel support areas.	
5.4	Staff members have access to the supplies needed to support proper hand hygiene, including properly supplied and functioning soap and towel dispensers or waterless, alcohol-based hand rubs in the working environment.	
8.2	The team follows safe work practices and infection control precautions when handling contaminated devices and equipment.	!
10.4	The organization maintains the integrity of each sterile package.	!

11.3	All endoscopic reprocessing areas are equipped with separate cleaning and decontamination work areas as well as storage, dedicated plumbing and drains, and proper air ventilation.	!
11.8	The organization stores endoscopic devices in a manner that minimizes contamination and damage.	!
13.10	The team collects new or uses existing data to establish a baseline for each indicator.	

Surveyor comments on the priority process(es)

The Medical Device Reprocessing department staff are very committed and knowledgeable. They are patient focused and work toward quality service. They should be commended for writing their departmental procedures cards with pictures.

The medical device reprocessing design does not allow for a one-way flow in the decontamination area due to the location of the washer disinfectors. Consideration should be given to bringing this department up to standard regarding flow, restricted access, environmental conditions and process.

The ambulatory care reprocessing area also requires review with regard to the decontamination area environmental conditions, sterile storage and endoscopy storage and transport. The transport of soiled and sterile supplies to Penetanguishene needs to be reviewed and the use of single-use devices investigated.

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:

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 Care Services - Direct Service Provision

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		
10.7	The team works with the client's referring service provider and other teams to manage pain experienced by the client outside of the ambulatory care environment, e.g. in the home.	
12.6	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		
18.6	The team collects new or uses existing data to establish a baseline for each indicator.	
18.8	The team regularly analyzes and evaluates its indicator data to determine the effectiveness of its quality improvement activities.	!
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

Ambulatory Care services at GBGH are offered at both the Midland and Penetanguishene sites. In Midland, a wide range of services, including an endoscopy suite and specialty clinics including urology, gynecology, ophthalmology and internal medicine are provided to meet community needs. Visiting specialists complement the services provided by local physicians and surgeons to improve access to care and reduce out-of-town travel for community residents.

The physical plant is well designed, clean and uncluttered and there are sufficient supplies and equipment to provide clinical care.

At the Midland site there is an Operational Steering Committee co-chaired by the manager and a physician. They jointly determine resource allocation and establish program goals and objectives with input from staff and clinicians.

The satellite outpatient dialysis clinic is located at the Penetanguishene site. Serving 36 patients, this clinic runs six days per week and will be expanding in the near future to offer an evening shift to meet the growing demand for hemodialysis. Affiliated with the Orillia Kidney Care Clinic as part of the Ontario Renal Network, the service is supported by nephrologists and a part-time social worker, dietician and pharmacist. Client-specific care planning occurs weekly via case-conferencing teleconference calls. In addition, there is a renal functioning clinic held monthly at the site.

Break Through goals aligned with the organization's strategic plan have been established within ambulatory care services at both sites. The goal of reducing pre-appointment wait times at the Midland site will be re-activated in the new year. Data is being collected to better understand the causes of the delays, and then a quality improvement strategy will be developed. Continued efforts are encouraged to incorporate SMART objectives into the goal setting to enhance measurement in the progress being made. The dialysis program over-achieved its Break Through goal from last fiscal year, successfully reducing the number of patients with central lines. Enhanced access to specialist services in the regional centre has come about through the increased coordination and collaboration associated with being part of a regional program.

The Break Through goal for the current year is to increase local access to residents of the community for hemodialysis and plans are underway to increase hours of operation and introduce Registered Practical Nurses into the care delivery team.

The current community-wide schedule of clinics used at the Midland site was established two years ago and the program is currently reviewing and revising this schedule to better balance clinic activity and meet the needs of the community. Plans are underway to gather more input on the community health needs through the GBGH Decision Support Analyst which will be incorporated into future scheduling revisions. Access to data is limited due to workload. All requests from within the organization need to be prioritized.

Priority Process: Competency

Care delivery within the ambulatory care settings at GBGH is provided by well-qualified and trained staff. Pharmacists and social workers are available as needed at the Midland site.

Care delivery in the dialysis program at the Penetanguishene site is provided through a well-rounded interdisciplinary team consisting of registered nurses, a social worker, dietician and pharmacist, with support from nephrologists. The program is introducing registered practical nurses to the service and the roles and responsibilities for these new team members have been shared with the larger group.

Orientation is provided to all new staff and ongoing education to support professional development is available within limited resources.

Priority Process: Episode of Care

Patients receiving care at GBGH ambulatory care have specific care plans to guide their treatment and follow-up. Plans of care have been developed for each of the procedures conducted in the clinics at the Midland site and documentation of assessments, treatments and actions/follow-up become part of the patient's permanent record. The assessment is holistic and includes a standardized scoring assessment for determining pain. The clinic updates the procedural plans as required.

