ACCREDITATION CANADA

Driving Quality Health Services

Accreditation Report

Prepared for:

Northumberland Hills Hospital

Cobourg, ON

On-site Survey Dates:

March 28, 2010 - April 1, 2010

April 15, 2010

ACCREDITATION CANADA
AGRÉMENT CANADA

Accredited by ISQua

Accreditation Report

About this Report

The results of this accreditation survey are documented in the attached report, which was prepared by Accreditation Canada at the request of Northumberland Hills Hospital.

This report is based on information obtained from the organization. Accreditation Canada relies on the accuracy of this information to conduct the survey and to prepare the report. The contents of this report is subject to review by Accreditation Canada. Any alteration of this report would compromise the integrity of the accreditation process and is strictly prohibited.

Confidentiality

This Report is confidential and is provided by Accreditation Canada to Northumberland Hills Hospital only. Accreditation Canada does not release the Report to any other parties.

In the interests of transparency, Accreditation Canada encourages the dissemination of the information in this Report to staff, board members, clients, the community, and other stakeholders.

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About the Accreditation Report

The accreditation report describes the findings of the organization's accreditation survey. It is Accreditation Canada's intention that the comments and identified areas for improvement in this report will support the organization to continue to improve quality of care and services it provides to its clients and community.

Legend

A number of symbols are used throughout the report. Please refer to the legend below for a description of these symbols.

Items marked with a GREEN flag reflect areas that have not been flagged for improvements. Evidence of action taken is not required for these areas.

Items marked with a YELLOW flag indicate areas where some improvement is required. The team is required to submit evidence of action taken for each item with a yellow flag.

Items marked with a RED flag indicate areas where substantial improvement is required. The team is required to submit evidence of action taken for each item with a red flag.

Leading Practices are noteworthy practices carried out by the organization and tied to the standards. Whereas strengths are recognized for what they contribute to the organization, leading practices are notable for what they could contribute to the field.

Items marked with an arrow indicate a high risk criterion.

Accreditation Summary

Northumberland Hills Hospital

This section of the report provides a summary of the survey visit and the status of the accreditation decision.

On-site survey dates	March 28 to April 1, 2010
Report Issue Date:	April 15, 2010

Accreditation Decision	Accreditation

Locations

The following locations were visited during this survey visit:

1 Northumberland Hills Hospital

Service areas

The following service areas were visited during this survey visit:

1 Ambulatory Care
2 Diagnostic Imaging
3 Emergency Department
4 Intensive Care Unit/Critical Care
5 Long Term Care
6 Managing Medications
7 Maternal/Perinatal
8 Medicine
9 Operating Room
10 Sterilization and Reprocessing of Medical Equipment

Surveyor's Commentary

The following global comments regarding the survey visit are provided:

The organization, Northumberland Hills Hospital (NHH) can celebrate many successes some of which are detailed under the sub headings of overall strengths and examples, communication, and organization and community relationships. As with any organization, there are challenges to face and these are detailed under the heading of overall areas for improvement and examples.

Overall Strengths and Examples

The NHH is embarking on a transformation journey. It has engaged the community in a meaningful manner with respect to service provision, given its financial imperatives. The community advisory panel, along with perspectives from other stakeholder groups were considered in the organization's new draft strategic plan and submission of the 2010/2011 operating plan.

New leadership has joined the organization. Joined by those with corporate memory, a number of structures have been revised to better support the hospital's focus on quality and organizational performance. The purpose and functioning of the former Administrative Advisory Committee has been refreshed, including a renaming to Leadership and Quality Committee, at the management level. The board quality and finance committees are each focused on their key mandates. Director positions have been added to support clinicians at the beside in the area of professional practice, ethics and quality including a more concerted effort to implement LEAN methodologies for process improvements. The voluntary integration with Ontario Shores in the area of mental health (MH) programming has been seen as value added and enhancing both access and outcomes for patients seeking MH services.

The physical facility is well maintained and there is an ongoing commitment to maintaining the infrastructure as it ages. A capital planning process is in place. There is an evergreen strategy being deployed for those assets that are assessed as end of life. The hospital has enjoyed a reputation as being at the leading edge of "being green" and for championing environmental stewardship. Numerous projects are being contemplated that if supported by a business case, will further position Northumberland Hills Hospital at the forefront of environmental awareness.

The fundraising support from the community is noteworthy, and a volunteer presence and engagement with the hospital is remarkable.

Strong teamwork is in evidence in all areas of the hospital. There is a genuine effort expended for all clinical programs to be client centred and keep patient safety as a top priority. The staff, including credentialed personnel are supported by the organization to keep patients at the centre of care by way of ongoing educational opportunities.

A number of patient safety indicators have demonstrated consistent and sustained improvement.

Feedback from the community partners and from patients, in contrast to some other hospitals, is such that staff really embody NHH's mission, vision and values. There is a real community hospital feel and much more transparency.

A balanced scorecard is used to monitor key indicators.

According to community partners, the hospital enjoys a positive reputation in the community, and its small town, community hospital feel is a positive, distinguishing characteristic.

The hospital's efforts and approach to internal and external communication is exemplary. Of note are the Monday report, survey on communication methods, and efforts to identify previously overlooked stakeholder groups such as low income residents of the community.

The board is knowledgeable and very engaged.

The awareness to action process/mechanism supports safety across the organization and it is well used.

To paraphrase a Director, the recent ten year capital planning exercise was not a lot of fun, but it was necessary and worthwhile.

Biomedical Engineering and Plant Operations each have a comprehensive preventive maintenance program.

Overall Areas for Improvement and Examples

The draft strategic plan is yet to be formally approved and implemented. Tactics for implementing the operational plan for 2010 and 2011 are in the process of being developed. It is suggested that further work needs to be done in clearly identifying the metrics/measures by which the strategic plan will be monitored to ensure that key milestones and deliverables are achieved.

Clinical service planning and strategic planning at the clinical program level warrants attention. There are indications that some capacity planning will be undertaken. It is suggested that clinical and medical leadership need to pay some focused attention as to where they want to take their programs in the future, in line with community need and strategic directions. This has implications at the program level in terms of activity levels, growth, skill set requirements and workforce planning.

Pain management assessment and documentation needs to be consistently done at emergency triage and ambulatory care.

The Patient Safety and Work Life Culture surveys provide a road map of areas for improvement. Span of control and workloads are an area that will require monitoring as the hospital takes action to "right size" given its cost structure.

Human resources (HR) planning and in particular, medical work force planning and recruitment and retention continue to be issues that need to be on the hospital's radar screen. Currently, locums cover forty percent of the emergency (ER) shifts. Longer term strategies need to be considered to address the gaps and prevent more gaps from occurring, as may potentially result in the intensive care unit (ICU). Further, the hospital is encouraged to maximize on the potential of having interdisciplinary teams working at their full professional capacity.

The quality and safety framework and new strategic plan are yet to be implemented. The clinical ethics framework is yet to be developed and implemented in a substantive manner.

The process of community engagement and developing a balanced budget plan has understandably, been all consuming. While moving forward with the changes will also be a challenge, there must also be a public focus internally and externally on the hospital's praiseworthy clinical accomplishments, such as quality measures and comparatively short wait times.

The new strategic plan is high level and more of a corporate nature. The clinical focus appears to be on areas that need improvement, such as cancer care, dialysis, obstetrics and recruitment of physicians for ER and internal medicine. Currently, there seems to be lacking a focus on the specific clinical priorities that are needed to serve the population over the longer term.

Communication Between Different Levels of the Organization

There is good information exchange between senior management and the board. The board is provided with timely information at the appropriate level. There is healthy debate and respect for differing opinions between board members and between the board and the CEO. The board is proud of its solidarity on issues once these have been debated and a decision made. The board and CEO have made efforts to maintain constructive relationships with Central East Local Health Integrated Network (CE-LHIN), with local political officials and with other providers in the CE-LHIN where discussions around more formal memorandums of understanding (MOUs) are anticipated in the future. Directors feel they are appropriately consulted and involved in planning around decisions that impact on their areas and the hospital as a whole. Front line staff are aware of the major changes that are anticipated. They do not know all the details, as some of those are not yet worked out but overall, the rapport between management and the front lines appears to be positive.

Relationship Between the Organization and the Community

Recognition is given for the involvement of more than five hundred community members in the initiative titled; "Shared Challenge, Shared Solution" and the development of a community advisory panel to help provide a community perspective on the hospital's issue of sustainable services. This illustrates how strongly the community is committed to its local service provider and the ownership that it feels for the organization. This is further evidenced in the community's strong financial support and volunteer commitment. The hospital's financial recovery plan and reduction of services has not had unanimous support in the community and the ramifications of this will need to be monitored and managed by the board and chief executive officer (CEO).

Organization's Commentary

The following comments were provided to Accreditation Canada post survey.

Northumberland Hills Hospital (NHH) is committed to providing every patient safe, appropriate and effective care in a dynamic, healthy environment for all. We are pleased, but not surprised, that this was reflected to the Accreditation Canada Surveyors during their visit March 28-April 1, 2010. The comments of the surveyors and the results of the on-site survey are a testament to the hard work and dedication of staff at every level and in each role at NHH. We value the feedback received from the Accreditation Surveyors and Accreditation Canada and are eager to incorporate the recommendations into our overall plans for on-going quality improvement and patient safety.

The current successes and challenges of the organization were generally captured by the surveyors and the survey report. As noted by the accreditation surveyors, NHH is embarking on a "transformation journey" - one which we are confident will lead to excellence in care and service in an organization positioned to sustain hospital services for the community now and into the future. At the time of the on-site survey, the draft Strategic Plan was a work in progress with solid plans in place to clearly identify and monitor performance indicators and to continue the strategic planning process at the program level. The 14 of the 42 unmet standards related to strategic planning at either the organization or program level will be readily addressed in the coming months as NHH progresses through its planning agenda.

Furthermore, NHH partnered with OHA in January of 2010 to develop a Talent Management plan which will be completed by June 2010 to ensure that the right people with the right skills are in the right place and are engaged and focused on the right activities to achieve targeted results. The talent management plan includes a leadership gap analysis and leadership training. The leadership development program will begin in the late spring/early summer of 2010.

The other comment to be made is with regards to the Medication Reconciliation on Discharge/Transfer Required Organizational Practice (ROP). This ROP was rated as "unmet" in both Ambulatory Care Services and Obstetrics/Perinatal Care Services. The requirement for this ROP is that there is a documented/demonstrated process with a plan to implement throughout the organization. Medication reconciliation on transfer/discharge was assessed by the surveyors as "met" in Critical Care Services, Emergency Services, LTC Services and Medicine Services and we have a documented plan for implementation across the organization which was available to the surveyors at the time of the on-site visit. This suggests that we have met the ROP criteria for Medication Reconciliation on transfer/discharge.

For a large number of the standards identified as "unmet" during the on-site survey, there was, and continues to be, work in progress that will bring these practices into compliance with the standards. Moving forward, we will ensure that this work incorporates the suggestions/recommendations from the Accreditation Report. For the remaining "unmet" standards and surveyor recommendations, NHH will engage in a detailed review of our practice and the requirements of the standard and will create and implement action plans including target dates and progress/outcome measures.

There was a general sense amongst staff at all levels of the organization that the new Qmentum program, and the tracer methodology, increased the engagement of staff in both the Accreditation process and the quality and safety initiatives and practices in place in the organization. We feel that Qmentum has increased the surveyors' ability to gauge the true quality of care and services. Staff report that they appreciated the opportunity to interact with the surveyors and that the surveyors put them at ease and asked relevant, thoughtful and appropriate questions.

Accreditation Report

On behalf of the staff, physicians, volunteers, patients and community, NHH acknowledges the commitment and expertise of the Accreditation Surveyors and Accreditation Canada (especially our Accreditation Specialists). We truly value the Accreditation process as a tool for realizing our commitment to ongoing quality improvement and safety for all.

Overview by Quality Dimension

The following table provides an overview of the organization's results by quality dimension. The first column lists the quality dimensions used. The second, third and fourth columns indicate the number of criteria rated as met, unmet or not applicable. The final column lists the total number of criteria for each quality dimension.

Quality Dimension	Met	Unmet	N/A	Total
Population Focus (Working with communities to anticipate and meet needs)	48	7	0	55
Accessibility (Providing timely and equitable services)	77	1	2	80
Safety (Keeping people safe)	399	8	20	427
Worklife (Supporting wellness in the work environment)	105	3	1	109
Client-centred Services (Putting clients and families first)	107	1	0	108
Continuity of Services (Experiencing coordinated and seamless services)	40	0	0	40
Effectiveness (Doing the right thing to achieve the best possible results)	487	22	25	534
Efficiency (Making the best use of resources)	56	0	2	58
Total	**1319**	**42**	**50**	**1411**

Overview by Standard Section

The following table provides an overview of the organization by standard section. The first column lists the standard section used. The second, third and fourth columns indicate the number of criteria rated as met, unmet or not applicable. The final column lists the total number of criteria for that standard section.

