ACCREDITATION
AGRÉMENT
CANADA
Qmentum

Accreditation Report

Northumberland Hills Hospital

Cobourg, ON

On-site survey dates: March 5, 2017 - March 9, 2017

Report issued: March 23, 2017

About the Accreditation Report

Northumberland Hills 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 March 2017. 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

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,

Leslee Thompson
Chief Executive Officer

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Executive Summary

Northumberland Hills 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.

Accreditation Decision

Northumberland Hills Hospital's accreditation decision is:

Accredited (Report)

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

About the On-site Survey

- **On-site survey dates: March 5, 2017 to March 9, 2017**

- **Location**

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

  1. Northumberland Hills Hospital

- **Standards**

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

  System-Wide Standards

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

  Service Excellence Standards

  5. Ambulatory Care Services - Service Excellence Standards
  6. Biomedical Laboratory Services - Service Excellence Standards
  7. Critical Care - Service Excellence Standards
  8. Diagnostic Imaging Services - Service Excellence Standards
  9. Emergency Department - Service Excellence Standards
  10. Medicine Services - Service Excellence Standards
  11. Obstetrics Services - Service Excellence Standards
  12. Organ and Tissue Donation Standards for Deceased Donors - Service Excellence Standards
  13. Perioperative Services and Invasive Procedures - Service Excellence Standards
  14. Point-of-Care Testing - Service Excellence Standards
  15. Rehabilitation Services - Service Excellence Standards
  16. Reprocessing of Reusable Medical Devices - Service Excellence Standards
  17. Transfusion Services - Service Excellence Standards

- **Instruments**

  The organization administered:

  1. Canadian Patient Safety Culture Survey Tool
  2. Worklife Pulse
  3. Client Experience Tool

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)	49	1	0	50
Accessibility (Give me timely and equitable services)	86	0	0	86
Safety (Keep me safe)	612	5	13	630
Worklife (Take care of those who take care of me)	131	3	1	135
Client-centred Services (Partner with me and my family in our care)	356	2	0	358
Continuity (Coordinate my care across the continuum)	64	0	2	66
Appropriateness (Do the right thing to achieve the best results)	1032	7	6	1045
Efficiency (Make the best use of resources)	63	1	0	64
Total	**2393**	**19**	**22**	**2434**

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	50 (100.0%)	0 (0.0%)	0	36 (100.0%)	0 (0.0%)	0	86 (100.0%)	0 (0.0%)	0
Leadership	49 (98.0%)	1 (2.0%)	0	96 (100.0%)	0 (0.0%)	0	145 (99.3%)	1 (0.7%)	0
Infection Prevention and Control Standards	40 (100.0%)	0 (0.0%)	0	31 (100.0%)	0 (0.0%)	0	71 (100.0%)	0 (0.0%)	0
Medication Management Standards	73 (100.0%)	0 (0.0%)	5	62 (100.0%)	0 (0.0%)	2	135 (100.0%)	0 (0.0%)	7
Ambulatory Care Services	43 (97.7%)	1 (2.3%)	2	75 (96.2%)	3 (3.8%)	0	118 (96.7%)	4 (3.3%)	2
Biomedical Laboratory Services **	71 (100.0%)	0 (0.0%)	0	105 (100.0%)	0 (0.0%)	0	176 (100.0%)	0 (0.0%)	0
Critical Care	50 (100.0%)	0 (0.0%)	0	114 (99.1%)	1 (0.9%)	0	164 (99.4%)	1 (0.6%)	0
Diagnostic Imaging Services	66 (98.5%)	1 (1.5%)	0	69 (100.0%)	0 (0.0%)	0	135 (99.3%)	1 (0.7%)	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
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Emergency Department	68 (95.8%)	3 (4.2%)	0	104 (97.2%)	3 (2.8%)	0	172 (96.6%)	6 (3.4%)	0
Medicine Services	45 (100.0%)	0 (0.0%)	0	76 (98.7%)	1 (1.3%)	0	121 (99.2%)	1 (0.8%)	0
Obstetrics Services	73 (100.0%)	0 (0.0%)	0	88 (100.0%)	0 (0.0%)	0	161 (100.0%)	0 (0.0%)	0
Organ and Tissue Donation Standards for Deceased Donors	53 (100.0%)	0 (0.0%)	1	95 (99.0%)	1 (1.0%)	0	148 (99.3%)	1 (0.7%)	1
Perioperative Services and Invasive Procedures	114 (100.0%)	0 (0.0%)	1	108 (100.0%)	0 (0.0%)	1	222 (100.0%)	0 (0.0%)	2
Point-of-Care Testing **	38 (100.0%)	0 (0.0%)	0	46 (100.0%)	0 (0.0%)	2	84 (100.0%)	0 (0.0%)	2
Rehabilitation Services	45 (100.0%)	0 (0.0%)	0	80 (100.0%)	0 (0.0%)	0	125 (100.0%)	0 (0.0%)	0
Reprocessing of Reusable Medical Devices	85 (98.8%)	1 (1.2%)	2	40 (100.0%)	0 (0.0%)	0	125 (99.2%)	1 (0.8%)	2
Transfusion Services **	70 (100.0%)	0 (0.0%)	5	68 (100.0%)	0 (0.0%)	1	138 (100.0%)	0 (0.0%)	6
Total	**1033 (99.3%)**	7 (0.7%)	16	1293 (99.3%)	9 (0.7%)	6	2326 (99.3%)	16 (0.7%)	22

* 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).

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
Patient safety incident disclosure (Leadership)	Met	4 of 4	2 of 2
Patient safety incident management (Leadership)	Met	6 of 6	1 of 1
Patient safety quarterly reports (Leadership)	Met	1 of 1	2 of 2
Patient Safety Goal Area: Communication			
Client Identification (Ambulatory Care Services)	Met	1 of 1	0 of 0
Client Identification (Biomedical Laboratory Services)	Met	1 of 1	0 of 0
Client Identification (Critical Care)	Met	1 of 1	0 of 0
Client Identification (Diagnostic Imaging Services)	Met	1 of 1	0 of 0
Client Identification (Emergency Department)	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			
Client Identification (Medicine Services)	Unmet	0 of 1	0 of 0
Client Identification (Obstetrics Services)	Met	1 of 1	0 of 0
Client Identification (Perioperative Services and Invasive Procedures)	Met	1 of 1	0 of 0
Client Identification (Point-of-Care Testing)	Met	1 of 1	0 of 0
Client Identification (Rehabilitation Services)	Met	1 of 1	0 of 0
Client Identification (Transfusion Services)	Met	1 of 1	0 of 0
Information transfer at care transitions (Ambulatory Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Critical Care)	Met	4 of 4	1 of 1
Information transfer at care transitions (Emergency Department)	Unmet	2 of 4	0 of 1
Information transfer at care transitions (Medicine Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Obstetrics Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Perioperative Services and Invasive Procedures)	Met	4 of 4	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information transfer at care transitions (Rehabilitation Services)	Met	4 of 4	1 of 1
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)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Emergency Department)	Unmet	3 of 4	0 of 0
Medication reconciliation at care transitions (Medicine Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures)	Met	8 of 8	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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Safe Surgery Checklist (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
The "Do Not Use" list of abbreviations (Medication Management Standards)	Met	4 of 4	3 of 3
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	4 of 4	2 of 2
Infusion Pumps Training (Critical Care)	Met	4 of 4	2 of 2
Infusion Pumps Training (Emergency Department)	Met	4 of 4	2 of 2
Infusion Pumps Training (Medicine Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Obstetrics Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Perioperative Services and Invasive Procedures)	Met	4 of 4	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Infusion Pumps Training (Rehabilitation Services)	Met	4 of 4	2 of 2
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
Patient safety plan (Leadership)	Met	2 of 2	2 of 2
Patient 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 (Critical Care)	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)	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)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Rehabilitation Services)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Suicide Prevention (Emergency Department)	Met	5 of 5	0 of 0
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)	Met	3 of 3	2 of 2

Summary of Surveyor Team Observations

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

Northumberland Hills Hospital (NHH) is a beautiful facility with modern infrastructure, wide hallways and doorways, wheelchair accessible bathrooms, and adequate space for patient care and staff administration. Quiet areas and lounges can be found throughout the organization for use by patients, families, and staff.