In the dialysis program, the patients are well known to the clinical staff in that they attend for treatment three times per week. Care plans are identified for each patient and members of the interdisciplinary team contribute to the plan at case conferencing. Patients are engaged and actively participate in their planning. A recent quality improvement initiative identified the opportunity to enhance communication among the team members and a whiteboard was created to facilitate patient-related communication on key variables. This whiteboard has been well received by staff.

The Best Possible Medication History is gathered on patients at both sites. Medication reconciliation is conducted largely by the nurses at the Midland site with the physician signing off on discharge to ensure new prescriptions or discontinuation of medication plans are documented. While good progress has been made, compliance with the new process is not 100 percent. In the dialysis unit, patients are asked about changes to their medications at each visit with full medication reconciliation occurring during case-conferencing reviews and/or as needed due to changes in prescribed medications.

Informed consents are witnessed by the nurses within the ambulatory care settings. Explanations on the procedures are provided by the physicians/surgeons before the appointment.

Priority Process: Decision Support

Ambulatory Care Services use Meditech as the primary information system. Patients are registered in the main registration office and directed to the clinic area. Within the last year they have been able to generate activity reports which help them monitor clinic activity and inform decision making and quality improvement activity. Opportunities to enhance the quality of the system's management reporting should be explored to eliminate the need for managers to analyze raw data.

Wait times are managed through the physician offices as they control the booking procedures. Work is underway to explore further opportunities to shift activity from within the main operating rooms to the surgical clinics for better resource utilization.

The outpatient dialysis program at the Penetanguishene site is well supported by the regional centre and good quality data is available to the manager and frontline staff.

Priority Process: Impact on Outcomes

Each of the sites providing ambulatory care services within GBGH has identified specific program goals and objectives for their services. The physical environment is conducive to quality patient care and they have sufficient resources (supplies and equipment) to provide needed services. Both sites have embraced the falls prevention program and seek opportunities to enhance patient safety in their environments. Recognizing that melting snow increases the likelihood of slips and falls, the Midland site encourages patients and families to remove their winter boots and use slippers/booties, to mitigate this risk. In addition, in the endoscopy suite, the clinical team has adapted the surgical safety checklist and before each procedure they pause, identify the patient and confirm the procedure, and introduce team members.

In the dialysis program they have implemented a patient identification process using recent photographs of each of their clients, and they do not use identification bracelets. This system works well for them and fulfills the requirements for this Required Organizational Practice.

Staff are familiar with the organizational process for reporting adverse events. Monthly reports on the frequency and category of incidents are available to the managers to monitor, trend and respond to recurring problems. In addition, patient complaints are reviewed by the manager. In the past two years there have been four patient complaints which have all been investigated. These complaints are balanced by letters and notes of appreciation from patients seen in the clinic.

3.2.2 Standards Set: Biomedical Laboratory Services - Direct Service Provision

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
Laboratory Services is a high-quality program that is well aligned to meet the needs of the organization.

3.2.3 Standards Set: Critical Care - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
The organization has met all criteria for this priority process.			
Priority Process: Competency			
4.6	Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.		
Priority Process: Episode of Care			
7.7	With the involvement of the client, family, or caregiver (as appropriate), the team generates a Best Possible Medication History (BPMH) and uses it to reconcile client medications at transitions of care.		ROP
	7.7.1	Upon or prior to admission, the team generates and documents a Best Possible Medication History (BPMH), with the involvement of the client, family, or caregiver (and others, as appropriate).	**MAJOR**
	7.7.2	The team uses the BPMH to generate admission medication orders OR compares the Best Possible Medication History (BPMH) with current medication orders and identifies, resolves, and documents any medication discrepancies.	**MAJOR**
	7.7.3	A current medication list is retained in the client record.	**MAJOR**
	7.7.4	The prescriber uses the Best Possible Medication History (BPMH) and the current medication orders to generate transfer or discharge medication orders.	**MAJOR**
	7.7.5	The team provides the client, community-based health care provider, and community pharmacy (as appropriate) with a complete list of medications the client should be taking following discharge.	**MAJOR**
10.11	The team follows a protocol to achieve glycemic control in clients.		
Priority Process: Decision Support			
The organization has met all criteria for this priority process.			
Priority Process: Impact on Outcomes			
16.3	The team informs and educates clients and families in writing and verbally about the client and family's role in promoting safety.		ROP
	16.3.2	The team provides written and verbal information to clients and families about their role in promoting safety.	**MAJOR**

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

Critical Care at GBGH is well aligned to meet the needs of the community.