Standard Section	Met	Unmet	N/A	Total
Sustainable Governance	84	7	0	91
Effective Organization	96	5	3	104
Infection Prevention and Control	99	0	4	103
Ambulatory Care Services	99	11	10	120
Critical Care Services	99	7	3	109
Diagnostic Imaging Services	96	0	8	104
Emergency Department Services	97	6	2	105
Long Term Care Services	118	1	0	119
Managing Medications	132	1	2	135
Medicine Services	103	1	0	104
Obstetrics/Perinatal Care Services	110	1	8	119
Operating Rooms	98	1	2	101
Reprocessing and Sterilization of Reusable Medical Devices	88	1	8	97
Total	**1319**	**42**	**50**	**1411**

Overview by Required Organizational Practices (ROPs)

Based on the accreditation review, the table highlights each ROP that requires attention and its location in the standards.

Criteria	Required Organizational Practices
Ambulatory Care Services 12.2	The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.
Obstetrics/Perinatal Care Services 11.3	The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.

Detailed Accreditation Results

System-Wide Processes and Infrastructure

This part of the report speaks to the processes and infrastructure needed to support service delivery. In the regional context, this part of the report also highlights the consistency of the implementation and coordination of these processes across the entire system. Some specific areas that are evaluated include: integrated quality management, planning and service design, resource allocation, and communication across the organization.

Findings

Following the survey, once the organization has the opportunity to address the unresolved criteria and provide evidence of action taken, the results will be updated to show that they have been addressed.

Planning and Service Design

Developing and implementing the infrastructure, programs and service to meet the needs of the community and populations served.

Surveyor Comments

Strengths:

The hospital's engagement and consultation strategy specific to its initiative titled; "Shared Challenge, Shared Solution" and creation of the citizen's advisory panel (CAP) are noteworthy. External expertise was provided to assist with informed planning and decision making for the organization in terms of its service provision in a manner that is more sustainable given the hospital's current financial imperatives. The areas looked at were independent research, objective environmental scanning, demographic analysis and community engagement strategies.

The organization (NHH) is embarking on a transformation journey. A new strategic plan has been developed and will receive board approval in May/June 2010. New mission, vision and values (MVV) have been articulated and now will require extensive communication once approved.

There has been turnover in the senior management, director and team leader levels. The organization is fortunate to have well qualified 'new blood' as well as a number of individuals that have the corporate history and memory in positions of responsibility. New management positions have been created such as the director of quality and safety and director of inter professional and ethical practice. Also, ER manager positions are anticipated to provide the internal support that is required for more focus on quality, professional practice and clinical planning. Further, a number of internal committee structures have been revamped for a more focused mandate to look at quality and performance. This includes a leadership and quality committee and a quality and safety committee at the board level.

The board is satisfied with the information it receives from management. There is evidence of regular monitoring at the board level for key quality and performance indicators. The board is made aware of major adverse incidents/sentinel events and monitors that the disclosure policy is followed in these events.

Ontario Shores Mental Health Centre began its relationship with NHH almost two years ago when it was approached by the hospital. In September 2008, NHH signed a Contract Services which included an assessment of both local mental health services and the clinical operations of the NHH Mental Health Program, which led to several recommendations. Since then, collaboration has been underway to address the recommendations. Ontario Shores and NHH share the leadership and oversight of the NHH MH Program. A steering committee oversees the collaboration, helps to move it forward, and monitors progress of recommendations. Outcome and process measures are yet to be tracked. However, from both the hospital's and community partner's perspective, this voluntary integration has been seen as making a constructive impact on MH programming, and in terms of access to MH professionals as well as programming. Ontario Shores has also initiated a metabolic clinic at NHH and other services are being considered.

The leadership team has conducted a review of its maternal child care program. This was done in response to the CE-LHIN's clinical services plan to ensure that the program is meeting quality standards expected of the service. Further work is being contemplated to assess capacity issues and how the program may evolve in the future, especially if more formalized partnership arrangements are developed particularly with another acute care provider within the CE-LHIN. Capacity assessments are also being considered in a number of other clinical services and this is supported.

The organization introduced LEAN methodology into the emergency department. As a result, the wait time indicators dropped thirty percent, and are seeing sustained success. There is also LEAN exposure for the Flo Collaborative. In fact, LEAN is a method of quality improvement to which NHH wants to commit. The hiring of the director of quality and safety is seen as resources to help move LEAN methodology forward in the organization.

Areas for Improvement:

The new strategic directions and operating plan for 2010/11 call for: closure of interim long term care; complex continuing care and 16 alternate level of care beds;closure of outpatient diabetes education; and, closure of out patient rehabilitation, which is the most difficult for the board given its understanding of the issues and risks, especially as they relate to restricting access to this service for those in the lower income level.
Key metrics and milestones need to be identified to monitor achievement of these closures. The senior management team and board understand this is an area where more work is required.
There is limited evidence of formal strategic planning at the clinical level. This is an activity that also requires engagement and involvement with medical leadership in the clinical areas.
The new ER director has some good ideas for improving wait times for Canadian Triage Acuity Scale (CTAS) 4 and 5. This is an area where LEAN methodology can be further employed to improve processes, access and thus, the patient experience.
The NHH is experiencing high numbers of alternate level of care (ALC) patients at between 25 and 30 percent. Patient flow and discharge of these patients must remain on the radar screen in order to move these clients to a more appropriate care setting especially in light of the impending bed reductions and their impact on the ER department if gridlock is experienced.
Abundant and complex information was provided to the CAP, which described relationships and inter relationships. The CAP members feel very engaged with the hospital. Although work is underway to become a centre of excellence for geriatric care, it is suggested that the NHH, being in a LHIN with the second highest proportion of seniors, collaborate among providers. The purpose would be to develop an effective program to care for seniors as they age, in large numbers, over the next ten years.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Effective Organization		
The organization's leaders support and participate in ongoing community development to promote health and prevent disease.	2.4	
The organization's leaders demonstrate progress toward achieving the organization's strategic goals and objectives.	4.9	
Sustainable Governance		
The strategic plan includes measurable strategic goals and objectives.	2.5	
The governing body identifies timeframes and responsibility for achieving the strategic goals and objectives.	2.6	
The governing body demonstrates that the organization achieves its strategic goals and objectives, and makes progress toward achieving its long term vision and direction.	12.6	

Resource Management

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

Surveyor Comments

Strengths:

There is evidence of good financial controls, with policies and approval processes in place to monitor financial expenditures at the management and governance levels.

The hospital utilizes a zero based budgeting approach for establishing its budgets for the various cost centres annually. Program directors are involved in the budget build, and subsequent monitoring and control of their budgets. There are mechanisms in place for escalating oversight when trends are identified and which may result in cost overruns requiring a course of correction. Sick time and overtime have been areas of focus and the board is monitoring performance on these indicators via its committee structures.

Board quality and finance committee are now separate committees so each one can pay focused attention to their respective key mandates.

Over the past two years, the NHH has focused on positioning itself for ongoing fiscal stability and ability to sustain its clinical programs. Initially, benchmarking and cost reduction strategies and the initiation of the extensive "Shared Challenges, Shared Solution" program which initially involved engagement of staff, physicians, the Board and community resulted in 1.4 M in savings.

The board faced a new 1.8M shortfall for the 2010/2011 fiscal year and as a result, "Shared challenges, Shared Solution" was then expanded with the development of the "Community Advisory Panel" and the 2010/11 operation plan. This process led to the creation of the citizen's advisory panel (CAP) and a mandate to provide the board with the public's perspective on service changes to balance the hospital's budget. The final report of the group along with the perspectives of the medical community and management team, informed the board on its new strategic directions as well as operational plans for 2010/2011, which entails service reductions. The consultation process and framework for decision making on scarce resources as well as priorities of services was prepared with a disciplined, fact based approach, using pre determined decision making criteria. The plan has the endorsement of the CE-LHIN. There are however, those in the community that object to the direction being taken. The board has expressed solidarity in its resolve to proceed.

There exists evidence of Ever Greening of capital assets and recently, an inventory of all assets has been conducted to ensure a more robust capital planning process, which is based on data.

The community has historically been very supportive of the hospital's fund raising in excess of $1 M annually i.e. new MRI, CT upgrade and additional diagnostic equipment ($6 M).

Auditors are appointed per best practice in the industry. Recommendations are addressed when made, and they have been the exception.

Capital planning for equipment involves input from clinical directors and physicians and they all are involved in priorities of purchases.

The organization does reserve designated funding for contingency situations.

Contracts are centralized in purchasing and overseen by the chief financial officer (CFO).

Areas for Improvement:

There is need to review and educate all managers on the policy titled; "Supply Chain Code of Ethics" and to review and update existing procurement policies in light of new legislated requirements as of April 1, 2010. The recently implemented Medworxx Learning Management System may be an appropriate vehicle to facilitate this training.

A review of how purchase requisitions are completed is suggested to allow for standard work on this front, including use of LEAN principles to streamline the work associated with this activity.

The CCAC case manager attends hospital bullet rounds. The CCAC also attends rounds on the rehabilitation unit. There are many seniors that present with multiple conditions. It is important that they are cared for appropriately, and not discharged for the sake of patient flow. The re admissions need to be monitored. As well, it was noted that expected discharge date (EDD) tracking is an area for improvement. Frequently, clinicians are unable to mobilize discharge arrangements in the community. This is because they are not given lead time around the EDD or actual discharge date by the most responsible physician (MRP). Further, the requirement of needing physician treatment orders for obtaining allied health assessments/interventions sometimes delays timely progress towards discharge. It is suggested that a number of process issues related to EDD and discharge planning be reviewed.

No Unmet Criteria for this Priority Process.

Human Capital

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

Surveyor Comments

Strengths:

The board has completed its self assessment and is taking action on those areas where the road map has indicated an opportunity for improvement.

The board has reviewed and updated its bylaws in 2009. A conflict of interest bylaw is contained in the updated bylaws document.

Patient Culture Survey and Work Life Pulse Surveys have been done. The leadership was surprised at how positive the survey results were. Data were analyzed, an action plan has been established and the organization is now working on the plan. Strategies to deal with the areas of concern have been identified in the HR plan. The intent is to resurvey the staff using an NRC Picker tool that the hospital feels will allow it to receive more data on workplace quality. It will also allow the NHH to benchmark with other organizations. A medical workforce plan is in place. It is suggested that when the hospital resurveys the staff on quality of work life at the hospital, consideration be given to also surveying the physician community at the same time.

There is evidence of efforts expended to ensure that staff are cross trained for more than one area. This has allowed not only for staffing flexibility given occupancy levels in certain services, but also for more marketable staff given the skill sets that they have acquired to work in the clinical areas. There is a general orientation program for new staff and specialized orientation programming that is customized to specific clinical areas. The staff indicated that they are well supported by the organization in terms of acquiring specialized certifications. It is noteworthy that the organization has built up its capacity to do specialized skills training such as advanced cardiac life support (ACLS), with medical and nursing personnel serving as instructors to facilitate such skills acquisition.

The occupational health and safety committee (OHSC) is involved in developing various initiatives. Initiatives include smoking cessation, theme of the month events, problems with teens and strategies and so on. These provide support to staff from a wellness perspective based on data and interest expressed by staff. An employee assistance program (EAP) is available when needed.

Exit interviews are conducted both on a random and selected basis, with an estimated seventy percent of those individuals exiting the organization being interviewed.

Performance appraisals are conducted for both clinical and medical staff. The uptake on this activity is reasonable given the number of new managers that have been recruited to the organization.

Areas for Improvement:

The organization is introducing multiple changes as well as concurrently attempting to constantly adjust and improve its internal processes with a leadership team that has had new additions. It is suggested that the organization consider investing in a talent management strategy and specifically, in leadership development programs. Doing so will enable the leadership and quality committee membership to effectively manage change given the hospital's culture. It is suggested also that mentor arrangements might help enhance performance at the management level.

The chief of staff (COS) is supportive of the CE-LHIN initiative specific to a common credentialing system. This would allow for a new framework based on best practices in this area. It would also enable the organization and physicians to benefit from a due diligence process, which should be less cumbersome, as well as administratively easier to maintain once implemented.

The organization has enjoyed some success with physician recruitment. Nevertheless, the issue of medical manpower still needs to be a priority on the hospital's radar screen, as locums still fill forty percent of the ER shifts. The current model of medical coverage in the ICU is practical. It meets the current needs for coverage and was a solution found as a result of input from the medical community as well as input from the critical care coaching team. Although functional for now, it will require review on an ongoing basis in terms of its long term sustain ability.