NHH serves the catchment area of west Northumberland County comprising the town of Cobourg, the municipality of Port Hope, and the townships of Hamilton, Cramahe, and Alnwick Haldimand. The catchment area has a mixed urban and rural population of approximately 60,000 residents. NHH is within the Central East Local Health Integration Network (LHIN). It employs approximately 600 staff.

NHH is commended for its work on patient- and family-centred care. This has been a board and organizational strategic direction for over six years. In 2013, several staff members went to the Institute for Client- and Family-Centered Care in Michigan and participated in their program. The board and staff across the organization truly recognize that patients and families are essential allies for quality and safety—not only in direct care interactions, but also in quality improvement, safety initiatives, facility design, and policy development.

Since the last on-site survey, NHH underwent a coaching review in 2014–2015 and an external operational review led by the Hay Group in 2015–2016. The review findings concluded that NHH was an efficient hospital that was well managed and well governed, and no service or bed reductions were recommended. NHH has developed a hospital improvement plan (HIP) to help realize $5 million in efficiencies, with 60 percent coming from clinical and operational efficiencies (combining smaller units) and 40 percent coming from integration (moving microbiology services to a regional centre). The HIP includes 53 initiatives divided into five general areas: board and management, utilization of services, clinical efficiencies, operating efficiencies, and integration and partnerships.

The board of directors has committed members who wish to advance services at the hospital. There is a strong relationship between the board and the CEO, and the CEO and management group report regularly to the board. The board understands its role as a governing body and, in particular, is aware that oversight of patient safety, risk management, and quality improvement are fundamental roles of the governance. The board is proud of its efforts and those of the organization in driving quality for all decisions it takes.

A comprehensive set of board policies guides board operations. There are good processes for operational and capital planning. There are written processes to elect a chair and select new candidates based on specific skills. A mandatory board member orientation outlines expectations for new board members. The organization is commended on its ability to attract an abundance of potential candidates who are interested in filling vacancies on a consistent basis.

The survey team was impressed with the depth and breadth of information received by the governing body, both at the board and at the subcommittee levels. This allows for strong governance oversight and ongoing and regular scans as to the continued applicability of strategies being pursued by the organization.

Creating our Future Together was launched in November 2016 to obtain widespread input (over 500 touch points) to inform NHH's next strategic plan (2017–2020), scheduled for completion in April 2017. Proposed strategic objectives include safe quality care, great place to work and volunteer, collaborative community partnerships, and operational excellence. A review of NHH's mission and vision resulted in condensing both into one shared purpose, “Exceptional patient care. Every time.”

The organization has proactive and engaged teams with strong and present leadership. The commitment to ongoing education is commendable. There is a strong focus on developing leaders throughout the organization and at every level.

Since the last on-site survey, the organization has developed programs and initiatives to address quality improvement and advance patient safety in the hospital. A number of teams are working on these initiatives. This is commendable. All teams have quality improvement committees at the unit level. These committees are engaged, work collaboratively, and proactively address unit-specific and staff process improvements.

Ten participants took part in the community partner focus group, representing two of the other hospitals in the Central East LHIN as well as the Community Health Centre, Family Health Team, Community Care Access Centre (CCAC), and various community agencies and provider groups. The community partners, without exception, spoke very positively about their relationship with the organization. It is apparent the hospital has a very good reputation in the community as a place to receive good patient care. Community partners feel the organization is open, collaborative, seeks to reach mutually beneficial solutions that benefit the broader community, and has a good understanding of the needs of the community. They spoke highly of the programs developed by the hospital and various community agencies. Community partners appreciate being involved in the board’s new strategic planning process and find that their opinions are valued by the hospital.

The organization has a great deal to celebrate in the area of human capital, and should be proud of the efforts that have been made to recruit and retain staff. At the time of the on-site survey there were no reported vacancies. This is even more commendable after the past year, which senior leaders and managers described as challenging for staff due to the focus on the HIP and the resultant changes.

The commitment to ongoing education is commendable. There is a strong focus on developing leaders throughout the organization and at every level. In particular, the organization has implemented educational opportunities and subsidized tuition for most health care–related programs.

Workplace wellness strategies are in place. The organization’s commitment to a healthy work culture is commended. In addition, numerous reward and recognition initiatives have been implemented.

The hybrid chart, with both paper-based and computerized elements, made it labour intensive and time consuming to confirm completeness. The organization recognizes this as an issue and is awaiting decisions

made at a higher level. The hybrid chart greatly increases risk as the possibility of missing important information increases when charting is done in two locations and is inconsistent between clinicians. While it waits for recommendations on new information technologies, the organization is encouraged to assess its available systems to determine if there is a way to improve consistency with existing technology.

Detailed Required Organizational Practices

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	
Information transfer at care transitions Information relevant to the care of the client is communicated effectively during care transitions.	· Emergency Department 12.16
Client Identification Working in partnership with clients and families, at least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them.	· Medicine Services 9.2
Medication reconciliation at care transitions Medication reconciliation is initiated in partnership with clients, families, or caregivers for clients with a decision to admit and for 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).	· Emergency Department 10.5

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

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.

Priority Process: Governance

Meeting the demands for excellence in governance practice.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

There is a strong relationship between the board and the CEO. The CEO and management group report regularly to the board. The board understands its role as a governing body and, in particular, is aware that oversight for patient safety, risk management, and quality improvement are fundamental roles of governance. The board is proud of its efforts and those of the organization to drive quality in all decisions taken.

A comprehensive set of board policies guides the operation of the board. There are good processes for operational and capital planning. There are written processes to elect a chair and select new board candidates based on specific skills needed. A mandatory board member orientation outlines expectations for new board members. The organization is commended on its ability to attract an abundance of potential candidates who are interested in filling vacancies on a consistent basis.

The board uses a number of resources when faced with ethical or difficult decisions, including the ethical framework, the code of business ethics, the bylaws, and the organization's values.

The Quality and Safety Committee of the board meets monthly and reviews the scorecard and quality improvement plan indicators, critical incidents if applicable, and compliments and complaints. Trends are tracked and variances are noted and questioned by the board.

The on-site survey team was impressed with the depth and breadth of information received by the governing body, at both the board and the subcommittee levels. This allows for strong governance oversight and ongoing and regular scans as to the continued applicability of strategies being pursued by the organization.

The board regularly discusses the patient experience and has started to invite patients to its meetings so they can hear their stories “through the patients’ eyes.”

The board has recently reviewed the mission, vision, and values in preparation for the new three-year strategic plan (2017–2020). This is the end result of widespread stakeholder input, a process called Creating Our Future Together. The draft plan has four proposed strategic objectives: safe quality care, great place to work and volunteer, collaborative community partnerships, and operational excellence.

Half of the Governance Functioning Tool respondents identified that there could be better feedback provided to board members about their individual contributions to the governing body. The board is encouraged to develop and implement a process to address this concern.

Priority Process: Planning and Service Design

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

NHH is commended for its work on patient- and family-centred care. This has been a board and organizational strategic direction for over six years. In 2013, several staff members went to the Institute for Client- and Family-Centered Care in Michigan and participated in their program. Staff across the organization truly recognize that patients and families are essential allies for quality and safety—not only in direct care interactions, but also in quality improvement, safety initiatives, facility design, and policy development.