Priority Process: Competency

Critical Care staff function as a cohesive multidisciplinary team. Improvements are underway to improve staff orientation and ongoing education with the Acute Care Nurse Educator recently returning to an on-site location.

Management is encouraged to regularly review staff performance.

Priority Process: Episode of Care

The multidisciplinary Critical Care team provides high quality comprehensive care.

However, the team does not generate a Best Possible Medication History or reconcile medications routinely as standard practice. They are strongly encouraged to do so. As well, a protocol to achieve glycemic control is lacking and should be developed.

Priority Process: Decision Support

The Critical Care team maintains high-quality medical records and charting. As well, the development of evidence-based clinical pathways and standard order sets help ensure best practices.

Priority Process: Impact on Outcomes

The Critical Care team are focused on quality and safety initiatives. However, patients do not regularly receive written and verbal information pertaining to their role in promoting safety and the team is encouraged to provide this important information.

Priority Process: Organ and Tissue Donation

Critical Care has policies and procedures in place and works with the Trillium Gift of Life Network to provide organ and tissue donation services.

3.2.4 Standards Set: Diagnostic Imaging Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Diagnostic Services: Imaging	
17.5 The team collects, analyzes, and interprets data on the appropriateness of examinations, the accuracy of the interpretations, and the incidence of complications and adverse events.	!

Surveyor comments on the priority process(es)

Priority Process: Diagnostic Services: Imaging

The Diagnostic Imaging Department provides CT, ultrasound and general radiology testing to support the community and clinical services at the hospital. Last fiscal year there were 7310 CTs, 7937 ultrasounds, and 28,752 general examinations performed. The service does not provide interventional work.

The department is overseen by a medical director and administrative manager. The medical director (chief of radiology) is on-site one day per week and interfaces formally with the medical staff through the Medical Advisory Committee and the Medical Staff Association, and informally through discussions and conversations with his colleagues when he is on-site. Supported by a PACs system, films can be read remotely by Georgian Bay Radiology(a contracted service) and there is always a radiologist on-call to support clinical care.

A number of quality indicators are monitored within the department to ensure quality and staff and patient safety. For example, each month the number of repeat or rejection images are monitored and the percentage remains below 5 percent. Other ongoing quality indicators include dosimetry readings, monitoring of turn around times, wait times and monitoring of incident reports.

Currently there is no formal mechanism for peer review to enable the radiologist to review the accuracy of image interpretation by colleagues. There is an informal process whereby all members of the radiology group share feedback with one another on "good catches" and areas where there could be improvement in the interpretation. The next upgrade to the PACs system will include peer review software and there is a commitment to move ahead with this quality assurance program.

New staff are well oriented to the department and receive ongoing training as required. Most recently, with the installation of a new Toshiba ultrasound unit, training was provided through the vendor. The department is currently upgrading the skills-based training for all general technicians to enable them to perform contrast CTs. This upgrading will reduce overtime costs related to on-call hours and reduce the requirement for 24-hour coverage for what is now currently a smaller group of employees with this additional skill set.

3.2.5 Standards Set: Emergency Department - Direct Service Provision

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			
9.3	With the involvement of the client, family, or caregivers (as appropriate), the team initiates medication reconciliation for clients with a decision to admit and a target group of clients without a decision to admit who are at risk for potential adverse drug events (organizational policy specifies when medication reconciliation is initiated for clients without a decision to admit).		ROP
	9.3.1	The team initiates medication reconciliation for all clients with a decision to admit. A Best Possible Medication History (BPMH) is generated and documented with the involvement of the client, family, or caregiver. The medication reconciliation process may begin in the emergency department and be completed in the receiving inpatient unit.	**MAJOR**
	9.3.3	When medications are adjusted for non-admitted clients in the target group, the team generates and documents the BPMH with the involvement of the client, family, or caregiver.	**MAJOR**
	9.3.4	For non-admitted clients in the target group, the team communicates medication changes to the primary health care provider.	**MAJOR**
	9.3.5	For non-admitted clients identified as requiring medication reconciliation, the team provides the client and the next care provider (e.g., primary care provider, community pharmacist, home care services) with a complete list of medications the client is taking.	**MAJOR**
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 at GBGH is a busy full service ED with approximately 46,000 patient visits annually. The program's Operational Committee membership is comprised of the department manager and medical director, the clinical nurse educator, a number of emergency physicians and emergency nurses as well as representatives from diagnostic imaging, the laboratory and the pharmacy as required. The Operational Committee reviews the department's utilization data and has implemented changes to address the needs of the population served. Included among these changes is the creation of a fast track area referred to as the "See & Treat" area to address the high number of CTAS 4 and 5 patients. In addition, to facilitate patient throughput time, the program established a Clinical Decision Unit with clinical guidelines and protocols. And most recently, the program is exploring way to use telemedicine to expedite the referral and assessment of their mental health and addictions patients with their local tertiary centre.