Management and staff are encouraged to continue to work together to review how they can further redesign work so that professionals can practice in a full scope, inter professional model. An objective review of staffing patterns and ratios, particularly during periods of low occupancy or acuity may help with what will be ongoing challenges of staffing within constraints created by funding, as well as availability of certain types of personnel.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Effective Organization		
The organization's leaders share the results of the Worklife Pulse Tool and use the results to make improvements.	8.8	↑
Sustainable Governance		
The governing body has a written statement that clarifies the division of responsibility between it and senior management.	6.3	
Each member of the governing body signs a statement or charter that defines his or her role and responsibilities, including legal duties, and expectations for the position.	6.7	

Integrated Quality Management

Continuous, proactive and systematic process to understand, manage and communicate quality from a system-wide perspective to achieve goals and objectives.

Surveyor Comments

The organization recently invested in human capital to support the quality program. The board has created a quality and safety committee of the board and previously, this was integrated with another committee. There is currently a gap in data support, and work towards recruiting a person to fill this role is ongoing. The NHH is also working toward making data easier to gather and more timely. It is currently in the process of refreshing the strategic plan. One of the commitments in the plan is the; "Patients First - Through our culture of service excellence, we deliver safe patient care every time". There are corporate performance indicators and each of the programs has a balanced scorecard that is reported on a quarterly basis. The quarterly

reports are received by the board. The scorecard is designed in a way that the board can readily see previous data to support identification of trends. The board identified several situations in which performance indicator review has led to opportunities for improvement identification and resultant efforts to improve the metrics. An example of improvements made as a result of these indicators are absenteeism rates. C. Difficile was another example and it involved room cleaning and hand washing. Yet another example is emergency wait times and how the CTAS 3 patients were approached. By using a LEAN approach, staff reduced the time from between six and seven hours to between three and four hours, which exceeds the provincial standards. The board reports that it has an excellent working relationship with the LHIN and also works proactively with other stakeholder groups. A failure modes effects analysis (FMEA) was done concerning the delivery of twins. After careful review and implementation of the requirements indicated for patient safety, as identified during the FMEA, the twin delivery proceeded with safety and success. After retrospective review, it was decided that although NHH was, in this case, able to meet the requirements identified to safely deliver the twins, due to the significant amount of resources required, the practice is not sustainable and hence was discontinued.

Strengths:

Staff readily indicate that completion of an incident report is done for review of processes and learning opportunities.
The organization has recently completed the Health Insurance Reciprocal of Canada (HIROC) Enterprise risk management program. This was a significant undertaking, which led to multiple improvements to reduce organizational risk.
Multiple units have undertaken 6S projects for their storage areas and have been able to sustain these improvements.

Areas for Improvement:

The organization is working toward establishing a Worklife Violence Prevention Program and the requirements of Bill 168. There is a mechanism built into the electronic patient record for alerting staff to situations with a risk of violent behaviour, based on past experience with an individual. This mechanism could be further strengthened by linking the alert to the original pertinent documentation.
The organization has worked toward integrating best practices into the order sets. Furthering the multidisciplinary approach to patient care with the development of protocols that would reduce the referral time to these services would assist in more timely patient service.

No Unmet Criteria for this Priority Process.

Principle Based Care and Decision Making

Identifying and decision making regarding ethical dilemmas and problems.

Surveyor Comments

Strengths:

The organization has invested resources to obtain external expertise to develop an ethical decision framework around priorities for services and to assist in the allocation of scarce resources. As well, the hospital has invested in creating a director level position titled "Director, Inter Professional and Ethical Practice" to support the delivery of ethical and best practice care at the bedside. Internal discussions have been undertaken as to the need to have a mechanism to access ethicist consultation should that be required in complex situations

Evidence based practice is supported by the organization. Staff have access to a number of resources that enables them to maintain currency with best practices as described in the literature.

Community partners and staff themselves have articulated that the values communicated by the organization are lived on a daily basis in how hospital services are delivered. This is an item that has been identified as a factor in individuals making the decision to work at the hospital and has helped with the organization's ability to recruit staff in a competitive job market.

Extensive internal and external consultation and iterative refinement was undertaken of the new mission, vision and values. Staff working at the hospital feel ownership to these foundation statements and indicate there is a good fit between these with their own personal values and beliefs.

In contrast to some other hospitals, staff really embody NHH's mission, vision and values. There is a real community hospital feel and much more transparency.

Areas for Improvements:

There is a formal process outlined on paper for managing ethics related issues. It has been used on occasion but infrequently. The organization is investing resources in strengthening inter professional practice and ethics with a director position to focus on this area. The individual has been tasked to look at developing a more robust model for clinical ethics however, has been unable to do so as yet due to competing priorities. The director and vice present (VP) of patient services have a model in mind and can describe the reporting structure that they would like to see developed to enhance this area of practice. It is anticipated that this will take better shape in the next few months. Further, the minutes reflect and the interview with the two key individuals overseeing ethics framework development confirms that the hospital is considering contracting external ethicist support should that expertise be required. External consultation was sought in the development of criteria and process for prioritizing services. It is suggested that consideration be given to looking at the ethics framework developed for the organization so that it can deal with both corporate and clinical issues as required.

There is a need to do more education on ethical subject matter so that ethical awareness is broadened in the hospital. Currently, staff rely on the expertise of the palliative care team for end of life issues amongst other clinical matters. There is also education required as to what does, in essence, constitute an ethics issue.

Once the board has approved its new strategic plan, mission, vision and values, a communication strategy will be required to ensure that staff, physicians, patients, community and pertinent stakeholders are aware of the new foundational information, which will guide the direction of the hospital over the next few years.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Effective Organization		
The ethics framework defines formal processes for managing ethics-related issues and concerns.	5.4	↑
The organization's leaders build the organization's capacity to apply the ethics framework by encouraging the governing body, leaders, staff, and service providers to develop and enhance their ethics-related knowledge.	5.8	↑
Sustainable Governance		
The governing body assigns responsibility for communicating the organization's values throughout the organization and educating staff, service providers, and clients and families about them.	3.3	
The governing body receives reports and updates from the CEO and senior management about initiatives to communicate with and provide education to staff, service providers, and clients and families about the organization's values.	3.4	

Communication

Communication among various layers of the organization, and with external stakeholders.

Surveyor Comments

Strengths:

The board has fostered a constructive relationship with the CE-LHIN, and perceives that both board and CEO are maintaining a productive relationship with this key stakeholder.

The CEO is a board member of the Diagnostic HDIRS Board that is overseeing the depository and archiving system for 23 hospitals. The CEO reports on a regular basis to the CE-LHIN CEO group on progress. NHH will be connected to the depository system in the near future.

Approximately two percent of the hospital budget is spent on information technology (IT). A new IT strategic plan has been developed and is in draft form, awaiting approval. An information management (IM) steering committee is in place. This committee looks at IM issues from a broad perspective, which encompasses not only IT, but also clinical informatics, decision support, privacy and medical records.

The NHH has made conscious efforts to evaluate the various communication vehicles that it has deployed over the last year. The number of communication presentations and the various modalities that have been used to communicate and inform internal staff and the external stakeholders is impressive.

Areas for Improvement:

From the community partner's perspective, hospital staff are accessible and supportive but many are not clear on the role of Northumberland community care services. There is no link to the hospital for prevention and promotion.

The hospital has a positive reputation in the community. It is seen as collaborative and a good partner. Becoming more involved in community events with a booth at the Home Show may help the hospital to 'tell its story' and be seen as more visible in the community.

There is potential for more partnerships for regional clinical services according to community partners. None of the participants has been involved in clinical service planning with the hospital. This is an area for consideration and opportunity.

No Unmet Criteria for this Priority Process.

Physical Environment

Providing appropriate and safe structures and facilities to successfully carry out the mission, vision, and goals.

Surveyor Comments

Strengths:

Special needs of clients are met with such things as privacy areas, wheelchair access, access to outdoor courtyards. There is universal signage and symbols with Braille in the elevators.

There is safe, effective and efficient use of equipment, supplies, medical devices and space. The hospital underwent major standardization of equipment when it first opened and asset purchases have continued to be standardized as part of the capital refresh process.

There is a good preventive maintenance (PM) program with tracking of assets in both facilities and bio medical services. Bio medical services are provided via a contract arrangement, with three days of dedicated service, and is also involved in the evaluation and acquisition of any new biomedical equipment.

Plant renovations have been undertaken to gain efficiencies and savings and to ensure that infrastructure is maintained as it starts to age for example, roof replacement, and pipe replacement for soft water use.

The hospital facility has been acknowledged historically for being at the leading edge of being "green" with three projects under active consideration or in the process of being implemented; Project Eco, which is designed to recover savings from heat recover from steam/water systems, has been completed and is achieving $120K in annual savings; a variable frequency drive in the existing ventilation system is being implemented and is expected to achieve $65k in annual savings; and solar cells on the rooftops and a co generation project are under investigation to determine the feasibility of the business cases and cost benefit.

New staff receive orientation on infection prevention and control procedures. They know how to follow protocols during construction and renovation projects, as well as when they need to do work on the in patient units such as hand hygiene and use of personal protective equipment (PPE).

There is a good skill set and age mix amongst the engineering staff, with recent recruitment that permits effective coverage during off hours and holidays. Educational support is given to those wishing to acquire further training and certification.

Good back up systems are in place for critical systems such as the boiler. The physical space and condition of these systems are well maintained, as are the areas where biomedical waste is stored.

The security monitoring system in ER works well. The ER has not only negative pressure patient rooms but an entire block of space including corridor space that can be maintained under negative pressure. It is assessed on an annual basis.

A preliminary facilities management (FM) global risk report has been submitted to the director of environmental services specific to fire safety and the sprinkler and hydrant system. The report is currently under internal review and it would appear that the hospital has taken the appropriate measures to ensure safety.

Areas for Improvement:

As the hospital implements its planned service and bed reductions, it is encouraged to implement plans that will keep the areas closed in a way that protects assets. It also needs to ensure that use of utilities and other energy sources are reduced to a minimum to prevent waste and maximize on cost savings.

The hospital is encouraged to continue with 6S activities for the purpose of reducing waste.

No Unmet Criteria for this Priority Process.

Emergency Preparedness

Dealing with emergencies and other aspects of public safety.

Surveyor Comments

Strengths:

Fire drills are conducted on a very regular basis and during the off shift hours. Fire awareness is at a very high level in this hospital. The fire chief conducts regular fire inspections and has commended the hospital for its vigilance, planning and practice in this area. The surveyor saw first hand, the responsiveness to a real code red when on site. It occurred in the laboratory and involved a piece of machinery. Staff response to the situation was immediate. The code was called and all measures outlined in the protocol were followed until the fire department took charge of the situation. A debriefing with staff occurred immediately after the incident and a further debriefing also took place regarding lessons learned. The above was all done in real time.

The NHH is engaged with external partners in planning local and county responses to disaster planning. The last large county wide simulation exercise occurred in 2007 and involved a train derailment. Another exercise involving community stakeholders is planned for the fall of 2010, and the hospital is actively involved in the planning of this event.

There is evidence that the contingency plans have been regularly reviewed and updated. There have been recent real life experiences with code orange, code black, and code white as well as table top exercise to practice code green in 2009.

The NHH has had a pandemic plan for more two years and it was refreshed after the H1N1 experience. Issues were identified with expectations of responsibilities for assessment centres associated with the HIN1 experience with the public health (PH) unit. It was noted that the NHH experience was not unique in terms of direction and planning support from public health.

Staff and the leadership and quality committee debrief after each major incident to learn from the experience and then subsequently, to modify their contingency plans as appropriate.

The NHH has invested in non violence crisis training in designated high risk areas such as ER.

Areas for Improvement:

The NHH has engaged an IMS consultant to rewrite its existing codes to conform with the IMS framework. The intent is to circulate the revised contingency plans in the revised framework to the JOHSC for approval and then to the leadership and quality committee. Further, a partnership arrangement is in place with Lakeridge Health Corporation to do training once the plans are in the IMS format. It was noted that Medworxx Learning Management System will be used for e-training for the codes, including the pandemic plan. The hospital is encouraged to follow up on the above action plan.

No Unmet Criteria for this Priority Process.

Patient Flow

Smooth and timely movement of clients and their families through appropriate service and care settings.

Surveyor Comments

Strengths:

This hospital has capacity in its emergency services, diagnostics imaging (DI), and laboratory services. The Emergency Department (ER) rarely has need to have admitted patients waiting overnight in ER, even though the ALC patients occupy between twenty and thirty percent of the in patient beds. Having said this, the leadership team is aware of the demographics, and the growing and aging population. The team is actively engaged in programs to enable the elderly to be looked after in the place of their choice and to be in the right place at the right time.