Five of the seven patient and family advisers attended the focus group and spoke positively as to how they were welcomed by the quality and leadership committees of which they are a part.

The community partners relayed that NHH has a stellar reputation within and surrounding its catchment area. The hospital collaborated with several of the partners to successfully advance its 2010–2016 strategic direction of Patients First: Care Closer to Home. Strategic and operational priorities (2010–2016) are supported by key performance indicators that are used throughout the organization to ensure the expectations of the plan are met.

Creating our Future Together was launched in November 2016 to obtain widespread input (over 500 touch points) to inform NHH's next strategic plan (2017–2020), scheduled for completion in April 2017. Proposed strategic objectives include safe quality care, great place to work and volunteer, collaborative community partnerships, and operational excellence. A review of NHH's mission and vision resulted in condensing both into one shared purpose, “Exceptional patient care. Every time.”

Close alignment with the LHIN ensures the organization’s programs and plans reflect the demographic make-up of the population served.

Priority Process: Resource Management

Monitoring, administering, and integrating activities related to the allocation and use of resources.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The use of financial staff to act as controllers and conduits for each of the clinical programs is favourably noted. This allows for better program engagement in the financial process and supports the fiscal education of the front-line managers and supervisors.

The relationships among the board and its Finance Committee, the CEO, and financial management services is open and supportive. This was confirmed in discussion with the board. They feel they have enough information to provide due diligence and yet do not cross the line into micromanagement. The financial staff regularly ask the board if more or less information is needed, and, along with the formal materials, make themselves available to discuss issues and add to the financial discussion.

There is a detailed process to set a capital budget. A number of criteria are considered including the impact on risk, safety needs, and replacement or new when setting a prioritized list of capital items. The list is finalized by a committee composed of various clinical leaders in the organization.

The relationship with the LHIN has generally been positive. In addition, the organization works with the community and other LHIN hospitals to explore cost savings and new approaches to generating income.

Despite investing in a coaching review (2014–2015) and external operational review (2015–2016), balancing the budget continues to be a challenge. Results of these reviews demonstrated that there were opportunities for some efficiencies, but even with the efficiencies realized, there would still be a need for increased base funding to sustain the organization. The hospital is encouraged to work with the LHIN to resolve the ongoing financial pressures.

Priority Process: Human Capital

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
10.15 Human resource records are stored in a manner that protects individual privacy and meets applicable regulations.	!

Surveyor comments on the priority process(es)

The organization has a great deal to celebrate in the area of human capital. It should be proud of its efforts to recruit and retain staff. At the time of the on-site survey, there were no reported vacancies. This is even more commendable after the past year, which senior leaders and managers described as challenging for staff due to the focus on the HIP and the resultant changes. For example, two smaller units were combined into one, resulting in a change in staffing (replacing registered nurses with registered practical nurses) and disbanding the float pool.

The commitment to ongoing education is commendable. There is a strong focus on developing leaders throughout the organization and at every level. In particular, the organization has implemented educational opportunities and subsidizes tuition for most health care–related programs.

Workplace wellness strategies are in place. Each year the Joint Occupational Health and Safety Committee develops a calendar of events to promote personal, environmental, and work-life health. In addition, a smoking cessation program, yoga, Weight Watchers, and massage therapy are available on site.

The commitment to a healthy work culture is commended. In addition, the organization participates in the late career nursing strategy, the nursing graduate guarantee, and innovative scheduling options to help retain staff.

The hospital has implemented the Communicate with Heart program to improve staff communication and customer service. Currently a quarter of the staff has taken part in the program. There is a plan to extend the program to all staff.

The Joint Occupational Health and Safety Committee is involved in educating staff and managers in health and safety programs throughout the year. In addition, they are members of the Ontario Hospital Association/Workplace Safety and Insurance Board (OHA/WSIB) safety group.

The focus on safety includes patients and staff. There is training related to violence and harassment in the workplace, safe lifting, transfer techniques, and other topics. Professional Practice oversees education requirements for clinical staff.

The organization has undergone the NRC Picker employee and physician survey and has committed to developing action plans for all areas of concern noted in the results.

A comprehensive succession plan has been developed. All senior leadership and middle management positions have been identified as key positions in the succession plan.

Numerous reward and recognition programs are in place and are well received by staff and physicians.

Human resource records (employee files) were noted to be kept in a unsecured storage shed where they would be accessible to others. It is suggested these records be stored in a restricted access area.

Although there are many human resources strategies for staff, there is no overarching formal human resources plan for the medical staff. The development of a formal plan is encouraged to guide medical human resources planning for the future growth of rehabilitative services.

There is an online performance appraisal process. However, this is not done consistently throughout the organization, as noted by a 55 percent completion rate.

Priority Process: Integrated Quality Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization has focused a lot of attention to quality improvement across all programs and services. The patient safety plan is part and parcel of the overall quality plan. In addition, there are quality representatives in every department who champion the quality aspect of all processes and services.

There is extensive safety education, done at least annually.

The comprehensive enterprise risk management plan is reviewed annually. There is clearly a blame-free culture and the organization has seen an increase in incident reporting, stemming from the focus on risk minimization.

Safety is a key strategic priority and there is an ongoing assessment of patient safety across the organization. Since the last on-site survey, falls prevention strategies have been put in place in all programs and services. Of note, there is a comprehensive post-fall policy and practice. In addition, the Safe Mobility Committee is tasked with identifying opportunities and making recommendations to reduce falls and falls injury prevention, which is commendable.

Foundational to the organization's commitment to integrated quality management has been the creation of the Patient and Family Advisory Council that has been instrumental in developing the framework for patient- and family-centred care.

A failure modes and effect analysis (FMEA) is conducted on any high risk or highly vulnerable process introduced in the hospital. Since the last on-site survey FMEAs have been completed on the purchase of cardiac monitors and fetal monitors as well as value stream analysis for the consolidation of 2A and 2B nursing units, the emergency department workflow, the 90-minute turnaround time for bed occupancy, and the in-patient rehabilitation admission process.

Also since the last on-site survey, the organization administered the Canadian Patient Safety Culture Survey Tool and 15 yellow flags and four red flags were identified. Survey results have been shared with staff, physicians, the quality and safety committees, and the board. Themes have been identified and an action plan developed to address them. There is a plan to re-survey staff in the spring of 2017.

The organization's performance monitoring system is very strong. Key performance indicators have been developed for all operational strategies and initiatives and these are regularly reviewed and monitored by key players. The governing body receives regular reports on all indicators through the various subcommittees of the board, with roll-up reports shared with the full board.

Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

An ethics framework is in place and many ethics resources available for staff and patients. An ethics tab on the intranet contains educational material and resources for staff and volunteers.

Research ethics approval from other facilities (e.g., University of Ontario Institute of Technology and University of Toronto) is acceptable at NHH.

Values ambassadors have been identified among staff and values definitions have been developed with input from staff, volunteers, and patients.

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)
NHH has a very informative website that is being revised to make it even more user friendly with large fonts, buttons for frequently asked questions, and reader-friendly fonts and backgrounds. Patient care materials are also being converted to standard formats with large fonts and easy-to-read language. Data are collected by the one-person data analysis department and disseminated on a regular basis to managers, committees, and staff. Privacy of information is protected according to standard. NHH has an arrangement with Queen's University to access its library resources for evidence-based research. Dynamed Plus and Clinical Key (Mosby) electronic tools are available so all staff can access evidence-based research. Two full-time professional practice nurses assist the manager and chief nursing executive whose portfolios include professional practice leadership. NHH also uses Registered Nurses' Association of Ontario best practice guidelines.

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)

NHH is a beautiful facility with modern infrastructure, wide hallways and doorways, wheelchair accessible bathrooms, and adequate space for patient care and staff administration. Quiet areas and lounges can be found throughout the organization for use by patients, families, and staff.