As part of the organization's strategic plan and transformational agenda, the department has established one Break Through goal aimed at achieving a 60 percent rate for completion of recording the Best Possible Medication History. There has been a recent change in accountability for completion of these forms, shifting the responsibility from pharmacy to nursing. The organization is encouraged to continue to promote and support this change in practice to achieve the desired outcomes, thus improving patient safety and quality of care. Evidence of completed BPMH for the targeted population in the Emergency Department was observed in one out of three charts reviewed.

In addition to the Break Through goal, there are a number of patient flow goals aimed at optimizing patient flow through the department. These goals are tied to the hospital's overarching patient flow strategy and are aligned with the provincial "Pay for Results" program.

Staff safety within the Emergency Department has been identified as a high-risk area for the program. The hospital's security department, while providing support to the entire hospital, is based in the ED. In addition to the security staff presence, safety lanyards are available to staff to activate alarms as required.

Approximately four years ago all staff received training on reducing workplace violence. This training is being incorporated into the master educational programming for the unit. It was noted that there are a number of cross-trained staff with a high degree of expertise in this area that support safety in the workplace.

Priority Process: Competency

The Emergency Department is staffed by an interdisciplinary team of health professionals supplemented by support from social work, discharge planners, pharmacists and other professionals from within the hospital as required. Team members have clarity on their roles and responsibilities and there was evidence of staffing adjustments being made in response to changing demands.

The department staff have good working relationships with their EMS (Emergency Medical Services) colleagues and there is a clear distinction among roles and responsibilities. One example provided was the process followed when the advanced care paramedics arrive to transport patients to higher centres of care.

The medical staff have good support from radiology and the laboratory to support diagnoses and there are a number of specialists in surrounding communities who are available for consult and/or transfer of care.

Priority Process: Episode of Care

All patients presenting to the Emergency Department at GBGH are assessed by the Triage Nurse using either the adult or pediatric CTAS scoring tool to determine the level of urgency to treat. The new e-Triage tool is very innovative and enhances the process. The electronic record of the triage assessment includes a standardized assessment for pain and risk for falls assessment which becomes part of the permanent record.

The Emergency Department staff work closely with their Emergency Medical Services (EMS) colleagues in the provision of care for patients arriving via ambulance. Off-load delay times are monitored closely and there is an official handover in care when the transition occurs.

Pediatric patients (infants and children from 0 to 16 years of age) make up approximately 20 percent of the Emergency Department volume. There is pediatric equipment and supplies to meet the needs of this patient population and medications are administered according to weight-based dosages.

Clinical guidelines and protocols guide delivery of care in the Emergency Department, reducing variation in treatment. The team works in collaboration with their colleagues in other centres and with provincial bodies to ensure guidelines are current and evidence informed.

Priority Process: Decision Support

The Emergency Department at GBGH works with the other regional hospitals and with their provincial counterparts to ensure evidence-based practices are adhered to in care delivery. They have prioritized the development of medical directives in concert with the work from the Ontario Hospital Association. In addition, the Emergency Department is part of the provincial "Pay for Results" program which is aimed at improving care delivery and patient flow within provincial emergency departments.

The Emergency Department should be commended for their work and partnership in research endeavours to improve the quality of patient care. They are currently partnering with the Children's Hospital of Eastern Ontario on a study looking at the adoption of evidence-based clinical pathways. Entitled PRAM, the focus of this study is on a clinical pathway for the treatment of childhood asthma in the Emergency Department.

Another innovative practice is using technology to facilitate patient self-registration combined with a partial triage assessment. This e-Triage system is supported by volunteers who instruct and guide patients who have not used the system before. Patients can self-register and enter the reason they are seeking care. Upon completion of the form, the information is immediately relayed electronically to the Triage Nurse. This new system speeds up the registration process and assists the Triage Nurse in prioritizing the order in which patients are seen.

Priority Process: Impact on Outcomes

The staff in the Emergency Department are committed to quality care. They track a number of key performance indicators related to patient flow and throughput and as previously reported have used this data to inform changes in service delivery.

A departmental whiteboard profiles daily activity as per the above indicators and at a glance all staff have a visual overview of the department's performance. In addition, the operational team reviews their patient satisfaction scores through NRC Picker and select key areas on which to focus their quality improvement

activities. Most recently they have chosen to focus on improving pain control for patients attending the emergency department.

Analysis and review of incident reports and adverse events are undertaken by the department manager.

As part of the transformational agenda, whiteboards are set up in all the departments to create opportunities for staff to contribute ideas for quality improvement. In the emergency department there was evidence of many suggestions and actions taken. Huddles occur weekly to review the progress made.