Current or planned initiatives include; the HELP program; and, the "NP stat" program which is LHIN based, and can also be utilized for follow up if a patient is discharged to one of the identified care facilities. There is also the "home at last" program; the "Hospital to Home" program; the Regional Geriatric Program Senior Friendly Hospital Strategy; and extending physiotherapy coverage to include the weekends.

The leadership is also undertaking a detailed analysis of the ALC patients to ensure a complete understanding of the issues.

The H1N1 surge was handled well and included a partnership with the Port Hope walk in clinic and coverage hours.

There are other areas that will be researched. These include the admission of persons with a fractured hip only to have to transfer them onward; and, re-admission of surgical patients within 24 hours of discharge and whether they should be readmitted to the facility where the surgery was done. The organization is exploring the potential to expand the chemotherapy and dialysis programs in line with the demographic shifts, along with exploring the potential to help other hospitals in the LHIN when their facilities are at capacity

The clinical tracers undertaken showed no major issues with flow, either within the organization or during transfers to tertiary centres and repatriation to NHH.

Areas for Improvement:

No areas for improvement are identified.

No Unmet Criteria for this Priority Process.

Medical Devices and Equipment

Machinery and technologies designed to aid in the diagnosis and treatment of healthcare problems.

Surveyor Comments

Strengths:

This team has an excellent physical layout with very clear flow patterns for separating dirty from clean. There is a "dirty" elevator and a clean elevator to/from the operating room. The team has space to do its job. The "dirty room" is a negative pressure room. There are colour coded bins for the transfer of clean and dirty endoscopes.

This team has made several improvements such as centralizing all sterilization/cleaning to CSR. None is done in diagnostics (DI) or obstetrics (OB).
There is no flash sterilization. Extra dental sets were purchased to enable this.
There is no re use of single use devices (SUDs).
No trays are released until three hours of the biological markers. Only under duress and after following a policy and procedure, might a tray be released after one hour.
Every load sterilized has a biological marker, exceeding the current standards which require only the first load of the day.
The humidity in the whole building is controlled with cooling the air to 55 and then re heating. This removes the humidity.

The PM scheduling is automated. All bio medical assets are entered into the computer, with details of purchase, serial numbers, and PM plan.
Baxter pumps have been recalled. All pumps are currently "loaners" and all were tested by the biomedical engineer via external contract before being put into use. This person is present three full days per week. The plan is that when Baxter returns the hospital pumps, or supplies new ones, each one will be tested before being put into use.

Areas for Improvement

No areas for improvement are identified.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Reprocessing and Sterilization of Reusable Medical Devices		
The record allows team members to track individual items or devices associated with a sterilizer or sterilization cycle.	6.3	↑

Direct Service Provision

This part of the report provides information on the delivery of high quality, safe services. Some specific areas that are evaluated include: the episode of care, medication management, infection control, and medical devices and equipment.

Findings

Following the survey, once the organization has the opportunity to address the unresolved criteria and provide evidence of action taken, the results will be updated to show that they have been addressed.

Ambulatory Care Services

Clinical Leadership

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

Surveyor Comments

Strengths:

Staff feel that they receive good support from leadership relative to education.
Staff identify that they are well informed about corporate initiatives. They particularly appreciate the Monday updates.
This is a fabulous geographic location, with well laid out and spacious facilities.

Areas for Improvement:

Following the completion of the corporate strategic plan, directors will be able to move ahead with establishing measurable, achievable and needs based goals and objectives that align with the strategic plan.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team collects information about its clients and the community.	1.1	

The team uses the information it collects about clients and the community to define the scope of its services and set priorities when multiple service needs are identified.	1.2
The team's scope of services is aligned with the organization's strategic direction.	1.3
The team regularly reviews its services and makes changes as needed.	1.6
The team works together to develop goals and objectives.	2.1
The team's goals and objectives for ambulatory care services are measurable and specific.	2.2

Competency

Developing a highly competent interdisciplinary team with the knowledge, skills and abilities to develop, manage, and deliver effective and efficient programs, services, and care.

Surveyor Comments

Strengths:

The staff in this department are a very dedicated group of individuals in their efforts to provide quality care for their patients. Staff bring targeted educational backgrounds to their work and attend in services readily to maintain their expertise.
Staff feel well supported by the dialysis program in Peterborough. While this team visits on a regular basis, they are readily available via telephone to provide more urgent support.
Staff indicate that they feel supported by the organization and one another to do this difficult, emotional work.

Areas for Improvement

No areas for improvement are identified.

No Unmet Criteria for this Priority Process.

Episode of Care

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

Surveyor Comments

Strengths:

The dialysis and chemotherapy programs have a good working relationship with the multidisciplinary team in providing holistic care to their patients.
Patients indicate that they are well informed of their clinical progress. The chemotherapy unit provides booklets for patients to keep track of their laboratory measures.

The dialysis program is supported by the Peterborough clinic in the assessment and management of patients that present with challenging behaviours.
Staff are particularly attuned to meeting the emotional needs of their patients, as well as their physiological needs. This includes supporting patients in their decisions regarding end of life planning.

Areas for Improvement:

Explore the adoption of a pain scale, consistent with the remaining clinical areas of the hospital.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team uses standardized clinical measures to evaluate the client's pain.	8.6	
The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.	12.2	
There is a demonstrated, formal process to reconcile client medications at referral or transfer.	12.2.1	
The process includes a timely comparison of the prior-to-referral or prior-to-transfer medication list with the list of new medications ordered at referral or transfer.	12.2.3	
The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made.	12.2.4	
The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff and pharmacists, as appropriate.	12.2.5	

Decision Support

Information, research and evidence, data, and technologies that support and facilitate management and clinical decision-making.

Surveyor Comments

Strengths:

There is a very robust program for the monitoring and maintenance of the dialysis machines.
Staff indicate that they have the tools for completing their work.
Staff state that they are adequately orientated to any new equipment brought into their work area.

There is a very well laid out plan for monitoring the patients' status relative to infections and vaccinations.

Areas for Improvement:

No areas for improvement are identified.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

The identification and monitoring of process and outcome measures to evaluate and improve the quality of services to clients and the impact on client outcomes.

Surveyor Comments

Strengths:

There is great care taken to ensure double checking of chemotherapy dosing.
Patient satisfaction surveys are sent out.
The ambulatory care department is very fortunate to have dedicated volunteers to support the program.

Areas for Improvement:

Identification of the program's goals and objectives will lead to the measures that can be taken to evaluate the team's progress at the program level.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team identifies and monitors process and outcome measures for its ambulatory care services.	18.1	↑
The team uses the information it collects about the quality of its services to identify successes and opportunities for improvement, and makes improvements in a timely way.	18.4	↑
The team shares evaluation results with staff, clients, and families.	18.5	

Critical Care Services

Clinical Leadership

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

Surveyor Comments

Strengths:

A critical care information system is available, which allows for good access to pertinent information for planning and trending purposes.

The critical care coaching team has provided support to the hospital to implement best practices given its local reality. One coaching initiative entailed looking at the model of medical coverage to the unit. The solution involves coverage by two internists doing Monday to Friday coverage, with qualified general practitioner (GP) coverage on the off shift hours and internist locum support on some weekends. This has proven effective in allowing the unit to be operational as well as supporting the hospital's ER department. A second critical care coaching team focusing on end of life care has allowed for the implementation of best practices in this area. Staff have had training to support these coaching initiatives namely ACES for physicians and end of life training for nurse champions. This has allowed for very good performance in managing the patients that present to the ICU.

The ICU is very well equipped and the staff are aware of the process to acquire new technology, which supports the care activity in the unit.

A plan for surge capacity is in place.

Areas for Improvement:

The clinical and medical leadership are encouraged to review the data collected for planning purposes. The current occupancy is fifty one percent. Pending approval of the corporate strategic plan, strategic planning for the clinical service must be considered so that informed and planned action can be taken with respect to the future of this service. Planning for this service needs to include the staffing of this area from both a medical and clinical personnel perspective.

Management and staff are encouraged to look at how the inter professional model of care can be further strengthened so that everyone is working at full scope. Also, there needs to be maximum flexibility of staff to be able to adjust to changing acuity and case mix in the units, especially in an environment of fiscal constraint.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team uses the information it collects about clients and the community to define the scope of its services and set priorities when multiple service needs are identified.	1.2	
The team regularly reviews its services and makes changes as needed.	1.5	
The team works together to develop goals and objectives.	2.1	
The team's goals and objectives for its critical care services are measurable and specific.	2.2	

Competency

Developing a highly competent interdisciplinary team with the knowledge, skills and abilities to develop, manage, and deliver effective and efficient programs, services, and care.

Surveyor Comments

Strengths:

Respiratory therapist (RT) and social worker coverage are relatively recent additions to the intensive care (ICU) team. The addition of the RT with seven day coverage has resulted in the unit being able to handle more acutely ill patients without their needing to be transferred out of the community for care.

The commitment to continuing medical education (CME) and the certification status of both the staff and physicians working in this ICU is impressive. Both a physician and nurse are ALC instructors. Having this capacity to train in house is noteworthy. To maintain their competency, two physicians work in an ICU at Kingston. Nursing staff in this area are supported in acquiring additional skills and education in critical and coronary care.

The team has been very receptive to the best practices brought to them via the coaching teams as well as the end of life coaching teams dealing with the intensivist led model of care. There is tangible evidence that the medical and clinical staff have customized their learning to the hospital's situation and are providing very good care to their patients.'

Areas for Improvement:

The clinical team is encouraged to look at the implementation of standardized order sets to guide care delivery.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	3.10	

Episode of Care

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

Surveyor Comments

Strengths:

There is a good understanding of best practices around end of life care. The team has demonstrated responsiveness to accommodate special requests for clients that have specific cultural needs. This is not common but when required, the team goes out of its way to do what they can to accommodate the exceptional requests for respecting aboriginal tradition, and other cultural needs.

The ICU has admission and discharge criteria, and Criticall is used when patients present with care needs beyond the capacity of the ICU. The unit does not do prolonged ventilation of patients. The clinicians indicate that they receive good support from hospitals to which they refer.

Patient assessments are comprehensive. If additional medical expertise is required, the MRPs in the ICU receive good support from specialists that they contact for telephone consultation around infectious diseases, neurology, and cardiology.

There is timely support provided by the radiologists and the laboratory .

The ICU has developed a visual management system in the unit. The system allows all staff to readily see what patients can be transferred out to accommodate surge activities should that be required and which patients can be moved out as soon as an in-patient bed is available. There do not appear to be any major obstacles to repatriating patients back to the community, provided the unit can manage the care with the medical and other resources available to it.

Assessment of pain and its management is well done. The PYXIS system is available for medication dispensing.

The staff have made improvements in communicating pertinent clinical information when the patient is transferred from one location to another. A work sheet has been developed to guide the type of clinical content that is shared when care is transferred to another provider.

The end of life follow up survey that is done with family when members of their families die provides very helpful feedback to staff. The information that is received is reviewed by staff and they respond to the suggestions and comments that are made. The feedback received is reinforcement to front line staff that they have made a difference in the lives of their patients. They are justifiably proud of the care and impact they had on the lives of families during difficult times.

Areas for Improvement

The ICU has initiated medication reconciliation on transfer, and the process was only recently established. Consequently, there is a learning curve for staff so they can adapt accordingly. It is suggested that with experience, the process be revisited to see if it can be further streamlined, especially in light of the paperwork that is currently being handled.

The team is encouraged to continue expanding the use of order sets. Also, work with the staff in ER to have these order sets implemented earlier such as for the sepsis protocol and so on.

No Unmet Criteria for this Priority Process.

Decision Support

Information, research and evidence, data, and technologies that support and facilitate management and clinical decision-making.

Surveyor Comments

Strengths:

The ICU physician model of coverage is customized to the local situation to allow for the best use of physician skills sets, given the medical manpower available in the community. The model has allowed the hospital to maintain its operation of six ICU beds and support the ER department for the community.

The staff working in the area are very well trained and committed to maintaining their skills. The introduction of an RT and another ventilator has allowed the staff to consider expanded modes of ventilation. It also has allowed them to look after sicker patients for longer periods than they otherwise would have been able to previously.

The team in ICU has demonstrated both interest and commitment to adopting best practices via coaching team exposure and more recently, changes in practice associated with the efforts to reduce and eradicate C-Difficile outbreaks. An antimicrobial stewardship program is in effect and all clinicians are aware of efforts being made on this front.

Area for Improvement:

It is suggested that the team consider interdisciplinary case reviews for both quality review, as well as shared learning.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

The identification and monitoring of process and outcome measures to evaluate and improve the quality of services to clients and the impact on client outcomes.

Surveyor Comments

Strengths:

There is high patient satisfaction from clients that have been hospitalized in the ICU.