Maintenance, food services, and housekeeping enjoy large clean areas in which to work and store required equipment. Storage areas are clean and well lit and provide ample space for their purpose.

Recycling bins are found throughout the organization. Continuing to educate patients, families, and staff on recycling and using signs that encourage appropriate use of bins may increase recycling rates.

In the perioperative area, oxygen and carbon dioxide tanks are housed together in a wooden frame. Consideration may be given to storing these tanks separately to prevent potential confusion. The wooden crates are also challenging to clean and alternate material may be considered to prevent the spread of infection.

Large canisters in the storage room were found to be unchained and free standing (two of the five groups of canisters). Ensuring staff are trained and including signs to remind staff of the importance of securing canisters may be considered.

Storage of files awaiting destruction needs to be reviewed to confirm they are secured appropriately. In the back of the housekeeping clean storage area, diagnostic imaging films and reports awaiting disposal are held in unlocked cabinets. The storage garage behind the hospital also holds paper files that include personal information and these need to be secured.

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)

NHH is a member of the Emergency Information Committee with local and regional partners. The organization has participated in high-level tabletop exercises with its community partners to strive for a coordinated and effective response to a disaster.

The organization is well designed physically to support critical incidents in the community. The large ambulance bay provides a closed and sheltered area outside the building if required for triage or decontamination. There is an entrance directly into an emergency room from this bay which has showers and a separate drainage system. This closed decontamination area was built with a local industry partner.

The facility has adequate storage for pandemic supplies. These are rotated with regularly stocked items to prevent expiration and waste of stored items. Other supplies required for specific codes are labelled and stocked appropriately.

In future reviews of the emergency response plan, the team may consider including pictures on the supply carts and bins to show how to don personal protective equipment, how to set up the tent (pictures with written instructions in a step-by-step manner), and how to set up signs and lay out a triage area so individuals can visualize the proper set up. As well, providing a site map of the hospital with colour-coded areas for triage, red/yellow/green patients, families, media, headquarters, and communications so people can see at a glance where things are located may help ensure people go to the correct area.

Different codes are exercised on a rotation throughout the year with after-action reports completed to facilitate discussion on potential areas of improvement and modifications to the plan.

Priority Process: Patient Flow

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Patient flow has been a challenge in the past few years. The newly combined inpatient medical surgical unit has been functioning over capacity since 2015. A patient flow manager sends twice daily updates on bed occupancy and pending admissions.

Changes have been made to the time to have patients return the next day for a CT and a mental health crisis worker role has been implemented in the emergency department.

An assess and restore intervention pilot was approved for NHH and implemented in 2016. This included a nurse practitioner lead and the implementation of a geriatric emergency management nurse role in the emergency department. The program was assessed to have saved NHH $1.7 million as of fall 2016.

Quality improvement projects to expedite admissions from the emergency department to an inpatient bed have been implemented, with a target of 90 minutes. Further examination of the process may eliminate even more steps, such as having housekeeping personnel call directly to the emergency department when the bed is clean.

Post-discharge appointments with a primary care provider are now made by the Family Health Team after a fax from the hospital.

Electronic bed boards assist with discharge planning and some physicians are writing an expected date of discharge on the order sheet in the chart.

A high number of alternate level of care patients, particularly in the assess and restore unit, are a barrier to patient flow. These are almost directly attributable to a lack of long-term care beds. NHH continues to lobby for access to more long-term care beds.

Priority Process: Medical Devices and Equipment

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

Unmet Criteria		High Priority Criteria
Standards Set: Diagnostic Imaging Services		
8.7	All diagnostic imaging reprocessing areas are equipped with separate clean and decontamination work areas as well as separate clean storage, dedicated plumbing and drains, and proper air ventilation and humidity levels.	!
Standards Set: Reprocessing of Reusable Medical Devices		
3.4	The MDR department has an area for decontamination that is physically separate from other reprocessing areas and the rest of the facility.	!

Surveyor comments on the priority process(es)

In general, the medical devices reprocessing department (MDRD) is well designed, spacious, and provides for excellent separation of clean and dirty.

However, soiled/used endoscopes are brought into and cleaned in the decontamination room by dedicated staff in a dedicated sink and counter space. The scopes are then placed in a clean bin and passed through a portal to the clean side and from there returned to the operating room. Vaginal ultrasound probes from diagnostic imaging are similarly processed in the decontamination room and returned from that room in dedicated clean containers which are stored in the decontamination room, following the same route as the scopes through the clean side. These two processes raise questions about the separation of clean and dirty in the department.

NHH strives to provide optimal standards for scope cleaning by calling in MDRD staff when after-hours endoscopy is required, to maintain standards for scope cleaning.

Future plans for the MDRD could include consideration of an electronic instrument tracking system with electronic guides for compiling trays and sets.

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:

Clinical Leadership

- Providing leadership and direction to teams providing services.

Competency

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

Episode of Care

- Partnering with clients and families to provide client-centred services throughout the health care encounter.

Decision Support

- Maintaining efficient, secure information systems to support effective service delivery.

Impact on Outcomes

- Using evidence and quality improvement measures to evaluate and improve safety and quality of services.

Medication Management

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

Organ and Tissue Donation

- Providing organ and/or tissue donation services, from identifying and managing potential donors to recovery.

Infection Prevention and Control

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

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

Point-of-care Testing Services

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

Transfusion Services

- Transfusion Services

Standards Set: Ambulatory Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.3	Service-specific goals and objectives are developed, with input from clients and families.	
1.4	Services are reviewed and monitored for appropriateness, with input from clients and families.	
Priority Process: Competency		
3.10	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
Priority Process: Episode of Care		
6.6	The length of time clients wait for services beyond the time the appointment was scheduled to begin is monitored and work is done to reduce that time as much as possible.	
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
Mental health care, chemotherapy, dialysis, and 16 other ambulatory care clinics are offered on an outpatient basis through partnerships with regional centres and nearby specialists. The leadership team collects information about the clients and communities that are served by the ambulatory care services. Services and programs are planned and implemented bearing in mind the work done at other organizations.

It is noted favourably that clients and families are part of the quality councils for many areas in the hospital, however, in Ambulatory Care, client and families are represented on a regional/program basis and not reflected specifically at the local level.

The organization has been proactive in seeking client, family, and community involvement in quality and strategic direction. As the program matures, expanding involvement to include the development of goals and objectives and review and monitoring of services may be considered.

Priority Process: Competency

The ambulatory team is a high-functioning interdisciplinary team that is committed to doing its best for the clients. The team provides client-centred care and develops comprehensive goals with the client.

Clients describe staff as professional and skilled at what they do.

The team uses many providers to deliver care using an interdisciplinary approach. The team functions well and shares information well among team members.

There are good processes to ensure each care/service provider has the appropriate license or credential from the relevant college or association, and these processes are ongoing.

Clear staff roles and responsibilities are in place, as is orientation. There is support for training and continuing education.

Staff performance appraisals have not been consistently performed every two years.

Priority Process: Episode of Care

The team provides information to the population it serves on its services and how to access them, as well as on how to access services after hours.

The medical assessment includes medication, social history, and the social determinants of health. This assessment is used as the basis for the physical exam and diagnostic testing.

Medication reconciliation is performed and standardized processes are followed for medication orders. Accurate allergy information is maintained. Abnormal lab tests are followed up.

Clients with complex needs have care plans developed, with their input. A summary of care provided is recorded in the client file.

Goals and objectives are developed from client and family input that is either formally or informally sent to the clinical team of nurses, ward clerks, and management. The regional cancer program and dialysis are satellite clinics with HUB hospitals and goals and objectives for these clinics are made at the regional level.

It was noted that several clients were waiting in excess of 75 to 90 minutes for their appointments with the oncologist. The organization is encouraged to review the process, with input from clients and families, as to how better serve clients during chemotherapy.