Priority Process: Organ and Tissue Donation

GBGH actively participates in the provincial Trillium Gift of Life organ and tissue donation program. The staff of the Emergency Department are aware of the program and work with the regional coordinator of the provincial program when there is an opportunity to speak with a family member about organ and/or tissue donation following the death of a loved one in the Emergency Department.

3.2.6 Standards Set: Infection Prevention and Control Standards - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Infection Prevention and Control		
2.2	The organization has one or more qualified IPC professionals as part of the IPC team.	
2.3	The organization has access to a qualified IPC physician to provide input to the IPC team.	
4.4	The organization has policies and procedures for loaned, shared, consigned, and leased medical devices.	!
4.8	The organization regularly updates IPC policies and procedures based on changes to the applicable regulations, evidence, and best practices.	!
7.7	The organization uses safety engineered devices for sharps.	!
Surveyor comments on the priority process(es)		
Priority Process: Infection Prevention and Control		

The Infection Prevention and Control staff have worked very hard on staff training on hand hygiene and personal protective equipment and should be commended for their good work. They have made great strides in infection prevention and control over the past year and should be supported in their endeavours.

It is recommended that they achieve certification as presently no one on the team is certified.

Infection prevention and control needs to supported by senior management.

3.2.7 Standards Set: Medication Management Standards - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Medication Management		
8.5	The organization manages alert fatigue by regularly evaluating the type of alerts required by the pharmacy computer system based on best practice information and input from staff and service providers.	
16.2	The organization maintains appropriate ventilation, temperature, and lighting in the medication preparation areas.	
21.2	Service providers provide clients and families with information on how to prevent medication errors.	!
Surveyor comments on the priority process(es)		
Priority Process: Medication Management		

Medication management at GBGH is an excellent program.

The antimicrobial stewardship program is exemplary.

The organization has developed standard order sets and should continue to expand these to include others, such as for glycemic control with insulin.

3.2.8 Standards Set: Medicine Services - Direct Service Provision

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			
7.6	With the involvement of the client, family, or caregiver (as appropriate), the team generates a Best Possible Medication History (BPMH) and uses it to reconcile client medications at transitions of care.		ROP
	7.6.1	Upon or prior to admission, the team generates and documents a Best Possible Medication History (BPMH), with the involvement of the client, family, or caregiver (and others, as appropriate).	**MAJOR**
	7.6.2	The team uses the BPMH to generate admission medication orders OR compares the Best Possible Medication History (BPMH) with current medication orders and identifies, resolves, and documents any medication discrepancies.	**MAJOR**
	7.6.3	A current medication list is retained in the client record.	**MAJOR**
	7.6.4	The prescriber uses the Best Possible Medication History (BPMH) and the current medication orders to generate transfer or discharge medication orders.	**MAJOR**
	7.6.5	The team provides the client, community-based health care provider, and community pharmacy (as appropriate) with a complete list of medications the client should be taking following discharge.	**MAJOR**
Priority Process: Decision Support			
The organization has met all criteria for this priority process.			
Priority Process: Impact on Outcomes			
15.4	The team informs and educates clients and families in writing and verbally about the client and family's role in promoting safety.		ROP
	15.4.2	The team provides written and verbal information to clients and families about their role in promoting safety.	**MAJOR**

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Medicine Services at GBGH is well aligned to meet the needs of the community.

Priority Process: Competency

Medicine Services staff function as a cohesive multidisciplinary team. Staff orientation and ongoing education are a priority focus for management and staff.

Priority Process: Episode of Care

The Medicine Services team provides high quality comprehensive care. From the day patients are admitted until their final day of discharge, the team is focused on patient-centred care.

However, the team does not generate a Best Possible Medication History or reconcile medications routinely as standard practice and they are strongly encouraged to do so.

Priority Process: Decision Support

The Medicine Services team maintain high-quality medical records and charting. As well, the team is focused on evidence-based care to ensure best practices.

Priority Process: Impact on Outcomes

The Medicine Services team is focused on quality and safety initiatives to improve patient-focused outcomes.