The team in ICU has implemented the Safer Health Care Now bundles for ventilator assisted pneumonia (VAP) and CLI. There have been no infections for a substantive time, and for which the staff are justifiably proud.

Staff are knowledgeable about how to report incidents, and know their responsibilities pertaining to the disclosure policy.

Hand hygiene behaviour is done consistently at a very high level by all staff including medical staff in the unit. Patients/clients are educated around hand hygiene and feel comfortable in asking staff to wash their hands if they have not observed them doing so. Families of patients are taught about hand hygiene and there are ongoing reminders when they are in the unit visiting.

Areas for Improvement:

The team is encouraged to do ongoing benchmarking of its practices including resource use, with other peer comparators.

The team should consider sharing its evaluative data with staff, clients and families in a more formal manner.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team shares benchmark and best practice information with its partners and other organizations.	14.4	
The team shares evaluation results with staff, clients, and families.	16.5	

Diagnostic Imaging Services

Impact on Outcomes

The identification and monitoring of process and outcome measures to evaluate and improve the quality of services to clients and the impact on client outcomes.

Surveyor Comments

Strengths:

The organization uses two known patient identifiers and engages the patient in this safety process.
There is a policy and procedure for client identifiers, which outlines what to do should the patient be unable to verify the processes themselves.
The DI department uses a form of "time out" prior to invasive procedures.
The organization has implemented an electronic adverse reporting system. The system has improved capacity to respond to events quickly and allows for issue trending.

No Unmet Criteria for this Priority Process.

Diagnostic Services - Diagnostic Imaging

Availability of diagnostic imaging to provide health care practitioners with information about the presence, severity, and causes of health problems, and the procedures and processes used by these services.

Surveyor Comments

Strengths:

The DI department trends volumes routinely to determine service trends and impact on wait times. A review is done on a weekly basis and adjustments are made accordingly. For example, wait times in ultrasound were increasing and a third room was implemented to reverse this trend.
There is a very collegial relationship between the radiologist team and family physicians. There are processes in place for radiology support of the ER department, feedback processes and critical value reporting.

The physical layout of this department was carefully considered relative to its proximity to high volume customers. Rooms are spacious, well designed and with generous facilities for patient waiting, changing and washrooms.

A new process has been established for reprocessing items used in the department. Facilities for the storage of the contaminated device are in place and the item is transported to SPD for reprocessing.

Areas for Improvement:

Consider establishing a formal system for the archiving of old policies and procedures at the department level. There is an informal system currently in place, but it was agreed that a more formal system would be helpful.
Consider establishing a formal quality review program for the radiologists. The current system is informal and feedback is readily given and encouraged.

No Unmet Criteria for this Priority Process.

Emergency Department Services

Clinical Leadership

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

Surveyor Comments

Strengths

This team is very aware of the percentage of CTAS grades of patients registered in the emergency department. Using a process study with engagement of the staff, analysis has identified the need to make changes to the "blue zone". The hope is that engaging staff in the analysis will help with the management of the changes.

Examples of partnerships with external partners include a partnership with the police to include on transfer a succinct description of a patient at risk for going AWOL for at risk patients. Another is the partnership with LHIN, police and emergency (EMS) to enable the crisis worker to make a community visit with these supports, rather than transfer the client to the emergency room for assessment. Analysis has shown that most of these clients would be assessed and discharged from the ER. It is hoped that this program would enable assessment and treatment in the community setting thus, making a transfer to the ER unnecessary. The third example is assessments of possible Form 1 patients OTN to avoid a transfer if they do not meet the criteria.

Student placement is encouraged. A laboratory student, and co operative high school student were interviewed. The students felt that their orientation was excellent and that it certainly covered patient safety and confidentiality. The acting head of ER physicians states that medical residents from Queens University are also on site at times.

Some audits have been done in this department. The nursing team has been actively involved in redesigning a nursing admission sheet, as an audit showed that the head to toe nursing assessment sheet was not being used. This team is encouraged to utilize the new form to ensure nursing assessments are documented, audit use and make changes where necessary.

Another audit examined the transfer of accountability (TOA) forms. As a result of multiple incomplete TOA forms, the team has redesigned the forms. The team is encouraged to repeat the audit to ensure that the forms are accurately and consistently used to enhance patient safety.

The staff in this department were under significant stress in November 2009. Employee assistance (EAP) support was accessed and was helpful to the team.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team works together to develop goals and objectives.	2.1	

Competency

Developing a highly competent interdisciplinary team with the knowledge, skills and abilities to develop, manage, and deliver effective and efficient programs, services, and care.

Surveyor Comments

Strengths

The team in the ER is made up of nursing, physicians, and gerontology emergency management (GEM) nurse, RT, IPAC, and crisis worker as necessary, and a volunteer. A hospital porter is eagerly awaited.

The RT has been active in training all the registered nurse (RN) staff on the new ventilator that included strip, rebuild, and retest.

The monitoring of up to date credentialing of nursing staff is done but not in a formal manner Regular performance appraisals coupled with the team's goals and objectives for the year would help plan an educational program for the staff. The new e-learning IT program will have capability to help with this when it is fully functional.
With the advent of the new e-learning module, credentialing with be kept electronically and will be easier to track.

Areas for Improvement

No areas for improvement are identified.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team monitors and meets each team member’s ongoing education, training, and development needs.	4.7	
Team leaders regularly evaluate and document each team member’s performance in an objective, interactive, and positive way.	4.10	

Episode of Care

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

Surveyor Comments

Strengths and Areas for Improvement

This team has excellent support from the laboratory, echocardiography (EKG) and DI. There is use of the picture archiving communications system (PACS) and there is a way to document and deal with discrepancies in DI interpretations.

The team does evaluate and assess patients' pain. However, the pain scale on the triage form is only infrequently, if ever filled out. The pain score is to be incorporated into the CTAS assessment. There is a place there for the pain using 0-10 but it is not filled in, and even for clients/patients that present with quite severe pain, this was empty. In the charts reviewed the pain was treated, and charted in the nursing notes. However, the routine use of 0 to 10 is not in place and a pain flow sheet is not in use. The team is encouraged to have triage include a 0 to 10 pain scale rating on the appropriate area of the triage form as a highlight for the nurses. The new nursing assessment form has the 0 to10 pain scale as a fifth vital sign and a pain flow sheet is incorporated. The team is encouraged to initiate a plan, do, study, act (PDSA) cycle, then implement an assessment form that includes pain assessment and treatment so that this becomes "hardwired" in the process.

The team has done an audit of transfer of accountability in the organization. The staff were surprised to find how, in a significant number of transfers within the two week period (17/19), pertinent information was not passed along. This has led to a change in practice.

Physician staff for coverage of all shifts in the emergency room continues to be a strain for this organization. All shifts are covered but at a cost.

The registration staff are concerned that having one of the registration clerks also work as the switchboard operator might be jeopardizing some confidentiality issues because of being physically located close to the waiting room. This person's voice can be heard in the room.

One surveyor tripped over the black rug upon entering the facility. The chair by the registration clerk is easily caught on another black rug.

Several clients/patients suggested that a coffee machine would be nice to have for after hours waiting in ER.

The registration clerk suggested the term, "common law" be added to the drop down list of relationship to next of kin, as the only other possibility for those living with someone was "partner" and that might imply a same sex relationship.

One patient, in pain, stood after registration because she was afraid if she sat down she might lose her place in the line up. This person suggested signage that detailed the steps to be seen in a timely manner might be helpful.

Abuse screening is done for all female registrants. The team is encouraged to choose other screening tools for use such as pain, falls screening assessments, as well as screening tools to case find for geriatric nurse services.

The best medication history forms are utilized. Frequently however, these forms contained simply a nursing list of medications that had been written on the sheet. The tick box for where the information was obtained is not utilized, neither is the reconciliation evident, nor was the form dated and signed, and this was the case for many of the charts that were reviewed.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team informs clients in the waiting area of wait times for assessment and treatment.	7.5	
Medication Reconciliation following triage.	8.4	
The team has addressed all priority for action flags, based on results of their indicator “medication reconciliation at admission”.	8.4.2	

Decision Support

Information, research and evidence, data, and technologies that support and facilitate management and clinical decision-making.

Surveyor Comments

Strengths:

The DI, and laboratory provide an excellent resource, which also includes quick reporting of results. There is also an excellent process for handling urgent results, as well as discrepancies in DI reports between ER physicians and the radiologist at their review.
There is consistent use of two identifiers.
There are good working relationships with external stakeholders such as specialists at tertiary centres, LHIN, police, and CCACs.
There has been a recent study of CTAS levels, utilization of space, and a time study and from these, decisions about redesign and flow of delivery are being implemented.
All of the staff here make good use of the "awareness to action" tool.
There is incorporation of students into the emergency team.
The orientation package for new staff and students is comprehensive and contains elements of patient safety and confidentiality.

Areas for Improvement:

Implement a process for the team to identify goals and objectives for the year. These should be measurable, achievable, and serve to guide the education plan.
Develop an education plan for the department. It is noted this will be facilitated by the new e-learning package that is becoming available.

Complete the development of the new nursing assessment documentation tool and the transfer of accountability form. Implement their use with education and then repeat the audit, informing the staff of the audit results.
Identify and implement screening tools applicable to the team's population for example, fall screening tool, and confusion/delirium screening.

Continue the work on pain assessment and management. Provide education to triage on use of the 0 to 10 scale to document the level of pain upon arrival at the site and as well, incorporate this into the CTAS score.
Implement the new nursing assessment sheet that is currently a work in progress. This will include a pain flow sheet using 0-10 for ease of documentation and assessment of medication's effectiveness. This would help their nursing colleagues at the next level of care to quickly assess what is required for adequate comfort.

Implement regular safety briefings with the team.

Continue to explore ways and means to have a full complement of physician coverage for the emergency room.

Ensure that the team is aware of policy and procedure for Disclosure.

The medication reconciliation is progressing, and the form meets Accreditation Canada's criteria. Opportunities for improving this process are as follows: ensure adequate understanding of verification versus reconciliation; ensure that multiple sources are utilized to complete the BMH form, not only the list from a pharmacy; ensure an understanding of the difference between BMH and medication reconciliation, as BMH is only the starting point; ensure the forms are completed thoroughly; and, ensure that the BMH list and the admission orders are compared and that the form shows the act of reconciliation between the two lists. It will be necessary to implement regular audits until this process is fully implemented.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

The identification and monitoring of process and outcome measures to evaluate and improve the quality of services to clients and the impact on client outcomes.

Surveyor Comments

Strengths

This team and its DI and laboratory partners are very clear and consistent in their use of two person identifiers.

All team members are involved in "awareness to action" documentation. A good example of housekeeping using this tool was shared.

Areas for Improvement

One patient interviewed was the mother of an eleven year old patient. The mother also had a 15 month and three month old and they had been waiting for more than an hour. The young boy was requiring IV antibiotics and had to come in every eight hours over the weekend. The long waits seem to be impractical for this family. Surveyors wonder were there other options to consider including whether CCAC were involved and if there was a way to avoid having to wait on return to the ER.

Benchmarking is done for time to be seen and the data fall within acceptable ranges. However, a couple of mothers with small children were interviewed and had been waiting to be seen for up to two hours and this was stressful to them.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Staff and service providers participate in regular safety briefings to share information about potential safety problems, reduce the risk of error, and improve the quality of service.	14.3	

Infection Prevention and Control

Infection Prevention and Control

Measures practiced by healthcare personnel in healthcare facilities to decrease transmission and acquisition of infectious agents.

Surveyor Comments

The organization consistently references the Provincial Infectious Diseases Advisory Committee (PIDAC) as its guide in establishing processes. It is currently reviewing the new PIDAC guidelines for environmental cleaning and considering the impact of these guidelines on their current practice.

Strengths:
The organization has low MRSA and VRE rates and is showing a downward trend in Clostridium Difficile rates.
The organization has been proactive in establishing initiatives for antibiotic stewardship.
The segregation of clean versus dirty supplies/equipment is well done.

Areas for Improvement:

The process "Rescu" is available for cleaning in a Clostridium Difficile outbreak. Consider using this for all terminal cleans of Clostridium Difficile rooms.
There are processes in place for the surveillance of infections. However, some of these processes are manual and could be streamlined through the use of automated summary reports from Meditech.
The organization may wish to consider expanding the infection control committee to include a representative from environmental services to further strengthen this important liaison.
Consideration should be given to the availability of barrier gowns for higher risk procedures.
The organization needs to establish a mechanism for the handling of visitor items when they are visiting a patient in isolation.

No Unmet Criteria for this Priority Process.