Priority Process: Decision Support

Records are accurate, up to date, and secure. Appropriate information is shared with staff and other organizations.

The team is provided with access to research-based evidence and best practice information. Staff explained how they use evidence and data in clinical decision making. Processes have been developed to communicate evidence-based guidelines, research, and best practice information with the team and with clients.

Priority Process: Impact on Outcomes

The team has a good focus on safety and does good, solid work.

Staff consistently followed the two-client identifier policy when doing medication administration and other activities where it is important to ensure the procedure or treatment is client specific.

The team completes a comprehensive review when adverse events occur.

Individual teams were able to provide many examples of quality improvement activities that they completed and were implementing.

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

The biomedical laboratory service is clean and uncluttered. The department has adequate space and is well laid out to facilitate flow. Equipment is modern and well maintained as per manufacturer requirements.

Information is collected on the types of tests performed and the team analyzes trends to monitor laboratory use.

When the microbiology laboratory was closed a year ago, the decision was supported by the business model and community partners and clinicians were involved to ensure the hospital would still be able to support their needs. The team is following appropriate processes as they continue to dispose of microbiology equipment that is no longer required.

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	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
6.1 Standardized criteria are used to determine whether potential clients require critical care services.	
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 intensive care unit (ICU) contains six beds in private rooms. All rooms are well lit and are an appropriate size for providing patient care. Staff have adequate desk space, chairs, and terminals for members of the interdisciplinary team. The ICU is appropriately stocked with required equipment.

The organization has been proactive in seeking patient, family, and community involvement in quality and strategic directions. As the program matures, expanding involvement to include the development of goals and objectives and a review and monitoring of services may be considered.

The organization has a code blue team and a critical care support team (CCST). The CCST is relatively new and is still in the evaluation process. Initial assessments and feedback have been positive. Education on the inpatient wards is ongoing to ensure staff are aware of the service and are familiar with the criteria and how to activate the team. Identifying appropriate team members is also in progress, ensuring that individuals have the right mix of skills and credentials. As the CCST matures, a growing depth in those who are qualified will help assure the team's availability. Monitoring the types and number of calls and

potentially correlating early intervention with decreased intensive care admissions, decreased morbidity and mortality, and shorter length of stay will also be important to substantiate the program.

Priority Process: Competency

Required training and credentialing are defined and documented for team members. Much of this documentation is paper based and department specific. As many staff work in multiple areas, it is suggested that tracking and documenting training and credentialing be computerized and centralized to facilitate tracking and identify gaps.

While the organization has done a good job communicating information about the ethical framework and raising awareness, it is encouraged to take the opportunity to improve front-line understanding of and involvement with ethics. Pertinent case studies or hypothetical situations presented during committees or discussed during staff huddles might be used to help make ethics more real to individual staff members. The case studies would need to be pertinent to the target audience (e.g., finance, governance, patient care, housekeeping, records).

Priority Process: Episode of Care

There is a code blue team with designated staff from intensive care, medicine, and the emergency department.

A code blue was observed during the on-site survey and the team worked well together in a calm and professional manner. There was a designated lead and defined roles but also flexibility to adjust as new staff arrived and the clinical situation changed. Communication from the lead and team members was clear. Input was sought by the lead as the code progressed to confirm all members had an opportunity to contribute regarding potential additional interventions.

The critical care support team (CCST) is a new team being trialed in the organization to provide additional specialized resources to patients who require additional medical assistance and prevent a code blue.

Developing and following standardized criteria to determine whether critical care services are required is key to supporting admission and discharge decisions.

Priority Process: Decision Support

The critical care team uses a combination of paper-based and electronic charting to document the patient's journey and clinical decisions made. To mitigate risk, the organization is encouraged to conduct ongoing monitoring to ensure this information is complete and legible

Priority Process: Impact on Outcomes

NHH has included patients and their families in its decision-making and review processes for several years. More recently, the organization has expanded patient and family involvement through the Patient

and Family Advisory Council and the Quality and Practice Committee. Although this program is relatively new, it is active and has been well received by families and patients as well as clinicians and the leadership team.

Priority Process: Organ and Tissue Donation

Northumberland Hills Hospital has a strong relationship with the Trillium Gift of Life Network that facilitates organ donation.

Standards Set: Diagnostic Imaging Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Diagnostic Services: Imaging	

The organization has met all criteria for this priority process.

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

The diagnostic imaging department is a beautiful department with modern infrastructure, wide hallways and doorways, wheelchair accessible bathrooms, and adequate space for patient care and staff administration.

NHH offers a full range of diagnostic services, including magnetic resonance imaging, computed tomography (CT) mammography, and bone density testing. Of particular note, the mammography imaging services were granted a three-year accreditation award (2016–2019) by the Canadian Association of Radiologists.

All diagnostic imaging sections have standardized procedures, relatively new equipment with preventive maintenance and quality assurance programs in full compliance with standards, and qualified staff with adequate training and current licensing with their professional bodies.

Various scorecard indicators such as repeat/reject rate, patient falls, wait times, and turnaround times are tracked and trended monthly.

Patient flow is good with emergency department patients and inpatients being accommodated quickly. The picture archiving and communication system (PAC) has enhanced the flow of information and the speed with which reports are read and made available to the referring physician.

Care providers and consumers of the diagnostic imaging services who were interviewed were very satisfied with the services they provided or received.

Quality assurance is done daily, monthly (including image quality and repeat/reject assessments), and biannually as per best practice. The radiologists undertake quality assessment rounds for peer review evaluation with the endpoints being to identify opportunities to implement system changes to reduce error, improve accuracy, and improve service and communication in the department and with referring physicians.

Of particular note, the team has been working on dose reduction protocols for CT.

In addition, the radiologists participate in prospective quality assurance where approximately every thirtieth case is automatically sent to another member of the radiology team for review.

Staff feel that the hospital's response to their requests for hospital-sponsored professional development has greatly improved over the last few years.

Since the last on-site survey, the diagnostic imaging department has developed and implemented a falls prevention strategy, which includes conducting a falls risk assessment of all diagnostic imaging patients at registration. Patients identified as being at high risk for a fall have a hospital armband with a purple sticker placed on their wrist.

Patient identification and procedural pause was favourably noted.

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			
4.14	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.		!
4.16	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.		!
Priority Process: Episode of Care			
9.11	Clients and families are provided with opportunities to be engaged in research activities that may be appropriate to their care.		
10.2	The assessment process is designed with input from clients and families.		
10.5	Medication reconciliation is initiated in partnership with clients, families, or caregivers for clients with a decision to admit and for 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
	10.5.4	For non-admitted clients in the target group, medication changes are communicated to the primary health care provider.	**MAJOR**
12.7	Treatment protocols are consistently followed to provide the same standard of care in all settings to all clients.		!
12.16	Information relevant to the care of the client is communicated effectively during care transitions.		ROP
	12.16.2	Documentation tools and communication strategies are used to standardize information transfer at care transitions.	**MAJOR**
	12.16.4	Information shared at care transitions is documented.	**MAJOR**

12.16.5	The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	**MINOR**

Priority Process: Decision Support

The organization has met all criteria for this priority process.

Priority Process: Impact on Outcomes

18.5	Ambulance offload response times are measured and used to set target times for clients brought to the emergency department by EMS.	

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

Northumberland Hills Hospital has been proactive for several years in engaging the community and including patients and their families in decision-making processes. The newly created Patient and Family Advisory Council is the latest iteration of this evolution and the emergency team is encouraged to engage with the council in future review of services.

The emergency team has been through staffing challenges recently that impacted morale and function of the department. The hospital leadership and the emergency team did an excellent job of tracking data, identifying elevated patient risk markers, and using the information to successfully reinstate staff.