3.2.9 Standards Set: Obstetrics Services - Direct Service Provision

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			
9.6	With the involvement of the client, family, or caregiver (as appropriate), the team generates a Best Possible Medication History (BPMH) and uses it to reconcile client medications at transitions of care.		ROP
	9.6.1	Upon or prior to admission, the team generates and documents a Best Possible Medication History (BPMH), with the involvement of the client, family, or caregiver (and others, as appropriate).	**MAJOR**
	9.6.2	The team uses the BPMH to generate admission medication orders OR compares the Best Possible Medication History (BPMH) with current medication orders and identifies, resolves, and documents any medication discrepancies.	**MAJOR**
	9.6.4	The prescriber uses the Best Possible Medication History (BPMH) and the current medication orders to generate transfer or discharge medication orders.	**MAJOR**
	9.6.5	The team provides the client, community-based health care provider, and community pharmacy (as appropriate) with a complete list of medications the client should be taking following discharge.	**MAJOR**
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 obstetrical manager and staff have developed regional induction policies and procedures which are used throughout the region. They should be commended for this work. They also collaborate and meet with the regional facilities regarding obstetrical protocols. There is excellent communication between staff and management and weekly staff meetings are well attended.
Priority Process: Competency
The obstetrical department has an excellent education program and was able to demonstrate staff attendance and competency in all required aspects.
Priority Process: Episode of Care
All medical devices are reprocessed in the central medical device reprocessing department. No flash sterilization occurs on the obstetrical department. All clients use the 24-hour rooming in program with excellent support from the staff. The breastfeeding program is well supported and partnerships to provide support on leaving the facility are excellent. The surgical checklist is well-executed on this unit. The team work towards generating a Best Possible Medication History for reconciling medications at transitions of care.
Priority Process: Decision Support
The obstetrical staff educational program is excellent and staff have input into their program. The team shares client information and coordinates its flow among service providers, other teams, and other organizations.
Priority Process: Impact on Outcomes
They have an excellent obstetrical program that is patient focused and performed in a well laid out department. The team uses at least two client identifiers before providing any service or procedure.

3.2.10 Standards Set: Point-of-Care Testing - Direct Service Provision

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
Point-of-Care Testing is a quality program that is well aligned to meet the needs of the organization.

3.2.11 Standards Set: Rehabilitation Services - Direct Service Provision

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	
15.4 The team informs and educates clients and families in writing and verbally about the client and family's role in promoting safety. 15.4.2 The team provides written and verbal information to clients and families about their role in promoting safety.	ROP **MAJOR**
Surveyor comments on the priority process(es)	
Priority Process: Clinical Leadership	
Rehabilitation Services and Complex Continuing Care at GBGH are well aligned to meet the needs of the community.	
Priority Process: Competency	
Rehabilitation Services and Complex Continuing Care staff function as a cohesive multidisciplinary team. Staff orientation and ongoing education are a priority for management and staff. Management is encouraged to regularly review staff performance.	
Priority Process: Episode of Care	
The multidisciplinary Rehabilitation Services and Complex Continuing Care teams provide high quality comprehensive care. From the day patients are admitted until their final day of discharge, the team is strongly focused on patient-centred care.	

The Patient Passport is a tremendous asset with regard to discharge planning and should be shared as a best practice.

Priority Process: Decision Support

The Rehabilitation Services and Complex Continuing Care teams maintain high-quality medical records and charting. As well, the team is focused on evidence-based care to ensure best practices.

Priority Process: Impact on Outcomes

The Rehabilitation Services and Complex Continuing Care teams are focused on quality and safety initiatives to improve patient-focused outcomes.

3.2.12 Standards Set: Transfusion Services - Direct Service Provision

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
Transfusion Services is a high-quality program that is well aligned to meet the needs of the organization.

3.2.13 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	
18.1 Team members follow a dress code within the surgical suite.	!

Surveyor comments on the priority process(es)

There is excellent surgical layout and sterile storage.

Staff are very committed to patient safety. Information received at all transitional points was well executed and understood by the client.

The department should be commended on their process that stopped the use of flashing of medical devices for the past two years. It is recommended that the flash sterilizer be decommissioned and removed from the facility.

Patients expressed that they received excellent care, understood the teaching received and felt very informed.

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: March 1, 2015 to April 17, 2015**
- **Number of responses: 9**

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.	0	0	100	93
2	Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	0	0	100	96
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	94
5	We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decisionmaking.	0	0	100	93

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
6 Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	95
7 Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	97
8 Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	0	0	100	97
9 Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	0	0	100	94
10 Our governance processes make sure that everyone participates in decision-making.	0	0	100	95
11 Individual members are actively involved in policy-making and strategic planning.	0	0	100	90
12 The composition of our governing body contributes to high governance and leadership performance.	0	0	100	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	0	100	90
15 Working relationships among individual members and committees are positive.	0	0	100	97
16 We have a process to set bylaws and corporate policies.	0	0	100	96
17 Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	98
18 We formally evaluate our own performance on a regular basis.	0	0	100	83
19 We benchmark our performance against other similar organizations and/or national standards.	0	11	89	71
20 Contributions of individual members are reviewed regularly.	0	22	78	66