Long Term Care Services

Clinical Leadership

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

Surveyor Comments

Strengths

The LTC services has three sections namely; complex continuing care, rehabilitation, and palliative care.
All the sections/areas are exceptional in physical layout and attributes such as storage space, sunlight, windows, therapy rooms, dining area and so on.
There is access to the outside for all three areas, with an enclosed area with a circular path for those that wander.
The palliative unit has a doorway wide enough for beds to pass through.

Rehabilitation, physiotherapy and occupational therapy (OT) have therapy rooms, access to the outside, and natural lighting. The program is patient centred and focuses on patients' goals.
There are many ancillary programs such as raised gardening beds outside space, music, a visiting pet/dog program, and so on.

Areas for Improvement

No areas for improvement are identified.

No Unmet Criteria for this Priority Process.

Competency

Developing a highly competent interdisciplinary team with the knowledge, skills and abilities to develop, manage, and deliver effective and efficient programs, services, and care.

Surveyor Comments

Strengths

There are excellent opportunities for education.

The palliative care specialty unit has nurses with level I, and most have advanced palliative care certificates.
Nine family physicians were supported to receive education on a regional pain and symptom management initiative.

Areas for Improvement

No areas for improvement are identified.

No Unmet Criteria for this Priority Process.

Episode of Care

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

Surveyor Comments

Strengths

The palliative care team has a list of direct admit for use at triage to avoid/shorten emergency room visits for known palliative clients. They work closely with CCAC. The palliative team's expertise is utilized in other locations of the hospital for end of life discussions, pain and symptom management, and CADD pumps.

This team has a minimal restraint policy and uses very few. When restraints are used they are both safe and patient friendly such as lap belts and "watch-mate". Currently, two lap belts are in use.

The team has used external partners such as a grief counsellor to help on occasion with debriefing after extremely stressful crises.

All the teams are interdisciplinary, and they are looking forward to the social worker and new chaplaincy program.

Areas for Improvement

No areas for improvement are identified.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Medication Reconciliation at Admission.	7.5	
The team does not have any unaddressed priority for action flags based on their medication reconciliation at admission indicator results.	7.5.2	

Decision Support

Information, research and evidence, data, and technologies that support and facilitate management and clinical decision-making.

Surveyor Comments

Strengths

This team for rehabilitation is participating in the Family Medicine Residents' Association of Toronto (FRAT) research, and is eagerly looking forward to the opportunity to learn more from the speciality nurse that is part of the program. Their participation was vetted through all the appropriate channels.

Areas for Improvement

No areas for improvement are identified.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

The identification and monitoring of process and outcome measures to evaluate and improve the quality of services to clients and the impact on client outcomes.

Surveyor Comments

Strengths

The physical facility for these programs provides adequate space, natural light, and access to the outdoors including beds from the palliative unit. Hallways are uncluttered and there is a storage room.
There are educational opportunities for the teams, including physicians.
There is interdisciplinary care planning and involvement and the care plan is built around the patient/family goals. There is a meeting at the time of admission, after the initial assessment, and again at six weeks.
The aboriginal community has been involved. A meeting of the elders has helped facilitate rituals and policy and procedures are in place to guide these when necessary.

Areas for improvement

Explore the development of region wide or community wide processes for palliative patients to facilitate seamless flow through to all sectors. Again, this might include a "one region, one pump" approach.

No Unmet Criteria for this Priority Process.

Managing Medications

Medication Management

Interdisciplinary provision of medication to clients.

Surveyor Comments

With the introduction of automated dispensing cabinets, the pharmacy was able to complete a LEAN process to streamline the processes and storage in the pharmacy department. Lexicom and Compendium of Pharmaceutical Specialties (CPS) are on line as medication information systems. The hospital formulary is also available on line. Staff and physicians are able to consult with pharmacy staff about specific medications or patient medication issues. There is a medication segment in the nursing orientation program, which pharmacy completes. It is unfortunate that the CCAC has changed their PCA pumps, as these are now inconsistent with the hospital pumps. This creates difficulty in ER when the patient comes in to the hospital. There is a process in place for the assessment and verification of patient allergies. This is done in partnership with the pharmacy technicians and nursing staff to determine whether there is a true allergy, or if this patient perceives it to be an allergy as a result of adverse drug reaction. There are processes in place for the identification of medication errors and appropriate investigation and follow up, which are done within a learning environment. Examples were provided whereby an incident report led to improvements. Multiple safety mechanisms are in place for procurement, storage and medication administration record processes

Strengths:

Pharmacists are part of clinical teams. Also, there is an active safe medication practices committee.
Quite impressive is the thoughtfulness evident in the design of the PYXIS drawers to minimize the risk of picking error. Both pharmacy and nursing staff are very engaged in making this system workable and as safe as possible.
There are good processes in place for the order entry and processing of chemotherapy treatments.

Areas for Improvement:

The organization has a double check process for several high risk medications. Encouragement is offered for the implementation of double check processes for all pressors, insulin, narcotics, chemotherapy and heparins (PINCH) drugs.
Clarify design of the medication reconciliation on admission as a physician order sheet. This will assist in reducing transcription error due to difficult to read hand writing.
Work on reducing the turn around time from physician order to pharmacy verification.
Consideration should be given to the routine cleaning of patient medication bins.
The process for clarifying physician orders through 'fax' forms is a good one however, it is suggested that a cue to identify patient allergies be added.
Select nursing staff have been delegated to enter the pharmacy department after hours to dispense a medication that is not available in the PYXIS system. Recertification is not currently being done, but it is understood that this is being planned. In keeping with best practices, it is recommended that the organization consider the implementation of an automated night cart dispensing unit, to limit the entry of only pharmacy personnel into this department.
While there are pre-printed orders available, frequency of use is limited.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The organization has access to a pharmacist on a 24-hour basis to answer questions about medications or medication management.	1.6	

Medicine Services

Clinical Leadership

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

Surveyor Comments

Strengths

This team has recently started to formulate goals and objectives. The work has been somewhat diverted by recent announcements. The team meets regularly and several good initiatives have moved forward such as changes to and processes around the crash cart, and development of a pamphlet for the families/patients that are deemed ALS.

Areas for Improvement

No areas for improvement are identified.

No Unmet Criteria for this Priority Process.

Competency

Developing a highly competent interdisciplinary team with the knowledge, skills and abilities to develop, manage, and deliver effective and efficient programs, services, and care.

Surveyor Comments

Strengths

There are several awards offered in this organization to staff. These include the Healing Hands award, an award for 100 percent attendance for the year; Bright Ideas award; education award; Group Achievement award; Outstanding Innovation award; Excellence in Leadership award; and, length of service awards.

Areas for Improvement

No areas for improvement are identified.

No Unmet Criteria for this Priority Process.

Episode of Care

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

Surveyor Comments

Strengths and Areas for Improvement

While the "bullet rounds" serve a good purpose, interdisciplinary functioning might be enhanced with the development of interdisciplinary care maps.

Some order sets are in place.

Development of interdisciplinary care plans for key diagnostic groups and/or high risk groups might facilitate timely assessment and treatment by all disciplines. This might also facilitate timely discharge, with consideration given to including automatic referrals and expected length of stay (LOS).

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Medication Reconciliation at Admission	7.5	
The team does not have any unaddressed priority for action flags based on their medication reconciliation at admission indicator results.	7.5.2	

Decision Support

Information, research and evidence, data, and technologies that support and facilitate management and clinical decision-making.

Surveyor Comments

Strengths

This team has undertaken two recent research initiatives namely, FRAT and Nutrition Day. The former was done with Rehabilitation and involved fractured hip in a patient with dementia. Both are research projects by larger institutions, and their involvement was vetted through the proper channels of this organization.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

The identification and monitoring of process and outcome measures to evaluate and improve the quality of services to clients and the impact on client outcomes.

Surveyor Comments

The system of "awareness to action" alerts the team to risk areas and safety risks.
Two potential safety items during 'surveyor rounds' are: an unattended and unlocked medication cart with medication in two of the drawers. A nurse sitting at the far end of the hall noticed a surveyor opening the drawers, and did appropriately intervene. It was not her cart. The second potential safety item is that a laboratory blood collection tray was left in a patient's room. It was there at least twenty minutes unattended.

Strengths:

Patients that were interviewed in person and by telephone were very pleased with their care and felt very safe.
There is excellent medication reconciliation on transfer and discharge. The physician filled in the medications from admission by hand and indicated they were to be discontinued.
The typed medication list is easy to read. It is used as a prescription when signed, with copies to the chart, CCAC, family physician, and specialist. This is an excellent innovation.
Complete assessments and all screening tools were used in the charts reviewed. Every bed had a mobility plan clearly marked.
The system of "awareness to action" is seen as a very helpful tool, including tracking adverse medication events and highlighting the importance of medication reconciliation.
The mobile physiotherapy cart seems a good innovation to save steps and time.
A good innovative idea by front line staff involves a pamphlet for ALS patients and their families regarding expectations.

Areas for Improvement:

Expand the medication reconciliation discharge medication list and prescription to include not only the discharge medications but also the admission medications that the patient might no longer be on. The physician can then clearly mark these as discontinued. This is important information for the patient, community pharmacy, and family physician. Otherwise, it can be assumed that the prescription is only for new medication and the old medication could be continued.

Explore best practice for discerning advance directives. There is an area on the nursing assessment form but there might be some reluctance to initiate the conversation as it is often left blank. Some charts reviewed were high risk for sudden events and there was no indication of patient's wishes. Currently, the staff indicate that this is physician driven. However, other professionals can help to raise the issue and open the discussion.

No Unmet Criteria for this Priority Process.

Obstetrics/Perinatal Care Services

Clinical Leadership

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

Surveyor Comments

Strengths:

The team collects data about its service via the NIDDAY system. There has been a twenty percent increase in volume over the last year and it is felt that the service will continue to grow as a result of larger volumes of young families entering the region. The midwives have a large referral basin.
The program has a Level 1 nursery and good relationships with its referral centres. Transport to these centres is easily facilitated. There is a strong team approach to program planning and patient care.

Areas for Improvement:

There is a good working relationship with the local Children's Aid Society. There may be some benefit in creating a proactive relationship with this organization to streamline future interactions.
Storage of supplies in a patient room increases the risk of infection transmission. The team is encouraged to consider alternative supply sources that will reduce this risk.

No Unmet Criteria for this Priority Process.

Competency

Developing a highly competent interdisciplinary team with the knowledge, skills and abilities to develop, manage, and deliver effective and efficient programs, services, and care.

Surveyor Comments

Strengths:

The program has been involved with the managing obstetrical risk (MORE) program for several years. Mock exercises to prepare for obstetrical and neonatal emergencies are practiced.
Staff from this program will assist with neonatal resuscitation should a code pink occur in the ER department.
Some staff from the neighbouring medical unit are cross trained, so that assistance can be provided when needed.
There are two delegated laboratory procedures for obstetrics staff. A certification program is in place for these procedures

Areas for Improvement:

Some nursing staff have been provided with pharmacist delegated dispensing and are allowed access to the pharmacy department. In keeping with best practices, consideration should be given to introducing an expanded night cart system, so that only pharmacy staff enter the pharmacy.

No Unmet Criteria for this Priority Process.

Episode of Care

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

Surveyor Comments

Strengths:

The obstetrician reports that there is excellent support from anaesthesia for this program. There is a high epidural request rate from this population and this is able to be accommodated.
There are good processes in place to reduce the risk of newborn abduction.
Patients/clients report that they are well informed of the unit routines and what to expect during their experience, as well as their return home.
Significant others are supported in their efforts to provide support to the new mother.

Areas for Improvement:

While some work has been done using LEAN methodology for the clean utility room and NICU, more work could be done to make these more streamlined areas

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.	11.3	
There is a demonstrated, formal process to reconcile client medications at referral or transfer.	11.3.1	
The process includes a timely comparison of the prior-to-referral or transfer medication list with the list of new medications ordered at referral or transfer.	11.3.3	
The process requires documentation that differences between the two lists have been identified, discussed, and resolved, and that appropriate modifications to the new medications have been made.	11.3.4	
The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff and pharmacists, as appropriate.	11.3.5	

Decision Support

Information, research and evidence, data, and technologies that support and facilitate management and clinical decision-making.

Surveyor Comments

Strengths:

This is the most recent unit to receive a PYXIS machine. It reports that it is well supported in both initial education and in ongoing adjustments.

This obstetrics/perinatal program has a very effective system for the identification of Children's Aid Society Alerts via the MediPost alert functionality.

Areas for Improvement:

Currently, the program is working toward improving its banding identification system to include a band for "dad".

No Unmet Criteria for this Priority Process.

Impact on Outcomes

The identification and monitoring of process and outcome measures to evaluate and improve the quality of services to clients and the impact on client outcomes.

Surveyor Comments

Strengths:

A recent experience with a situation of potential violence was supported with security and police presence.
Patients report that they are informed about methods to use to support their own safety during the hospital experience.
There are good double check processes in place for verification of pediatric medication dosages.