Priority Process: Competency

The emergency department effectively employed department use data to determine staffing allocations and scheduling when the opportunity to increase staff became available. The organization is encouraged to continue to monitor trends so as to adjust should usage patterns change and to support staffing models.

Required training and credentialing are defined and documented for team members. Much of this documentation is paper based and department specific. As many staff work in multiple areas, it is suggested that tracking and documenting training and credentialing be computerized and centralized to facilitate tracking and identify gaps.

Priority Process: Episode of Care

The emergency department is well marked and has a sheltered ambulance bay with doors to keep out the elements. The department is clean and bright with adequate space for staff, patients, and families. The organization is fortunate to have adequate bed space and patient flow processes to minimize the need for patients to be held in corridors.

Treatment protocols for common and high acuity conditions have been implemented and are being used more frequently as clinicians become accustomed to their availability. Continuing to educate clinicians on the protocols and the evidence supporting their use and ensuring the protocols are readily available will increase compliance and consistency in use.

Priority Process: Decision Support

The emergency department continues to use a paper-based charting system that does not integrate with the charting system of the rest of the hospital. Legibility is an ongoing issue with communications in the department, at transition points, and for external clinics.

Gaps in technology specifically related to differing charting practices between the emergency and other departments is recognized. It is understood that leadership wants to delay decisions on new technology until decisions on potential integrated systems are made but, depending on the timelines, the organization may need to develop new policies or expand the use of existing technology to prevent miscommunication due to medical information being recorded in two separate areas.

Priority Process: Impact on Outcomes

NHH has included patients and their families in its decision-making and review processes for several years. More recently, the organization has expanded patient and family involvement through the Patient and Family Advisory Council and the Quality and Practice Committee. Although this program is relatively new, it is active and has been well received by families and patients as well as clinicians and the leadership team.

Priority Process: Organ and Tissue Donation

NHH has a strong relationship with the Trillium Gift of Life Network that facilitates organ donation.

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

Unmet Criteria	High Priority Criteria
Priority Process: Infection Prevention and Control	

The organization has met all criteria for this priority process.

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

The infection prevention and control (IPAC) team consists of 1.0 FTE of IPAC practitioner provided by three or more people who are all qualified or working on qualifications in infection control.

An infectious diseases physician is available via Lakeridge Health in Oshawa for consult on IPAC and antimicrobial stewardship questions.

A unique order set with empiric antibiotic therapy and alternate regimens was developed by the Antimicrobial Stewardship Committee. This is provided to the emergency department for use as a prescription with a view to standardize and reduce the use of a variety of antibiotics.

NHH reports that it has not experienced an outbreak since 2013. Hand-hygiene education is provided via an electronic learning module and auditing is done on a regular basis which demonstrates compliance by area and by discipline. The chief of staff personally addresses physicians who are reported as non-compliant with hand hygiene.

The IPAC team reports that they are not usually involved with the MDRD. The team is encouraged to consider becoming familiar with processes in that department to understand and assist with any questions that may arise.

Standards Set: Medication Management Standards - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Medication Management	

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)
Priority Process: Medication Management

Northumberland Hills Hospital demonstrates an interdisciplinary approach throughout the organization. Specific to medication management, the Pharmacy and Therapeutics (P&T) and Antimicrobial Stewardship Committees include representatives from a variety of areas and disciplines.

The pharmaceutical team is energetic and their enthusiasm for medication management and implementing best practice is apparent in the department's recent initiatives. The focus on clinical practice and being on the front lines of the hospital is apparent in every department.

The pharmacy team and the organization as a whole will need to remain vigilant as new programs are implemented, to assess whether they are having the desired effect and whether further improvements are needed. As many of the initiatives are relatively new, the organization is encouraged to monitor and review new processes and policies to confirm they are being used and are having the desired impact on quality, patient safety, and risk management. The pharmacy team and the interdisciplinary teams that support their efforts (P&T, antimicrobial stewardship) have done a great job in establishing new programs and they are encouraged to maintain their momentum.

The decentralization of the pharmacy team to place staff on the front clinical lines has been positively received and seems to have had a positive impact on patient care through direct consultation with patients and improved discussion and collaboration with physicians, nurses, physiotherapists, and other team members.

Standardized order sets for common admission diagnoses have been developed and implemented. The organization is encouraged to continue to educate team members on the availability and use of these sets to increase compliance and standardization of care.

The chemotherapy transportation training module is comprehensive, easy to understand, and well laid out, with clear pictures and narrative. Successful completion of the test and sign off from the supervisor effectively closes the loop to ensure transporting staff have the knowledge needed to decrease risk.

The best possible medication history (BPMH) is well done. As a paper-based system, it is labour intensive and there is duplication of effort (a significant amount of which would be eliminated with a computerized order entry system), but the pharmacy technicians and clinical pharmacists are consistently completing the forms in an accurate and timely manner. This paper-based system inherently increases the potential of error due to transcription and legibility. The organization is aware of these challenges and is evaluating options to mitigate this risk through the purchase of new technology. The paper BPMH form currently in use provides the required information but consideration may be given to expanding the dosage box to provide adequate room to write dosages.

Standards Set: Medicine Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
2.1 Resource requirements and gaps are identified and communicated to the organization's leaders.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
9.2 Working in partnership with clients and families, at least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them.	ROP
9.2.1 At least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them, in partnership with clients and families.	**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 medicine department has recently combined two smaller units to form a new medical-surgical ward which created staffing efficiencies between the two departments. Managing this change and staff expectations was a large undertaking that seems to have been well communicated and accepted.

The wards have wide halls and doorways and the rooms have adequate space and accessible bathrooms. The care station provides adequate workspace and seems relatively free of clutter though an ongoing review of paper notices is required to ensure that postings are pertinent and recent.

The electronic patient tracker uses initials as identifiers to maintain privacy while being visible and providing useful information to staff.

Some room numbers since the 2A/2B amalgamation are similar and can cause confusion.

It was noted during a code blue that staff were hampered by lack of equipment, specifically an intraosseous gun which was obtained from the emergency department and a laryngeal mask airway which would have provided an airway alternative. This lack of equipment was brought up by staff during the debriefing and it was indicated that these concerns had previously been raised. Ensuring staff are aware of appropriate channels to identify missing or inadequate equipment is essential to ensuring teams have the resources they require to fulfill their roles.

The medicine team participates in regular staff huddles that serve as frequent and informal meetings to reinforce the mission, vision, and values; pass on new information; confirm understanding of new processes; and remind staff of best clinical practices.

The patient information booklet available at the bedside effectively provides patients and families with information on services available and things they should know regarding admission and discharge. The print is large and the graphics are very useful when trying to find information.

Priority Process: Competency

Organizational data show that performance appraisal was an area for improvement. In medicine, all staff who were asked indicated they had a performance appraisal in the last two years. Physicians interviewed stated that they also had performance appraisals as part of the credentialing process.

Opportunities exist to recognize staff with particular interests and offer additional training so they can act as resources in the department. Examples include palliative care, wound care, and training to support the code blue and critical care support teams.

Priority Process: Episode of Care

Medicine services enjoys a large and bright ward with large patient rooms with private bathrooms, wide hallways, and comfortable lounge areas for patients and families.

Patient transitions between the emergency and inpatient department must bridge a predominantly paper chart with a predominantly computerized chart, although both are hybrids. Standardized transition checklists have been developed but are not in widespread use as staff feel they do not meet their needs or improve the transition process. Leadership recognizes this concern and is in the process of developing a new version of the form that will be trialed soon.

The use of two patient identifiers continues to be an opportunity for improvement for the organization. Improvements in education and auditing results have been achieved since the last on-site survey but use remains inconsistent, particularly when staff are familiar with patients. It is suggested the policy be updated to indicate what types of information qualify as identifiers, as this may help staff use appropriate identifiers at each encounter. Continuing to educate on what is acceptable as a patient identifier and when it is required, as well as auditing compliance, will be an ongoing process.