	% 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	0	100	79
22 There is a process for improving individual effectiveness when non-performance is an issue.	0	33	67	62
23 We regularly identify areas for improvement and engage in our own quality improvement activities.	0	11	89	79
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.	0	0	100	81
25 As individual members, we receive adequate feedback about our contribution to the governing body.	0	11	89	69
26 Our chair has clear roles and responsibilities and runs the governing body effectively.	0	0	100	96
27 We receive ongoing education on how to interpret information on quality and patient safety performance.	0	0	100	90
28 As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	96
29 As a governing body, we hear stories about clients that experienced harm during care.	0	0	100	88
30 The performance measures we track as a governing body give us a good understanding of organizational performance.	0	0	100	95
31 We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	0	0	100	91
32 We have explicit criteria to recruit and select new members.	0	0	100	87
33 Our renewal cycle is appropriately managed to ensure continuity on the governing body.	0	0	100	94

		% 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	0	100	93
35	Clear written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	95
36	We review our own structure, including size and subcommittee structure.	0	11	89	91
37	We have a process to elect or appoint our chair.	0	0	100	93

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2015 and agreed with the instrument items.

4.2 Canadian Patient Safety Culture Survey Tool: Community Based Version

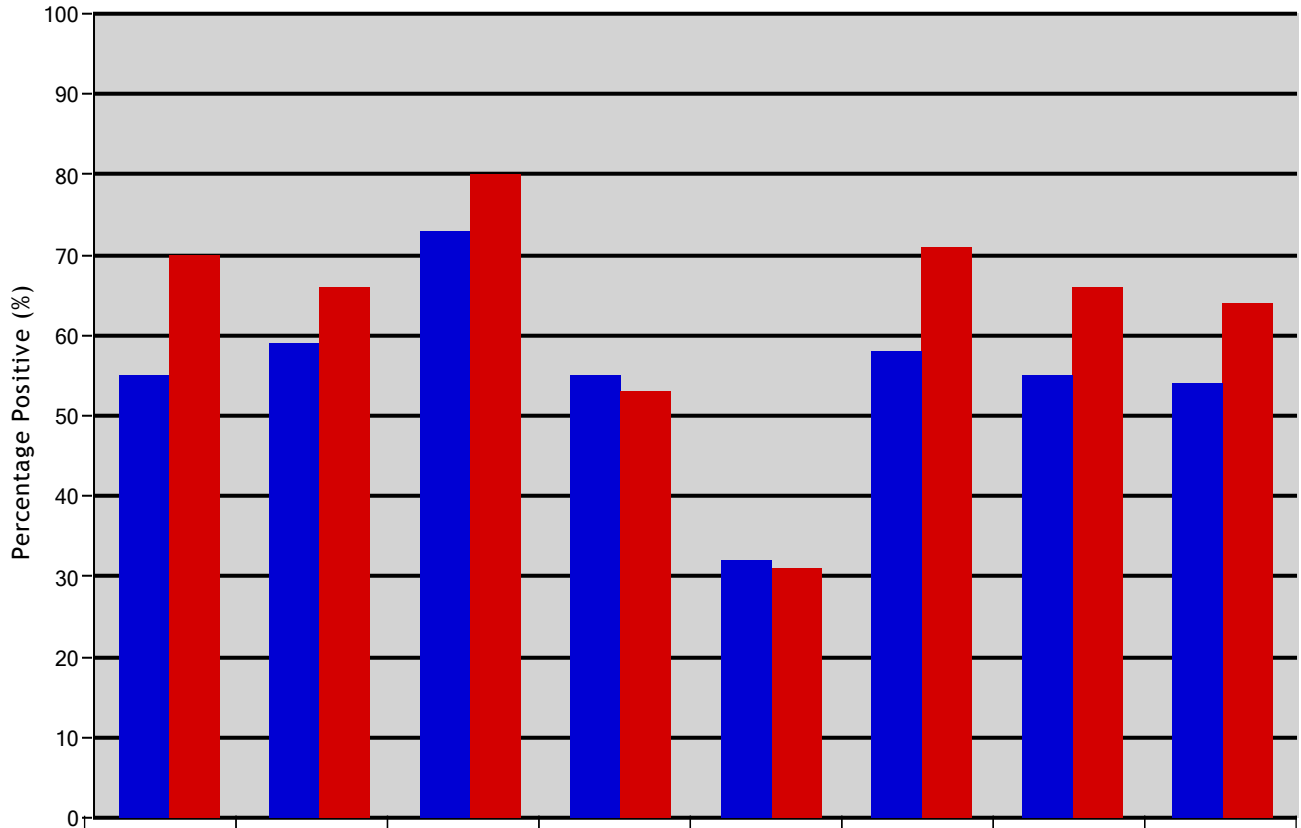
Organizational culture is widely recognized as a significant driver in changing behavior and expectations in order to increase safety within organizations. A key step in this process is the ability to measure the presence and degree of safety culture. This is why Accreditation Canada provides organizations 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: February 19, 2015 to April 17, 2015**
- **Minimum responses rate (based on the number of eligible employees): 158**
- **Number of responses: 169**

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
	55%	59%	73%	55%	32%	58%	55%	54%
	70%	66%	80%	53%	31%	71%	66%	64%

Legend

Georgian Bay General Hospital

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2015 and agreed with the instrument items.

4.3 Worklife Pulse

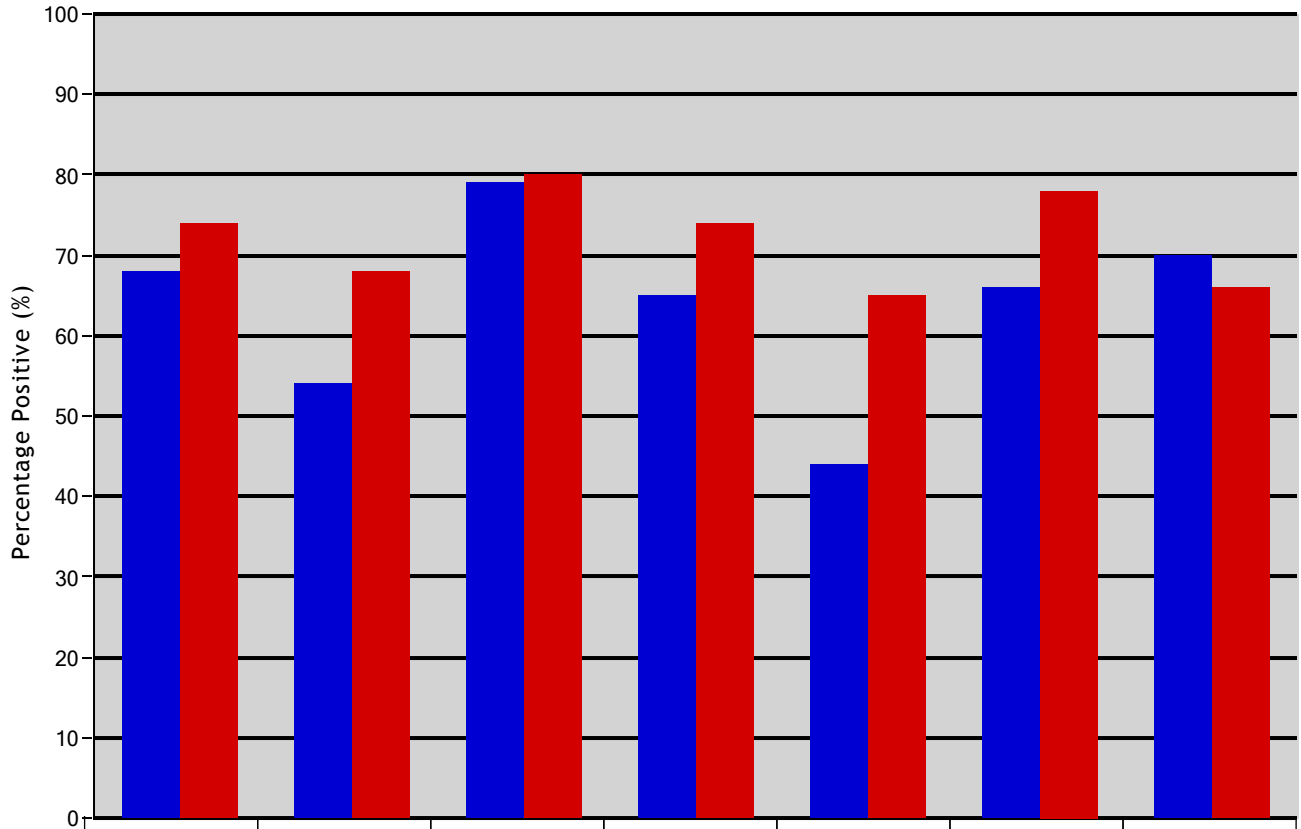
Accreditation Canada helps organizations create high quality workplaces that support workforce wellbeing and performance. This is why Accreditation Canada provides organizations with the Worklife Pulse Tool, an evidence-informed questionnaire that takes a snapshot of the quality of worklife.

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.

Accreditation Canada provided the organization with detailed results from its Worklife Pulse 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: February 19, 2015 to April 17, 2015**
- **Minimum responses rate (based on the number of eligible employees): 221**
- **Number of responses: 221**

Worklife Pulse: Results of Work Environment



	Job	Training and Development	Coworkers	Immediate Supervisor	Senior Management	Safety and Health	Overall Experience
	68%	54%	79%	65%	44%	66%	70%
	74%	68%	80%	74%	65%	78%	66%

Legend

Georgian Bay General Hospital

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2015 and agreed with the instrument items.

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