Areas for improvement.

No specific areas for improvement are identified.

No Unmet Criteria for this Priority Process.

Surgical Procedures

Delivery of safe surgical care to clients, from preparation and the actual procedure in the operating room, to the post-recovery area and discharge.

Surveyor Comments

Strengths
This team participated in a peer peri-operative/coaching review in the fall of 2009. The team has made changes as a result of this. They have developed a check list to ensure thoroughness of the interdisciplinary team process from before the patient enters the operating theatre, preparation in the room, through to assessing readiness for transfer to PACU. There are also checklists to ensure stability for transfer from PACU to the floor, or when the patient is stable to be discharged from day surgery.

This team is involved in Safer Health Care Now Initiatives.

I saw patient handouts that were thorough, easy to understand that reviewed the pre-operative assessment, date and time of surgery, and included elements of patient's safety. I also saw and commend some patient handouts developed for gynaecological surgery - very clearly laid out for the patient expectations on day 1 to day 4 post-op. The patient found this very empowering.

Since the last accreditation, this team has done much work on the consent process and is now operating under best practice, for both surgical procedures and blood product infusions. The consent is reviewed on the pre-op check list, and the patient is asked if they understand and are comfortable proceeding.

"Bullet Rounds" were observed and are a quick interdisciplinary review of expectations, any unexpected issues, planned discharge while at the same time maintaining patient confidentiality.

The team is in the process of designing and implementing a screening tool to identify patients with sleep apnea. A PDSA cycle will be implemented.

The team is partnering with DI to develop a rapid assessment of breast lump/abnormal mammogram results

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Operating Rooms		
The team is able to track all reprocessed or sterilized items so they can be recalled in the event of a breakdown or failure in the sterilization system.	12.11	

Performance Measure Results

The following section provides an overview of the performance measures collected for the entire organization. These measures consist of both instrument and indicator results, which are valuable components of evaluation and quality improvement.

Instrument Results

The instruments are questionnaires completed by a representative sample of clients, staff, leadership and/or other key stakeholders that provide important insight into critical aspects of the organization's services. The following tables summarize the organization's results and highlight each item that requires attention. Results are presented in three main areas: governance functioning, patient safety culture and worklife.

Governance Functioning Tool

The Governance Functioning Tool is intended for members of the governing body to assess their own structures and processes and identify areas for improvement. The results reflect the perceptions and opinions of the governing body regarding the status of its internal structures and processes.

Summary of Results

	Governance Structures and Processes	% Agree	% Neutral	% Disagree	Priority for Action
		Organization	Organization	Organization	
1	We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	95	0	5	
2	We have explicit criteria to recruit and select new members.	100	0	0	
3	Our renewal cycle is appropriately managed to ensure continuity on the governing body.	100	0	0	
4	The composition of our governing body allows us to meet stakeholder and community needs.	100	0	0	
5	Clear written policies define term lengths and limits for individual members, as well as compensation.	100	0	0	
6	We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations.	100	0	0	
7	Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	100	0	0	
8	We review our own structure, including size and sub-committee structure.	100	0	0	
9	We have sub-committees that have clearly-defined roles and responsibilities.	100	0	0	
10	Our roles and responsibilities are clearly identified and distinguished from those delegated to the CEO and/or senior management. We do not become overly involved in management issues.	100	0	0	
11	We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decision-making.	100	0	0	

12	Disagreements are viewed as a search for solutions rather than a “win/lose”.	100	0	0	
13	Our meetings are held frequently enough to make sure we are able to make timely decisions.	100	0	0	
14	Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	100	0	0	
15	Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	100	0	0	
16	Our governance processes make sure that everyone participates in decision-making.	100	0	0	
17	Individual members are actively involved in policy-making and strategic planning.	100	0	0	
18	The composition of our governing body contributes to high governance and leadership performance.	100	0	0	
19	Our governing body’s dynamics enable group dialogue and discussion. Individual members ask for and listen to one another’s ideas and input.	100	0	0	
20	Our ongoing education and professional development is encouraged.	100	0	0	
21	Working relationships among individual members and committees are positive.	100	0	0	
22	We have a process to set bylaws and corporate policies.	100	0	0	
23	Our bylaws and corporate policies cover confidentiality and conflict of interest.	100	0	0	
24	We formally evaluate our own performance on a regular basis.	100	0	0	
25	We benchmark our performance against other similar organizations and/or national standards.	89	0	11	
26	Contributions of individual members are reviewed regularly.	68	0	32	
27	As a team, we regularly review how we function together and how our governance processes could be improved.	95	0	5	
28	There is a process for improving individual effectiveness when non-performance is an issue.	58	0	42	

29	We regularly identify areas for improvement and engage in our own quality improvement activities.	95	0	5
30	As a governing body, we annually release a formal statement of our achievements that is shared with the organization's staff as well as external partners and the community.	100	0	0
31	As individual members, we receive adequate feedback about our contribution to the governing body.	79	0	21
32	We have a process to elect or appoint our chair.	100	0	0
33	Our chair has clear roles and responsibilities and runs the governing body effectively.	100	0	0

Patient Safety Culture Survey

The patient safety culture survey results provide valuable insight into staff perceptions of patient safety, as well as an indication of areas of strength, areas of improvement, and a mechanism to monitor changes within the organization.

Summary of Results

Number of survey respondents = 239 respondents

A. Patient Safety: Activities to avoid, prevent, or correct adverse outcomes which may result from the delivery of health care	% Disagree	% Neutral	% Agree	Priority for Action
	Organization	Organization	Organization	
1 Patient safety decisions are made at the proper level by the most qualified people	8	14	78	
2 Good communication flow exists up the chain of command regarding patient safety issues	11	18	71	▲
3 Reporting a patient safety problem will result in negative repercussions for the person reporting it	76	15	9	
4 Senior management has a clear picture of the risk associated with patient care	22	25	54	▲
5 My unit takes the time to identify and assess risks to patients	5	12	83	
6 My unit does a good job managing risks to ensure patient safety	5	9	86	
7 Senior management provides a climate that promotes patient safety	11	19	70	▲
8 Asking for help is a sign of incompetence	91	5	4	
9 If I make a mistake that has significant consequences and nobody notices, I do not tell anyone about it	95	1	3	
10 I am sure that if I report an incident to our reporting system, it will not be used against me	17	22	61	▲
11 I am less effective at work when I am fatigued	8	12	79	
12 Senior management considers patient safety when program changes are discussed	12	28	61	▲
13 Personal problems can adversely affect my performance	25	24	51	▲
14 I will suffer negative consequences if I report a patient safety problem	86	10	4	

15	If I report a patient safety incident, I know that management will act on it	6	20	73	⚠
16	I am rewarded for taking quick action to identify a serious mistake	28	38	34	✖
17	Loss of experienced personnel has negatively affected my ability to provide high quality patient care	48	25	27	✖
18	I have enough time to complete patient care tasks safely	18	23	59	⚠
19	I am not sure about the value of completing incident reports	68	17	15	⚠
20	In the last year, I have witnessed a co-worker do something that appeared to me to be unsafe for the patient in order to save time	69	10	20	⚠
21	I am provided with adequate resources (personnel, budget, and equipment) to provide safe patient care	22	23	55	⚠
22	I have made significant errors in my work that I attribute to my own fatigue	87	8	5	
23	I believe that health care error constitutes a real and significant risk to the patients that we treat	14	13	73	⚠
24	I believe health care errors often go unreported	30	25	45	✖
25	My organization effectively balances the need for patient safety and the need for productivity	11	27	62	⚠
26	I work in an environment where patient safety is a high priority	4	12	84	
27	Staff are given feedback about changes put into place based on incident reports	26	29	45	✖
28	Individuals involved in patient safety incidents have a quick and easy way to report what happened	22	20	58	⚠
29	My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures	24	26	50	✖
30	My supervisor/manager seriously considers staff suggestions for improving patient safety	12	16	72	⚠
31	Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts	73	16	11	⚠
32	My supervisor/manager overlooks patient safety problems that happen over and over	77	14	10	

33	On this unit, when an incident occurs, we think about it carefully	6	15	79	
34	On this unit, when people make mistakes, they ask others about how they could have prevented it	8	26	66	⚠
35	On this unit, after an incident has occurred, we think about how it came about and how to prevent the same mistake in the future	6	10	83	
36	On this unit, when an incident occurs, we analyze it thoroughly	13	26	61	⚠
37	On this unit, it is difficult to discuss errors	69	21	10	⚠
38	On this unit, after an incident has occurred, we think long and hard about how to correct it	11	28	61	⚠
B. These questions are about your perceptions of overall patient safety		**% Good/ Excellent**	**% Acceptable**	**% Poor/ Failing**	**Priority for Action**
		Organization	Organization	Organization	
39	Please give your unit an overall grade on patient safety	76	22	2	
40	Please give the organization an overall grade on patient safety	66	31	4	⚠
C. These questions are about what happens after a Major Event		**% Disagree**	**% Neutral**	**% Agree**	**Priority for Action**
		Organization	Organization	Organization	
41	Individuals involved in major events contribute to the understanding and analysis of the event and the generation of possible solutions	8	26	66	⚠
42	A formal process for disclosure of major events to patients/families is followed and this process includes support mechanisms for patients, family, and care/service providers	9	32	60	⚠
43	Discussion around major events focuses mainly on system-related issues, rather than focusing on the individual(s) most responsible for the event	11	36	54	⚠
44	The patient and family are invited to be directly involved in the entire process of understanding: what happened following a major event and generating solutions for reducing re-occurrence of similar events	11	49	40	✖

45	Things that are learned from major events are communicated to staff on our unit using more than one method (e.g. communication book, in-services, unit rounds, emails) and / or at several times so all staff hear about it	13	25	63	
46	Changes are made to reduce re-occurrence of major events	5	17	78	

Worklife Pulse

The concept of 'quality of worklife' is central to Accreditation Canada's accreditation program. The Pulse Survey enables health service organizations to monitor key worklife areas. The survey takes the 'pulse' of quality of worklife, providing a quick and high level snapshot of key work environment factors, individual outcomes, and organizational outcomes. Organizations can then use the findings to identify strengths and gaps in their work environments, 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.

Summary of Results

Number of survey respondents = 263 respondents

How would you rate your work environment	% Disagree	% Neutral	% Agree	Priority for Action
	Organization	Organization	Organization	
1 I am satisfied with communications in this organization.	22	27	51	Δ
2 I am satisfied with communications in my work area.	20	16	63	Δ
3 I am satisfied with my supervisor.	13	13	74	Δ
4 I am satisfied with the amount of control I have over my job activities.	18	17	64	Δ
5 I am clear about what is expected of me to do my job.	7	5	87	
6 I am satisfied with my involvement in decision making processes in this organization.	25	32	43	×
7 I have enough time to do my job adequately.	27	25	48	×
8 I feel that I can trust this organization.	21	33	46	×
9 This organization supports my learning and development.	11	23	65	Δ
10 My work environment is safe.	8	10	82	
11 My job allows me to balance my work and family/personal life.	14	18	68	Δ

Individual Outcomes	% Not Stressful	% A bit Stressful	% Quite or Extremely Stressful	Priority for Action
	Organization	Organization	Organization	
12 In the past 12 months, would you say that most days at work were…	16	46	37	✕
	% Very Good/ Excellent	% Good	% Fair/ Poor	Priority for Action
	Organization	Organization	Organization	
13 In general, would you say your health is…	61	34	5	△
14 In general, would you say your mental health is…	65	28	7	△
15 In general, would you say your physical health is…	52	40	8	△
	% Very Satisfied	% Somewhat Satisfied	% Not Satisfied	Priority for Action
	Organization	Organization	Organization	
16 How satisfied are you with your job?	92	6	2	
	% < 10	% 10 - 15	% > 15	Priority for Action
	Organization	Organization	Organization	
17 In the past 12 months, how many days were you away from work because of your own illness or injury? (counting each full or partial day as 1 day)	84	6	9	
18 During the past 12 months, how many days did you work despite an illness or injury because you felt you had to (counting each full or partial day as 1 day)?	86	10	5	
	% Never/ Rarely	% Sometimes	% Often/ Always	Priority for Action
	Organization	Organization	Organization	
19 How often do you feel you can do your best quality work in your job?	2	21	78	

	% Disagree	% Neutral	% Agree	Priority for Action
	Organization	Organization	Organization	
20 Overall, I am satisfied with this organization.	8	29	63	⚠
21 Working conditions in my area contribute to patient safety.	5	16	78	

Indicator Results

Indicators collect data related to important aspects of patient safety and quality care. The tables in this section show the indicator data that has been submitted by the organization.