The Move and Walk program is championed by hospital staff on the inpatient wards to get people moving and to encourage patients and families to continue walking where able. This is an excellent program with multiple benefits including prevention of pressure ulcers and clot development. Exercise improves mental health and movement, decreases the long-term risk of falls, and prevents deconditioning. These benefits ultimately improve health and reduce the length of stay.

Priority Process: Decision Support

The hybrid chart, with both paper-based and computerized elements, made it labour intensive and time consuming to confirm completeness. The organization recognizes this as an issue and is awaiting decisions made at a higher level. The hybrid chart greatly increases risk as the possibility of missing important information increases when charting is done in two locations and is inconsistent between clinicians.

While it waits for recommendations on new information technologies, the organization is encouraged to assess its available systems to determine if there is a way to improve consistency with existing technology.

Priority Process: Impact on Outcomes

NHH has included patients and their families in its decision-making and review processes for several years. More recently, the organization has expanded patient and family involvement through the Patient and Family Advisory Council and the Quality and Practice Committee. Although this program is relatively new, it is active and has been well received by families and patients as well as clinicians and the leadership team.

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	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The maternal child unit was designed and built 14 years ago to support a labour-delivery/birth-recovery-postpartum approach.

Gases and air are provided through central distribution systems. All have different connectors so there can be no mistake in delivery of gases.

Priority Process: Competency

NHH has completed the MORE OB program of training and education and continues to participate in skills drills and education sessions.

Staff are required to complete obstetrical nursing courses prior to or as a condition of hiring.

An electronic education and training tracking system notifies staff when they are due to review and complete testing on an area such as infusion pump training. Managers are able to view the status of each staff member for their education reviews.

Priority Process: Episode of Care

NHH provides a level one service for obstetrics. Staff and physicians report no barriers to accessing a higher level of care for patients who require it. A team from The Hospital For SIck Children in Toronto will come to assess and stabilize, triage, and transport newborns in distress. NHH is drafting a protocol to trial breech deliveries as is recommended by the Society of Obstetricians and Gynaecologists of Canada.

Medication reconciliation is fully supported by pharmacists on hospital units. Medications are provided via an automated dispensing machine.

Falls risk assessment is done for all patients as evidenced in the electronic record. Patients report that they are instructed to call for help when getting up or when they need help placing the newborn back in the bassinette.

NHH is fortunate to have strong support for capital equipment and has an infant warmer for every room. Skin-to-skin care was witnessed in the patient rooms.

Electronic tools provide a forcing function for information shared at transitions in care.

Priority Process: Decision Support

NHH uses a hybrid documentation system on obstetrics. The labour portion of care is documented on paper which does not include a partogram.

Record keeping, retention, and sharing follow the accepted protocols for hospitals.

Priority Process: Impact on Outcomes

There is a quality information board on the obstetrics unit, with indicator data and action plans.

Standards Set: Organ and Tissue Donation Standards for Deceased Donors - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
1.3 Organ and tissue donation is part of the organization's strategic priorities.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	
Priority Process: Organ and Tissue Donation	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The hospital has been increasingly active in working with Trillium Gift of Life Network around many kinds of organ donation.

While NHH strategic priorities include many quality of patient care initiatives, organ donation is not specifically named.

Priority Process: Competency

The chief of staff is currently acting as the medical director for organ donation, with plans to recruit one of the staff physicians or specialists to act in this capacity.

With the assistance of Trillium Gift of Life Network, ongoing education on organ donation is provided to staff and the public.

Policies regarding consecutive working hours are guided by collective agreements.

Priority Process: Episode of Care

Trillium Gift of Life Network provides templates for all documentation required for donation of organs and tissues.

Priority Process: Decision Support

NHH has implemented a forcing function in the electronic documentation that prevents a chart from being closed without completing a screen for potential for and interventions in organ donation.

Donor organs and tissue can be traced via Trillium Gift of Life Network to connect with the recipient.

Priority Process: Impact on Outcomes

The mandatory electronic documentation around organ donation was the result of a quality improvement initiative to increase organ donor participation rates.

Priority Process: Organ and Tissue Donation

The Trillium Gift of Life Network notifies donor families about the ways in which the donor's gifts were used and follows up with families at three, six, and nine months.

An annual celebration dinner is attended by Northumberland Hills Hospital representatives where families are presented with hero's medals and a rose, and a candle lighting ceremony is held.

Standards Set: Perioperative Services and Invasive Procedures - 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	
The organization has met all criteria for this priority process.	
Priority Process: Medication Management	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Space design is well organized for patient flow in this 14-year-old hospital at Northumberland Hills Hospital. The team converted a two-stretcher bay into interview space to enhance privacy.

Required resources are quickly supplied by a supportive foundation for capital equipment funding, and the leadership is successful in meeting needs as they arise.

Registered nurses and registered practical nurses are fully utilized in the operating room.

Priority Process: Competency

A patient and family representative now sits on the Quality and Practice Committee for perioperative services. Their input is welcomed on all agenda items.

An electronic learning system includes training on respectful workplaces, IV pump use, and other modules. It includes email reminders when refreshers are required.

Priority Process: Episode of Care

NHH has successfully implemented a nurse navigator role for the surgical program, as part of the rollout of the ERAS (enhanced recovery after surgery) initiative for bowel surgery. The nurse also assists with navigation of other surgical patients, gives them a card so they can call with questions after surgery, helps with coordination of CCAC services, and problem solves regarding post-operative side effects, among other things.

The perioperative group conducted a suture consolidation to reduce the variety of sutures and thereby reduce costs.

Post-discharge calls are conducted for post-procedure colonoscopy patients. The calls are made by post-anaesthesia care unit staff. Plans to make post-discharge calls to other patients are underway.

While pre-operative assessment is undertaken, patients must attend on different days to see different disciplines (e.g., anaesthesia and nursing). Future quality improvement to the service might include coordinating visits, to focus on patient convenience.

Surgery after hours (i.e., call-back surgery) is monitored to address cases where this happens due to care provider convenience rather than patient urgency.

At NHH, there are no wooden cupboards or shelves in the operating rooms or other patient care areas affiliated with the surgical program. However, there is a large raw wooden cupboard in the staff lounge, and a plywood wooden cart is used for portable oxygen and carbon dioxide tanks. Cleaning of such wood is never absolutely effective and raises a concern about infection control.

The surgical safety checklist is in three parts as agreed by the surgical services team and is conducted for surgery. The checklist, pause, and debrief are largely led by nursing staff and do not include a component of discussion around quality improvement opportunities.

Priority Process: Decision Support

Care and procedures in the perioperative care program are recorded using an electronic documentation system that allows for analysis of various parts of care.

The Meditech perioperative module was implemented to be consistent with Meditech documentation in other parts of the hospital.

Priority Process: Impact on Outcomes

A quality board with goals and objectives and indicator data is posted on the wall near the patient waiting area of the perioperative services.

Priority Process: Medication Management

Anaesthetists at NHH obtain narcotics for the day from a separate automated drug dispensing machine and return them to the same machine at the end of the day. All other medications are dispensed from a different automated dispensing machine.

Malignant hyperthermia and difficult intubation carts are available outside the operating rooms. Larger, clear labels for the carts might help in an emergency where new or unfamiliar staff are assisting.

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

NHH evaluated point-of-care testing through a business model to determine whether point-of-care testing in the emergency department and intensive care unit would be appropriate. It was determined there was no financial benefit and that they were able to provide required laboratory services through existing mechanisms.

Glucometers are the main point-of-care testing devices used and they are widespread throughout the organization. The organization also has a creatinine point-of-care device in the diagnostic imaging department for after-hour CT scans when this test is required.