Medication Reconciliation at Admission

Transition points in the care continuum are particularly prone to risk, and the communication of medication information has been identified as a priority area for improving the safety of healthcare service delivery. This performance measure will provide a practical guide for organizations as medication reconciliation is conducted more widely throughout the organization.

Medication Reconciliation at Admission				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% Formal medication reconciliation at admission
YELLOW	Northumberland Hills Hospital (Ambulatory Care Services)	Ambulatory Care Services	01/01/2009 31/03/2009	86
YELLOW	Northumberland Hills Hospital (Critical Care Services)	Critical Care Services	01/01/2009 31/03/2009	90
YELLOW	Northumberland Hills Hospital (Emergency Department Services)	Emergency Services Team	01/01/2009 31/03/2009	85
YELLOW	Northumberland Hills Hospital (Long Term Care Services)	Long Term Care Services	01/01/2009 31/03/2009	85
GREEN	Northumberland Hills Hospital (Long Term Care Services)	Long Term Care Services	01/04/2009 30/06/2009	90
RED	Northumberland Hills Hospital (Long Term Care Services)	Long Term Care Services	01/07/2009 30/09/2009	49
YELLOW	Northumberland Hills Hospital (Long Term Care Services)	Long Term Care Services	01/10/2009 31/12/2009	85

Medication Reconciliation at Admission				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% Formal medication reconciliation at admission
YELLOW	Northumberland Hills Hospital (Medicine Services)	Medicine Services	01/01/2009 31/03/2009	85
YELLOW	Northumberland Hills Hospital (Obstetrics/Perinatal Care Services)	OBS/Perinatal	01/01/2009 31/03/2009	90
GREEN	Northumberland Hills Hospital (Obstetrics/Perinatal Care Services)	OBS/Perinatal	01/04/2009 30/06/2009	92
RED	Northumberland Hills Hospital (Obstetrics/Perinatal Care Services)	OBS/Perinatal	01/07/2009 30/09/2009	3.4
RED	Northumberland Hills Hospital (Obstetrics/Perinatal Care Services)	OBS/Perinatal	01/10/2009 31/12/2009	33

Threshold for Flags
RED: < 75/100
YELLOW: >= 75/100 AND < 90/100
GREEN: >= 90/100

Surgical Site Infection

Post-surgical infection rate is a key outcome measure that reflects process interventions.

The thresholds for this performance indicator are currently in development. Performance ratings will be provided when the thresholds are finalized.

Surgical Site Infection: Post-Surgical Infection - Colorectal Surgery

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% post-surgical infections
	Northumberland Hills Hospital (Infection Prevention and Control)	Infection Control Team	01/04/2008 30/06/2008	0
	Northumberland Hills Hospital (Infection Prevention and Control)	Infection Control Team	01/07/2008 30/09/2008	11
	Northumberland Hills Hospital (Infection Prevention and Control)	Infection Control Team	01/10/2008 31/12/2008	22
	Northumberland Hills Hospital (Infection Prevention and Control)	Infection Control Team	01/01/2009 31/03/2009	8.3
	Northumberland Hills Hospital (Infection Prevention and Control)	Infection Control Team	01/04/2009 30/06/2009	18
	Northumberland Hills Hospital (Infection Prevention and Control)	Infection Control Team	01/07/2009 30/09/2009	20

Surgical Site Infection: Post-Surgical Infection - Colorectal Surgery				
Flag	**Location**	**Team Name (standard section)**	**Dates (dd/mm/yyyy)**	**% post-surgical infections**
	Northumberland Hills Hospital (Infection Prevention and Control)	Infection Control Team	01/10/2009 31/12/2009	13

Surgical Site Infection

Timeliness of administering antibiotic prophylaxis is a universal process measure applicable to many surgical procedures and with widely recognized benefits in reducing post-surgical infections in selected high risk procedures.

Surgical Site Infection: Prophylactic Antibiotics - Colorectal Surgery				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics
YELLOW	Northumberland Hills Hospital (Infection Prevention and Control)	Infection Control Team	01/04/2008 30/06/2008	86
GREEN	Northumberland Hills Hospital (Infection Prevention and Control)	Infection Control Team	01/07/2008 30/09/2008	100
YELLOW	Northumberland Hills Hospital (Infection Prevention and Control)	Infection Control Team	01/10/2008 31/12/2008	89
RED	Northumberland Hills Hospital (Infection Prevention and Control)	Infection Control Team	01/01/2009 31/03/2009	58
GREEN	Northumberland Hills Hospital (Infection Prevention and Control)	Infection Control Team	01/04/2009 30/06/2009	100
GREEN	Northumberland Hills Hospital (Infection Prevention and Control)	Infection Control Team	01/07/2009 30/09/2009	100

Surgical Site Infection: Prophylactic Antibiotics - Colorectal Surgery				
Flag	**Location**	**Team Name (standard section)**	**Dates (dd/mm/yyyy)**	**% timely administrations of antibiotics**
GREEN	Northumberland Hills Hospital (Infection Prevention and Control)	Infection Control Team	01/10/2009 31/12/2009	92

Threshold for Flags
RED: < 80/100
YELLOW: >= 80/100 AND < 90/100
GREEN: >= 90/100

Health Care Associated Infection Rates

Health care associated C. difficile and MRSA infections represent a significant risk to the individuals receiving care and are a substantial resource burden to organizations and the health care system. Measuring infection control performance measures has the additional benefit of informing and shaping the staff's view of safety. Evidence suggests that as staff become more aware of infection control rates and the evidence related to infection control there is a change in behaviour to reduce the perceived risk.

Health Care-Associated MRSA & C. difficile - C. difficile

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection / 1000 patient days
GREEN	Northumberland Hills Hospital (Infection Prevention and Control)	Infection Control Team	01/04/2008 30/06/2008	2.7
GREEN	Northumberland Hills Hospital (Infection Prevention and Control)	Infection Control Team	01/07/2008 30/09/2008	1.4
GREEN	Northumberland Hills Hospital (Infection Prevention and Control)	Infection Control Team	01/10/2008 31/12/2008	0.91
GREEN	Northumberland Hills Hospital (Infection Prevention and Control)	Infection Control Team	01/01/2009 31/03/2009	0.11
GREEN	Northumberland Hills Hospital (Infection Prevention and Control)	Infection Control Team	01/04/2009 30/06/2009	0.92

Health Care-Associated MRSA & C. difficile - C. difficile				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection / 1000 patient days
GREEN	Northumberland Hills Hospital (Infection Prevention and Control)	Infection Control Team	01/07/2009 30/09/2009	0.11
GREEN	Northumberland Hills Hospital (Infection Prevention and Control)	Infection Control Team	01/10/2009 31/12/2009	0.22

Threshold for Flags
RED: > 8/1000
YELLOW: >= 6/1000 AND < 8/1000
GREEN: <= 6/1000

Health Care-Associated MRSA & C. difficile - MRSA				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection + colonization / 1000 patient days
GREEN	Northumberland Hills Hospital (Infection Prevention and Control)	Infection Control Team	01/04/2008 30/06/2008	0
GREEN	Northumberland Hills Hospital (Infection Prevention and Control)	Infection Control Team	01/07/2008 30/09/2008	0
GREEN	Northumberland Hills Hospital (Infection Prevention and Control)	Infection Control Team	01/10/2008 31/12/2008	0.1

Health Care-Associated MRSA & C. difficile - MRSA				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection + colonization / 1000 patient days
GREEN	Northumberland Hills Hospital (Infection Prevention and Control)	Infection Control Team	01/01/2009 31/03/2009	0
GREEN	Northumberland Hills Hospital (Infection Prevention and Control)	Infection Control Team	01/04/2009 30/06/2009	0
GREEN	Northumberland Hills Hospital (Infection Prevention and Control)	Infection Control Team	01/07/2009 30/09/2009	0
GREEN	Northumberland Hills Hospital (Infection Prevention and Control)	Infection Control Team	01/10/2009 31/12/2009	0

Threshold for Flags
RED: > 8/1000
YELLOW: >= 6/1000 AND < 8/1000
GREEN: <= 6/1000

Next Steps

Congratulations! You have just completed your Qmentum on-site survey visit. Please note the following check list items that you need to attend to in the coming days and months.

- ☐ We ask that you review this report within the next five days for errors in titles of names of services. This will help ensure the report and our records are accurate. Once you have reviewed, please send your requested changes to your Accreditation Specialist.

- ☐ In 10 business days, a letter outlining your accreditation decision and requirements will be e-mailed to your Chief Executive Officer. If revisions to the report were required, a copy of a revised report will be sent along with that letter.

- ☐ You are required to submit your quarterly reports on indicators on May 31st, every year. If you have any questions regarding this submission, please contact your Accreditation Specialist.

Appendix A – Accreditation Decision Guidelines

Quality improvement continues to be a key principle of Accreditation Canada's Qmentum program. Accreditation Canada's standards assess the quality of services provided by an organization and are constructed around eight dimensions of quality:

1. Population focus
2. Accessibility
3. Safety
4. Worklife
5. Client-centred services
6. Continuity of services
7. Effectiveness
8. Efficiency

Each standard criterion is related to a quality dimension. Organizations participating in Accreditation Canada's Qmentum program are eligible for the recognition awards: Accreditation; Accreditation with Condition (Report and/or Focused Visit) and Non-accreditation.

Under the Qmentum accreditation program, Accreditation Canada High Priority Criteria and Required Organization Practices (ROPs) are the two main factors that are considered in determining the appropriate recognition award.

Accreditation Canada High Priority Criteria

Accreditation Canada identifies high priority criteria by their alignment with several key areas:

- Quality Improvement
- Safety
- Risk
- Ethics

Required Organization Practices (ROPs)

A Required Organizational Practice is defined as an essential practice that organizations must have in place to enhance patient/client safety and minimize risk. It is a specific requirement for healthcare organizations in the accreditation program.

Based on the above, the three accreditation decisions for 2010 Qmentum surveys are:

Option 1: Accreditation
An organization is eligible for full accreditation (with a resurvey in three years) if all of the following criteria are met:

(a) 90% or more of high priority criteria met per standard section, AND
(b) Compliance with all of the Required Organizational Practices, AND
(c) Compliance with collection of all the performance measures,

If the organization is a CSSS, participating in the Joint Program with Conseil québecois d'agrément (CQA) and Accreditation Canada, the following additional criteria are required, which are specific CQA indicators relating to customer service and worklife:

(d) Compliance with ≥66.6% of Client Satisfaction Indicators AND
(e) Compliance with ≥66.6% of Employees Mobilization Indicators

Option 2: Accreditation with Condition: Report and/or Focused Visit
An organization will receive Accreditation with Condition: Report and/or Focused Visit if any of following criteria is met:

(a) More than 10% and less than 30% of high priority criteria unmet in any standard section,
OR
(b) Non-compliance with any one of the Required Organizational Practices
OR
(c) Non-compliance with the collection of any one of the performance measures

If the organization is a CSSS, participating in the Joint Program with CQA and Accreditation Canada, the following addition criteria apply:

(d) Compliance with less than 66.6% of Client Satisfaction Indicators,
OR
(e) Compliance with less than 66.6% of Employees Mobilization Indicators

The condition, i.e. submission of a report or focused visit; and timeframe, i.e. 6 months or 12 months; is based upon the nature of the recommendations. If the organization is a CSSS, and their compliance with the Client Satisfaction Indicators OR Employees Mobilization Indicators is less than 66.6%, they must conduct the survey(s) again within 18 months following the onsite visit as a condition of accreditation.

Organizations are required to submit follow-up reports as a condition of maintaining accreditation status. If a satisfactory report is not submitted within the required timeline, Accreditation Canada may grant a one-time extension of 6 months, based on surveyor input, proof of progress, and a plan to meet the conditions. Failure to comply with these requirements within the maximum allotted time extension will result in removal of accreditation status, at the discretion of Accreditation Canada.

For organizations that fail to complete a satisfactory focused visit within the required timeline, Accreditation Canada may grant a one-time extension of 6 months, based on surveyor input, proof of progress and a plan to meet the conditions. Failure to comply with these requirements within the maximum allotted time extension will result in removal of accreditation status, at the discretion of Accreditation Canada.

Option 3: Non-accreditation
An organization will NOT be accredited if the following conditions exist:

(a) One or more ROPs not in place
AND
(b) 30% or more high priority criteria unmet in one or more standards sections
AND
(c) 20% or more criteria unmet overall for all standards applied to the organization

Should an organization wish to have their non-accreditation status reviewed within 6 months post survey, they are required to complete a focused visit within 5 months. Organizations that fail to complete a satisfactory focused visit within the required timeframe will maintain a non-accreditation status.

If the organization is a CSSS, and their compliance with the Client Satisfaction Indicators OR Employees Mobilization Indicators is less than 66.6%, they must conduct the survey(s) again within 18 months following the onsite visit as a condition of accreditation.