Monitoring of the equipment is regularly completed. Staff are trained and training is refreshed as per hospital policy.

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	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)
Priority Process: Clinical Leadership
Rehabilitation and restorative services is well equipped and has bright and comfortable patient rooms, wide corridors, and accessible bathrooms. Dining areas are clean and bright and there are several lounges available for patients and their families. The physiotherapy and occupational therapy treatment areas are large, bright, and uncluttered and have a wide range of equipment. Recreational activities are offered to patients to encourage them to participate. The interdisciplinary team works collaboratively to provide care to patients. The organization has been proactive in seeking patient, family, and community involvement in quality and strategic direction. The patient involvement on the board has been well received by the team.
Priority Process: Competency
Rehabilitation and restorative services boasts a wide range of professional backgrounds and competencies enabling the team to provide a full range of services.

Priority Process: Episode of Care

Rehabilitation and restorative services successfully blends aspects of hospital care with a focus on returning the individual to their home.

While risk of falls is assessed and mitigated, patients are encouraged to build and expand their independence including maximizing their mobility.

The WanderGuard system effectively prevents patients at risk from leaving the department. Painting doors as bookshelves is both aesthetically pleasing and provides a low tech adjunct to preventing prone individuals from attempting to leave the department.

Priority Process: Decision Support

Rehabilitation and restorative services has a combination of electronic and paper charting. While the majority of allied health professionals chart electronically, there is variation among the physicians in their preferred charting location. This variation may impact patient safety as it increases the risk that notes will be missed. Consistency of charting with all clinical notes in the same document needs to be a priority for the organization.

Priority Process: Impact on Outcomes

NHH has included patients and their families in its decision-making and review processes for several years. More recently, the organization has expanded patient and family involvement through the Patient and Family Advisory Council and the Quality and Practice Committee. Although this program is relatively new, it is active and has been well received by families and patients as well as clinicians and the leadership team.

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 are co-located with biomedical services in a large, clean, and uncluttered area. Appropriate procedures are in place for ordering, dispensing, delivering, and infusion of blood service products.

The Transfusion Committee is a subset of the Pharmacy and Therapeutics Committee, which is appropriate given its size. This ensures an interdisciplinary approach to transfusion services.

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.

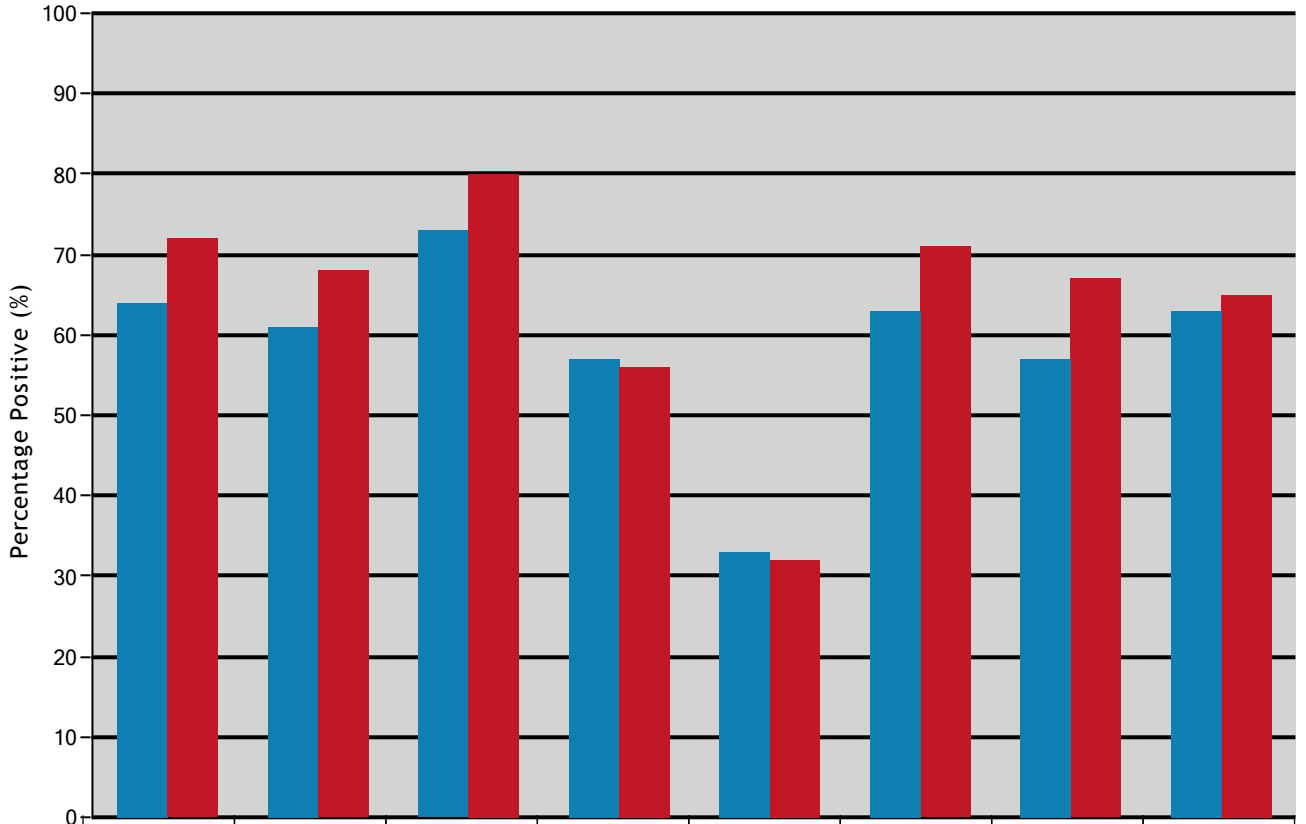
Canadian Patient Safety Culture Survey Tool

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: May 16, 2016 to July 15, 2016**
- **Minimum responses rate (based on the number of eligible employees): 208**
- **Number of responses: 252**

Canadian Patient Safety Culture Survey Tool: 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
	64%	61%	73%	57%	33%	63%	57%	63%
	72%	68%	80%	56%	32%	71%	67%	65%

Legend

Northumberland Hills Hospital

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2016 and agreed with the instrument items.

Worklife Pulse

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

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

The organization used an approved substitute tool for measuring quality of Worklife. The organization has provided Accreditation Canada with results from its substitute tool and had the opportunity to identify strengths and address areas for improvement. During the on-site survey, surveyors reviewed actions the organization has taken.

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 making decisions about ethical dilemmas and problems.
Resource Management	Monitoring, administering, and integrating activities related to the 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

Priority Process	Description
Population Health and Wellness	Promoting and protecting the health of the populations and communities served through leadership, partnership, and innovation.

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 direction to teams providing services.
Competency	Developing a skilled, knowledgeable, interdisciplinary team that can manage and deliver effective programs and services.
Decision Support	Maintaining efficient, secure information systems to support effective service delivery.
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	Partnering with clients and families to provide client-centred services throughout the health care encounter.
Impact on Outcomes	Using evidence and quality improvement measures to evaluate and improve safety and quality of services.
Infection Prevention and Control	Implementing measures to prevent and reduce the acquisition and transmission of infection among staff, service providers, clients, and families
Living Organ Donation	Living organ donation services provided by supporting potential living donors in making informed decisions, to donor suitability testing, and carrying out living organ donation procedures.
Medication Management	Using interdisciplinary teams to manage the provision of medication to clients

Priority Process	Description
Organ and Tissue Donation	Providing organ and/or tissue donation services, from identifying and managing potential donors to recovery.
Organ and Tissue Transplant	Providing organ and/or tissue transplant service from initial assessment to follow-up.
Point-of-care Testing Services	Using non-laboratory tests delivered at the point of care to determine the presence of health problems
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 to assess, protect, and promote health.
Surgical Procedures	Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge