ACCREDITATION AGRÉMENT CANADA

Accreditation Report

Qmentum Global™ for Canadian Accreditation Program

Northumberland Hills Hospital

Report Issued: July 14, 2026

Confidentiality

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About Accreditation Canada

Accreditation Canada is a global, not-for-profit organization with a vision for safer care and a healthier world. Our people-centred programs and services have been setting the bar for quality across the health ecosystem for more than 60 years. We continue to grow in our reach and impact. Accreditation Canada empowers and enables organizations to meet national and global standards with innovative programs that are customized to local needs. Accreditation Canada's assessment programs and services support the delivery of safe, high-quality care in health systems, hospitals, laboratories and diagnostic centres, long-term care, rehabilitation centres, primary care, home, and community settings. Our specialized accreditation and certification programs support safe, high-quality care for specific populations, health conditions, and health professions.

About the Accreditation Report

The Organization identified in this Accreditation Report (the "**Organization**" has participated in Accreditation Canada's Qmentum Global™ for Canadian Accreditation program.

As part of this program, the Organization has partaken in continuous quality improvement activities and assessments, including an on-site survey from March 22, 2026 to March 26, 2026. This Accreditation Report reflects the Organization's information and data, and Accreditation Canada's assessments, as of those dates.

Information from the assessments, as well as other information and data obtained from the Organization, was used to produce this Report. Accreditation Canada relied on the accuracy and completeness of the information provided by the Organization to plan and conduct its on-site assessments and to produce this Report. It is the Organization's responsibility to promptly disclose any and all incidents to Accreditation Canada that could impact its accreditation decision for the Organization.

Program Overview

The Qmentum Global Program enables your organization to continuously improve quality of care through the sustainable delivery of high-quality care experiences and health outcomes. The program provides your organization with standards, survey instruments, assessment methods and an action planning feature that were designed to promote continuous learning and improvement, and a client support model for on-going support and advice from dedicated advisors.

Your organization participates in a four-year accreditation cycle that spreads accreditation activities over four years supporting the shift from a one-time assessment while helping your organization maintain its focus on planning, implementing, and assessing quality and improvements. It encourages your organization to adopt accreditation activities in everyday practices.

Each year of the accreditation cycle includes activities that your organization will complete. Accreditation Canada provides ongoing support to your organization throughout the accreditation cycle. When your organization completes year 4 of the accreditation cycle, Accreditation Canada's Accreditation Decision Committee determines your organization's accreditation status based on the program's accreditation decision guidelines. The assessment results and accreditation decision are documented in a final report stating the accreditation status of your organization. After an accreditation decision is made, your organization enters year 1 of a new cycle, building on the actions and learnings of past accreditation cycles, in keeping with quality improvement principles.

The assessment manual (Accreditation Canada Manual which supports all assessment methods (self-assessment, attestation, and on-site assessment, is organized into applicable Standards and ROPs/RSPs. To promote alignment with the assessment manual (Accreditation Canada Manual), assessment results and surveyor findings are organized by Standard, within this report.

Additional report contents include a comprehensive executive summary, the organization's accreditation decision, locations assessed during the on-site assessment, required organizational practices results, and conclusively, People-Centered Care and Quality Improvement Overviews.

Executive Summary

About the Organization

By the Organization

Northumberland Hills Hospital (NHH) provides a broad range of acute, post-acute, outpatient, and diagnostic services. Acute care includes emergency, intensive care, medical/surgical, obstetrical, and palliative services, while post-acute specialty services focus on rehabilitation and restorative care. Outpatient offerings include mental health, cancer, dialysis, and other ambulatory clinics through regional partnerships. NHH serves a mixed urban and rural population of about 67,000 in west Northumberland County and employs over 850 staff, supported by physicians, midwives, and volunteers. The hospital is part of Ontario Health (East) and the Ontario Health Team of Northumberland.

By the surveyors

Northumberland Hills Hospital (NHH) delivers a broad range of acute, post-acute, outpatient and diagnostic services. Acute services include emergency and intensive care, medical/surgical care, obstetrical care, and palliative care. Post-acute specialty services (PASS) include restorative care and rehabilitation. Mental health care, cancer and supportive care, dialysis, and other ambulatory care clinics are offered on an outpatient basis through partnerships with regional centres and nearby specialists. NHH offers a full range of diagnostic services, including magnetic resonance imaging (MRI), computed tomography (CT), and mammography. The hospital serves the catchment area of west Northumberland County. A mixed urban and rural population of approximately 67,000 residents, west Northumberland comprises the Town of Cobourg, the Municipality of Port Hope, Alderville First Nation, and the townships of Hamilton, Cramahe and Alnwick/Haldimand. NHH employs more than 895 people and relies on the additional support provided by 160 physicians and midwives and over 300 volunteers within an operating budget of $132,000,000. NHH is an active member of Ontario Health (East) and the Ontario Health Team Northumberland.

Surveyor Overview of Team Observations

The surveyor team observed that Northumberland Hills Hospital (NHH) is a well-led, community-focused organization that delivers a broad range of acute, outpatient, and diagnostic services within a strong culture of quality, safety, and people-centred care. Governance was identified as a significant strength, with an engaged and skilled Board that demonstrates clear accountability for quality, risk, and strategic oversight while maintaining appropriate separation from day-to-day operations. Board practices, including the use of dashboards, balanced scorecards, and evaluation tools, support effective monitoring of organizational performance, succession planning, and medical staff privileging. The Board's commitment to community representation, diversity, equity, reconciliation, and meaningful patient and family engagement was evident, with opportunities noted to continue strengthening representation and formal action planning in these areas.

Leadership across the organization was described as cohesive, collaborative, and visibly committed to patient-centred, team-based care. Clinical and operational leaders actively support staff development and foster a people-first culture in which staff and physicians reported feeling valued, engaged, and proud to work at NHH. Strategic priorities are clearly articulated and supported by performance indicators, with effective monitoring at the organizational level. Surveyors noted opportunities to further embed strategic alignment at the unit level by cascading strategic pillars into huddles and daily work practices to strengthen frontline engagement and shared purpose.

NHH benefits from strong partnerships within its community and across the Ontario Health Team, which were repeatedly described by external stakeholders as collaborative and effective. These relationships support system planning, patient flow, and capacity management and position the organization as a trusted regional partner. Communications were identified as a core organizational strength, with a motivated and high-performing team supporting strategy execution, staff engagement, and diversity, equity, and antiracism efforts. While communication practices are effective, the organization would benefit from consolidating these efforts into a comprehensive organization-wide communication plan that integrates emergency management, business continuity, service delivery, and public relations.

Financial and resource stewardship was observed to be disciplined and well structured, supported by formal processes for operating and capital planning and prioritization. Surveyors noted opportunities to strengthen long-term sustainability through the establishment of reserve or restricted funds in anticipation of future capital needs, master planning, and expanded community-based services. Human resource practices reflect a strong commitment to staff safety, wellness, recognition, and worklife balance, with visible initiatives to support recruitment, retention, and professional development. As the organization grows, opportunities exist to further align performance management with strategic goals and to develop a comprehensive talent management approach to support succession planning and workforce sustainability.

Quality and patient safety were found to be deeply embedded throughout the organization, from the Board to the bedside. NHH has a mature quality and risk management framework supported by strong leadership, robust incident reporting and disclosure processes, data-driven monitoring, and active involvement of staff, physicians, and patient and family advisors. Quality improvement expertise and tools are readily accessible, and patient and family partners are integrated into committees and improvement initiatives. Surveyors identified opportunities to enhance staff engagement by strengthening the visibility and use of huddle boards, increasing the frequency of huddles, and encouraging frontline-led quality initiatives linked to organizational priorities.

Overall, the surveyor team concluded that Northumberland Hills Hospital demonstrates mature governance, strong leadership, effective community partnerships, and a pervasive culture of safety, quality, and people-centred care. The organization is well positioned for continued growth and system leadership, with opportunities focused on deeper strategic alignment at the frontline, enhanced talent and succession planning, strengthened communication and emergency planning, and continued advancement of equity, inclusion, and meaningful patient and community engagement.

Key Opportunities and Areas of Excellence

This nimble and responsive organization benefits from an engaged Board, physicians, staff, PFAC (Patient and Family Advisory Council, and community partners who recognize the collaborative spirit of NHH. There is an organizational focus and engagement on quality improvement and risk management initiatives supported through a palpable culture of caring for patients and staff. This is demonstrated through the commitment to their Peoplec First program overarching its strategic plan. There is a commitment to education of staff, advisors, and patients through the use of clinical scholars, academic affiliations, and strong support from the NHH Foundation. The organization is well supported in its acquisition of new technology and the upkeep of its facility.

Challenges facing the organization include financial resources to address such things as community growth, the growth in early career staff, physician and professional staff recruitment, cyber security, data analytics, the continued evolution of the role of the Patient and Family Advisory members, and the emerging changes in the demographics of the patient population being served and staff representation of the changing demographics. NHH is encouraged to pursue its Master Plan within its uncertain growth environment, noting changes can be made as projections firm up. The organization is encouraged to enhance its suicide prevention policies, procedures, and protocols.

People-Centred Care

The organization demonstrates strong commitment to People-Centred Care, clearly defined by the organization's shared purpose of People First, which is consistently embedded across programs and services. This commitment is evident through meaningful partnerships with patients, families, and caregivers, including the ongoing development of the Essential Caregiver program that recognizes caregivers as integral members of the care team. An engaged and active PFAC provides valuable input and has codesigned new initiatives such as the Patient's Bill of Rights and Responsibilities, Essential Care Giver planning, and improvement efforts, ensuring the patient voice meaningfully informs care delivery. The Foundation plays a key role in enhancing people-centered care through targeted support for education and essential equipment that directly improve the patient experience. A dedicated Patient Experience team actively gathers, analyzes, and shares patient experience data to inform service improvements and organizational learning. Staff working both within NHH and in the Community Mental Health Hub consistently report feeling safe, supported, and cared for by the organization, contributing to a positive care environment that supports compassionate, high quality care. The implementation of the outpatient stroke clinic further reflects a people-centered approach by enabling access to specialized care closer to home, reducing travel burdens and supporting recovery within patients’ own communities.

Quality Improvement Overview

A culture of caring and commitment to patients and quality improvement is recognizable throughout the organization from the boardroom to the bedside. NHH is commended for the energy and effort that has been made to implement a quality program across the organization. Quality improvement experts are available to educate teams and PFAC members on the use of various quality management tools such as process mapping, root-cause analysis, and use of huddle boards. Patient and Family Advisory Council members participate in several different committees and groups which identify, develop, and evaluate quality improvement initiatives. As well, physicians are actively engaged in quality initiatives within their own programs as well as corporate projects. The Board is commended for making its Quality Committee key to Board discussions of quality and safety issues as well as all having members hear the patient/family stories that are regularly provided to the Board.

Patient safety is a key priority for NHH. The organization's Patient Safety plan is informed by the Quality Improvement Plan, the strategic plan, results from the most recent Patient Safety Culture survey as well as input from staff, physicians, patients, and family members. Quality and potential risk indicators are monitored on a regular basis and reported to the leadership team and the Board. Staff receive patient safety training, and should an incident occur there is an incident management system including an on-line incident report that is completed. Near misses are also reported. Incident reports are reviewed by the manager, and any findings or recommendations from the incident are reported back to staff. A root cause analysis may also be conducted to determine the cause of the incident, and a work plan initiated to reduce a recurrence of the incident. Patients and families are instructed on how to report incidents and there is a full disclosure process and policy which is used to inform patients and families when an incident has occurred. NHH has adopted an integrated risk management program to identify, monitor and manage key risk to the organization. Reports are monitored frequently by the leadership team and provided regularly to the Board.

The huddle boards, found across the organization, could be enhanced with the themes of the strategic plan demonstrating good alignment of the units with the organization's strategic plan and quality improvement plan. The organization would benefit from weekly or daily huddles and a mechanism for staff to recommend quality initiatives specific to their unit to engage staff in the organization's strategic and quality journey.

Accreditation Decision

Northumberland Hills Hospital's accreditation decision is:

Accredited with Exemplary Standing

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

Required Organizational Practices

Required Organization Practices (ROP) and Required Safety Practices (RSP) are essential practices that an organization must have in place to enhance client safety and minimize risk. ROP/RSP contain multiple criteria, which are called Tests for Compliance (TFC).

Table 1: Summary of the Organization's ROPs/RSPs

ROP/RSP Name	Standard(s)	# TFC Rating Met	% TFC Met
Accountability for Quality of Care	Governance	5 / 5	100.0%
Adhering to a Do-Not-Use List of Abbreviations, Symbols, and Dose Designations	Medication Management	5 / 5	100.0%
Antimicrobial Stewardship	Medication Management	5 / 5	100.0%
Cleaning and Low-Level Disinfecting Medical Equipment	Infection Prevention and Control	5 / 5	100.0%
Client Flow	Leadership	5 / 5	100.0%

Table 1: Summary of the Organization's ROPs/RSPs

ROP/RSP Name	Standard(s)	# TFC Rating Met	% TFC Met
Client Identification	Ambulatory Care Services	1 / 1	100.0%
	Critical Care Services	1 / 1	100.0%
	Diagnostic Imaging Services	1 / 1	100.0%
	Emergency Department	1 / 1	100.0%
	Inpatient Services	1 / 1	100.0%
	Mental Health and Addictions Services	1 / 1	100.0%
	Obstetrics Services	1 / 1	100.0%
	Perioperative Services and Invasive Procedures	1 / 1	100.0%
	Point-of-Care Testing	1 / 1	100.0%
	Rehabilitation Services	1 / 1	100.0%
	Transfusion Services	1 / 1	100.0%
Improving Hand Hygiene Practices	Infection Prevention and Control	5 / 5	100.0%
Infection Rates	Infection Prevention and Control	3 / 3	100.0%

Table 1: Summary of the Organization's ROPs/RSPs

ROP/RSP Name	Standard(s)	# TFC Rating Met	% TFC Met
Information Transfer at Care Transitions	Ambulatory Care Services	5 / 5	100.0%
	Critical Care Services	5 / 5	100.0%
	Diagnostic Imaging Services	5 / 5	100.0%
	Emergency Department	5 / 5	100.0%
	Inpatient Services	5 / 5	100.0%
	Mental Health and Addictions Services	5 / 5	100.0%
	Obstetrics Services	5 / 5	100.0%
	Perioperative Services and Invasive Procedures	5 / 5	100.0%
	Rehabilitation Services	5 / 5	100.0%

Table 1: Summary of the Organization's ROPs/RSPs

ROP/RSP Name	Standard(s)	# TFC Rating Met	% TFC Met
Infusion Pump Safety	Service Excellence for Ambulatory Care Services	6 / 6	100.0%
	Service Excellence for Critical Care Services	6 / 6	100.0%
	Service Excellence for Diagnostic Imaging Services	6 / 6	100.0%
	Service Excellence for Emergency Department	6 / 6	100.0%
	Service Excellence for Inpatient Services	6 / 6	100.0%
	Service Excellence for Mental Health and Addictions Services	0 / 0	0.0%
	Service Excellence for Obstetrics Services	6 / 6	100.0%
	Service Excellence for Perioperative Services and Invasive Procedures	6 / 6	100.0%
	Service Excellence for Rehabilitation Services	6 / 6	100.0%
Limiting High-Concentration and High-Total-Dose Opioid Formulations	Medication Management	5 / 5	100.0%

Table 1: Summary of the Organization's ROPs/RSPs

ROP/RSP Name	Standard(s)	# TFC Rating Met	% TFC Met
Maintaining an Accurate List of Medications during Care Transitions	Ambulatory Care Services	5 / 5	100.0%
	Critical Care Services	5 / 5	100.0%
	Diagnostic Imaging Services	5 / 5	100.0%
	Emergency Department	5 / 5	100.0%
	Inpatient Services	5 / 5	100.0%
	Mental Health and Addictions Services	5 / 5	100.0%
	Obstetrics Services	5 / 5	100.0%
	Perioperative Services and Invasive Procedures	5 / 5	100.0%
	Rehabilitation Services	5 / 5	100.0%
Managing High-Alert Medications	Medication Management	5 / 5	100.0%
Medication Reconciliation as a Strategic Priority	Leadership	5 / 5	100.0%

Table 1: Summary of the Organization's ROPs/RSPs

ROP/RSP Name	Standard(s)	# TFC Rating Met	% TFC Met
Optimizing Skin Integrity	Critical Care Services	6 / 6	100.0%
	Emergency Department	6 / 6	100.0%
	Inpatient Services	6 / 6	100.0%
	Obstetrics Services	6 / 6	100.0%
	Perioperative Services and Invasive Procedures	6 / 6	100.0%
	Rehabilitation Services	6 / 6	100.0%
Patient Safety Education and Training	Leadership	1 / 1	100.0%
Patient Safety Incident Disclosure	Leadership	6 / 6	100.0%
Patient Safety Incident Management	Leadership	7 / 7	100.0%

Table 1: Summary of the Organization's ROPs/RSPs

ROP/RSP Name	Standard(s)	# TFC Rating Met	% TFC Met
Preventing Falls and Reducing Injuries from Falls	Critical Care Services	7 / 7	100.0%
	Emergency Department	7 / 7	100.0%
	Inpatient Services	7 / 7	100.0%
	Obstetrics Services	7 / 7	100.0%
	Perioperative Services and Invasive Procedures	7 / 7	100.0%
	Rehabilitation Services	7 / 7	100.0%
Preventing Venous Thromboembolism	Critical Care Services	6 / 6	100.0%
	Emergency Department	6 / 6	100.0%
	Inpatient Services	6 / 6	100.0%
	Obstetrics Services	6 / 6	100.0%
	Perioperative Services and Invasive Procedures	6 / 6	100.0%
Preventive Maintenance Program	Leadership	4 / 4	100.0%
Safe Surgery Checklist	Obstetrics Services	5 / 5	100.0%
	Perioperative Services and Invasive Procedures	5 / 5	100.0%

Table 1: Summary of the Organization's ROPs/RSPs

ROP/RSP Name	Standard(s)	# TFC Rating Met	% TFC Met
Suicide Prevention Program	Service Excellence for Ambulatory Care Services	5 / 5	100.0%
	Service Excellence for Critical Care Services	5 / 5	100.0%
	Service Excellence for Diagnostic Imaging Services	5 / 5	100.0%
	Service Excellence for Emergency Department	5 / 5	100.0%
	Service Excellence for Inpatient Services	5 / 5	100.0%
	Service Excellence for Mental Health and Addictions Services	5 / 5	100.0%
	Service Excellence for Obstetrics Services	5 / 5	100.0%
	Service Excellence for Perioperative Services and Invasive Procedures	5 / 5	100.0%
	Service Excellence for Rehabilitation Services	5 / 5	100.0%
Workplace Violence Prevention	Leadership	8 / 8	100.0%

Assessment Results by Standard

The following section includes the outcomes from the attestation (if applicable) and on-site assessments, at the conclusion of the on-site assessment.

Core Standards

Qmentum Global™ for Canadian Accreditation has a set of core assessment standards that are foundational to the program and are required for the organization undergoing accreditation. The core assessment standards are critical given the foundational areas of high quality and safe care they cover.

The core standards are always part of the assessment, except in specific circumstances where they are not applicable.

Emergency and Disaster Management

Standard Rating: 96.5% Met Criteria

3.5% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

NHH embraces an IMS (Integrated Management System) framework and is in the process of developing a comprehensive and integrated Emergency and Disaster Management program. Several components exist at the department and organization levels with the intention to coordinate and integrate the various components to develop a more comprehensive plan. The organization is encouraged to continue its work in this area to align with the expanded Accreditation Standards.

NHH has done extensive work in developing its business continuity plans and would benefit from having a comprehensive business continuity plan covering all areas of the organization as a reference document in the place of departmental and functional business continuity plans specific to their relevant areas.

Table 2: Unmet Criteria for Emergency and Disaster Management

Criteria Number	Criteria Text	Criteria Type
3.1.18	The organization engages with the community and other stakeholders to establish procedures to address a potential surge in demand for culturally safe mortuary services during an emergency or disaster.	NORMAL
3.4.13	The organization plans for how it will manage high volumes of inquiries during an emergency or disaster.	NORMAL

Criteria Number	Criteria Text	Criteria Type
3.4.14	The organization establishes a reunification strategy, including a communication plan, to help reunify families during an emergency or disaster.	NORMAL

Governance

Standard Rating: 98.8% Met Criteria

1.2% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

NHH benefits from a committed Board that uses a skills matrix to ensure an appropriate mix of skills while demonstrating a responsiveness to recruiting a Board that is representative of its community's evolving profile. The Board is engaged in the development and operationalization of NHH's strategic plan and has embedded quality and risk as important pillars of the organization's strategic and operational plans. The use of a dashboard methodology at its committee level enables the Board to fulfill its monitoring role without getting drawn into the day-to-day operations of the organization. The Board is encouraged to continue development of its balanced scorecard methodology aligned to its strategic plan and monitoring of key strategic, operational, and quality initiatives. The Board takes seriously its role in the privileging of its medical staff, ensuring succession plans are in place for key executive positions, and monitoring the evolution of its human capital plan to support the organization going forward. The Board uses various evaluation tools to monitor it's performance and that of its committees, and members. The Board is encouraged to continue to pursue Board representation that is reflective of the diversity of the community it serves as its community and catchment area continue to grow. The further development of action plans and the monitoring of systemic racism and Indigenous racism is encouraged. The continued engagement with its patient and family advisors for input on key Board decisions is encouraged as well as identifying PFAC members as a potential pool of future Board members. The Board could also monitor the development of a comprehensive business continuity plan and emergency and disaster management plan that align with the Accreditation Standards.

Table 3: Unmet Criteria for Governance

Criteria Number	Criteria Text	Criteria Type
3.1.10	The governing body ensures that the organization has a comprehensive strategy for business continuity to minimize service disruption.	HIGH

Infection Prevention and Control

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

NHH demonstrates a strong commitment to Infection Prevention and Control (IPAC), with well-established structures, processes, and a culture that supports safe, high-quality care. All staff receive comprehensive IPAC orientation upon hire, supported by standardized eLearning modules that reinforce foundational knowledge and organizational expectations.

IPAC governance is well defined, with an active IPAC committee and visible leadership engagement across the organization. This structure supports accountability, strategic oversight, and the integration of IPAC principles into daily practice. Data is readily available and is used to inform organizational strategy, guide decision making, and support ongoing quality improvement initiatives.

Hand hygiene is embedded as a core cultural practice. Routine hand hygiene audits are conducted, and results are transparently shared at the unit level, promoting staff awareness and accountability. While results are currently displayed in a paper-based format, there is a clear plan to transition to digital unit boards, further enhancing visibility and real time engagement.

NHH experienced one outbreak in the past year, which was effectively managed and well controlled. This outcome reflects the strength of IPAC practices and rapid response capabilities, particularly noteworthy given the organization’s physical footprint, which includes a high proportion of shared patient rooms.

Environmental and equipment safety practices are consistently applied. Hand hygiene stations are readily accessible throughout the organization, supporting compliance at point of care. Cleaned medical equipment is appropriately stored in designated clean rooms, clearly signaling readiness for safe use and reinforcing staff confidence in infection prevention practices.

Occupational Health and Safety play a key role in supporting IPAC through the monitoring of staff immunization status, provision of vaccinations when required, and the operation of a robust return to work program. This program ensures staff are supported to return to work safely and promptly, minimizing risk while maintaining workforce sustainability.

Overall, NHH demonstrates strong alignment with IPAC standards, supported by leadership, data-driven practice, and a deeply embedded culture of safety and accountability.

Table 4: Unmet Criteria for Infection Prevention and Control

There are no unmet criteria for this section.

Leadership

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

Northumberland Hills Hospital (NHH) demonstrates strong and cohesive leadership across governance, clinical services, quality, and community partnership. The Board is skilled, engaged, and strategically focused, using effective dashboards to oversee performance while maintaining an appropriate distance from operations. It actively supports quality and risk oversight, succession planning, and the privileging of medical staff, and continues to advance its commitment to diversity, equity, community representation, and the inclusion of patient and family voices. Strong community partnerships, particularly through the Ontario Health Team, enhance system planning and contribute significantly to patient flow and capacity solutions across the region. Community stakeholders repeatedly characterize NHH as a collaborative and trusted partner.

Clinical and operational leaders are unified in their commitment to patient-centred care, teamwork, and quality. Staff and physicians are well supported, engaged, and proud to work at NHH. Strategic priorities are clearly defined and monitored through key performance indicators and balanced scorecard methodologies, with opportunities to strengthen alignment by more fully integrating strategic pillars into unit-level huddles and daily practice. Communications efforts are highly effective and grounded in a comprehensive framework that advances corporate strategy and supports EDI and antiracism priorities. A more consolidated, organization-wide communications plan would further enhance readiness and coordination across emergency response, business continuity, public relations, and service delivery communications.

The organization demonstrates disciplined financial and resource management, supported by formal planning processes for operating and capital needs. Establishing reserve and restricted funds would strengthen long-term financial sustainability as the organization prepares for major capital planning and community-based service development. Human resources practices are evolving toward contemporary talent management, with visible organizational commitment to staff wellness, safety, recognition, and worklife balance. Continued advancement of performance alignment and the development of a comprehensive talent management strategy will be essential to supporting future growth.

Quality and patient safety are deeply embedded throughout NHH, with strong Board leadership, an effective incident management system, regular monitoring of risk indicators, and meaningful involvement of physicians, staff, and patient and family advisors in improvement efforts. Quality tools and methodologies are well understood across the organization, and there are opportunities to heighten staff engagement by enhancing huddle boards with strategic themes and encouraging more frequent unit-based huddles that empower frontline-led improvement.

A regional ethicist model with two ethicists based at Ontario Shores supports NHH. The ethicists are engaged and responsive to the needs of the staff and physicians, providing educational sessions and awareness campaigns. The organization is encouraged to ensure that the regional policy on decision-making for end-of-life care is completed expeditiously and aligns with the College of Physicians and Surgeons of Ontario’s 2023 policy.

Overall, NHH benefits from mature governance, strong clinical and operational leadership, positive community relationships, and a pervasive culture of quality and patient-centred care. The organization is well positioned for continued growth, with opportunities centered on deeper strategic alignment, expanded talent management, strengthened communication planning, and ongoing advancement of diversity, equity, and community representation across all levels of leadership.

Table 5: Unmet Criteria for Leadership

There are no unmet criteria for this section.

Medication Management

Standard Rating: 99.4% Met Criteria

0.6% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

NHH has a modern, technologically advanced medication management system. This is supported by robust processes and a strong commitment to excellence. Renovations are underway to upgrade the pharmacy and ensure the refreshed space meets ventilation and safety requirements, allowing medications, including those used in chemotherapy delivery, to be prepared in compliance with current standards.

The Safe Medication Practice Committee is a valuable forum for interdisciplinary thought sharing around medication administration practices. It comprises frontline nurses, nurse educators, pharmacists, pharmacy technicians, and other team members, enabling the generation of relevant ideas and quality improvement collaboration. The committee may wish to consider integrating patient and family partners.

The pharmacy department is active and committed to learning and education initiatives. They participate in team-based interdisciplinary rounds throughout the organization and have purposefully increased their presence on the wards and in the emergency department. They hold a local journal club to share best practices and emerging evidence.

Medication reconciliation occurs collaboratively between nursing, pharmacy technicians, pharmacists, and admitting physicians. The team may benefit from creating standard work that clearly articulates each team member's responsibilities and how the process differs by time of day, as the pharmacy technicians and pharmacists are not in the hospital 24/7.

There is an active Antimicrobial Stewardship program supported by the infectious diseases department at Lakeridge Health. A local antibiogram exists to guide practice and antibiotic choice. The organization has subscribed to the Firstline app to provide practical support to clinicians in choosing appropriate antibiotic treatments. The organization is encouraged to further promote its use among both organization-based physicians and those practicing in the community. Progress and effectiveness tracking are encourage through monitoring uptake among providers.

There is an opportunity for the organization to optimize the route of medication administration. Doing so has multiple benefits, including reducing nursing time spent on medication administration, improving patient comfort, reducing medication costs, reducing environmental impact from supply use, and potentially shortening lengths of stay. A pharmacy-directed medical directive to step down from intravenous to oral medications has been created but is not currently in use. Although the antimicrobial stewardship policy references a systematic plan for the parenteral-to-oral conversion of antimicrobials, the process for stepping down is manual and relies on pharmacists on inpatient units to identify potential patients for step-down; there is no standardized approach.

Table 6: Unmet Criteria for Medication Management

Criteria Number	Criteria Text	Criteria Type
6.1.2	The team regularly evaluates intravenous therapy in clients using an established intravenous to oral conversion program that has been approved by the interdisciplinary committee.	HIGH

Service Specific Assessment Standards

The Qmentum Global™ for Canadian Accreditation program has a set of service specific assessment standards that are included in the accreditation program based on the services delivered by different organizations. Service standards are critical to the management and delivery of high-quality and safe care in specific service areas.

Ambulatory Care Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

The ambulatory care department is well managed and designed for good patient flow. Its universal design works well for the scope of services offered as well as providing flexibility for the addition of new services. Staff are engaged and supported in their skill development. Patients are booked through their referring physicians' offices and followed up by their referring physicians. Patient records are shared through NHH's Epic system. Patients spoke positively about their experiences.

Table 7: Unmet Criteria for Ambulatory Care Services

There are no unmet criteria for this section.

Service Excellence for Ambulatory Care Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

Patients are booked through their referring physicians' offices and followed up by their referring physicians. Patient records are shared through NHH's Epic system. Patients spoke positively about their experiences. Staff are engaged and supported in their skill development.

Table 8: Unmet Criteria for Service Excellence for Ambulatory Care Services

There are no unmet criteria for this section.

Critical Care Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

The Intensive Care Unit (ICU) at NHH has recently evolved from a Level Two to a Level Three ICU with a closed medical model in which the intensivist is the most responsible provider. This has included expanded room capacity, increased nursing staffing (five RNs 24/7), and increased allied health support.

Leadership at all levels is engaged, approachable, and responsive. Recent changes have been well managed by leadership, and team members report feeling supported throughout the transition.

The team is commended for implementing scripted, interdisciplinary, team-based rounds daily in the unit. They are encouraged, as a rule, to invite patients and family members to attend and participate in these daily rounds.

The additional ICU rooms present challenges in the current configuration and create inequities for patients placed in those rooms. NHH is encouraged to identify opportunities to alter and enhance the physical infrastructure to support patient care.

Leadership has identified the need to strengthen the Critical Care Response Team (CCRT) processes and format by clarifying roles and strengthening standard operating procedures. Optimizing this process may require a human resource investment to ensure that the RN serving as the ICU team lead has the capacity to consistently lead the CCRT response.

The teams are supported by organizational policy in transferring information using the Situation, Background, Assessment, and Recommendation (SBAR) format. This electronic tool exists within Epic and can be used to support consistent, standardized sharing of information. However, it is unclear whether the tool is consistently used to support standardization and reduce variation. NHH is encouraged to consider implementing a standard auditing process to ensure that a Transfer of Accountability consistently occurs in an optimized manner.

Table 9: Unmet Criteria for Critical Care Services

There are no unmet criteria for this section.

Service Excellence for Critical Care Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

Within the ICU, a real-time digital balanced scorecard has been installed. The team are encouraged to ensure the metrics that are shared matter to the people involved in the work. It is suggested that sharing data through regular huddles involves discussion around understanding what impacts and impedes success. Audits of intervention effectiveness and compliance with standardized tools are best shared with staff regularly when metrics are discussed.

There has been a concerted focus on enhancing nursing education, including the onboarding of new ICU nursing staff. MD-led education rounds occur regularly, and educational topics are responsive to team needs. There is an opportunity to ensure that learning occurs in an interdisciplinary manner, wherever possible, to build and share knowledge among all team members and enhance team culture.

Table 10: Unmet Criteria for Service Excellence for Critical Care Services

There are no unmet criteria for this section.

Diagnostic Imaging Services

Standard Rating: 99.3% Met Criteria

0.7% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

Diagnostic imaging (DI) at NHH provides a broad scope of services to its community. The radiologists are a group of external radiologists that predominantly serve within the organization providing 24/7 coverage. The leadership is well versed in their wait times as a key performance indicator with strong awareness of the current state of wait across the various priority levels within each diagnostic modality. Overall, NHH is making efforts to improve wait times through initiatives that ensure timely access to imaging and rapid results for both internal and external stakeholders.

DI would benefit from implementing standard reporting formats for the procedures performed. The department could also maintain quality control for DI equipment being used remotely in emergency, operating rooms, and obstetrics. The department is encouraged to evolve its quality program and update its standard operating procedures given its rapid replacement of aging technology.

Table 11: Unmet Criteria for Diagnostic Imaging Services

Criteria Number	Criteria Text	Criteria Type
5.4.1	The team adheres to a standardized report format for each type of procedure.	NORMAL

Service Excellence for Diagnostic Imaging Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

The leadership is well versed in their wait times as a key performance indicator with strong awareness of the current state of wait across the various priority levels within each diagnostic modality. Overall, NHH is making efforts to improve wait times through initiatives that ensure timely access to imaging and rapid results for both internal and external stakeholders.

DI would benefit from implementing standard reporting formats for the procedures performed and formalizing its suicide prevention training, awareness, reporting, and documentation. The department should also maintain quality control for DI equipment being used remotely in emergency, operating rooms, and obstetrics to ensure consistent standards across the organization. The department is encouraged to evolve its quality program and update its standard operating procedures given its rapid replacement of aging technology.

Table 12: Unmet Criteria for Service Excellence for Diagnostic Imaging Services

There are no unmet criteria for this section.

Emergency Department

Standard Rating: 98.5% Met Criteria

1.5% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

As emergency services volumes have increased in recent years, NHH is evolving from an emergency room model of care to a true emergency department (ED). The dedicated and engaged leadership team has been focused on improving processes and role clarity so that patient presentations determine placement within zones that meet each patient's unique needs. This will benefit from being supported by a revamped role for the charge nurse so that they function as an air traffic controller, troubleshooting problems, and predominantly directing the flow of patients throughout the department.

The creation of a Rapid Access Zone (RAZ) has been a necessary change to achieve the new model of care. The team must continue this work to clearly define which types of patients are placed where within the department, aiming to ensure that any ambulatory and medically stable patients are routed through the RAZ, with a rapid-turnover model supported by standard work to ensure patients receive timely and efficient care. The leadership is on the right track by establishing exclusion criteria to ensure most patients flow through the RAZ. The criteria would best be continuously re-evaluated, with consideration given to routing patients presenting with atypical chest pain and a normal ECG through that zone as well. Leadership is encouraged to monitor the flow to ensure that as the volume of patients seen through the RAZ increases, the allocation of nursing resources within the ED is re-evaluated, including the introduction of other care providers such as expanded roles for Registered Practical Nurses (RPNs) and Personal Support Workers (PSWs).

The department struggles to reduce its time-to-physician initial assessment metric. However, NHH faces challenges with physician recruitment, and flow efficiencies will not be fully realized until all available shifts can be consistently filled. To achieve this, there has been an active recruitment campaign and the creation of an innovative practice-readiness program (STEP Program) that also serves as an assessment strategy for locum physicians. This program enrolls locum physicians who gain the necessary skills to work in a medium-sized ED, allowing them to work shifts with available backup from experienced emergency physicians. As the physician resource needs are more consistently established, it will be important for physicians to transition within their designated shifts from a high-acuity to a low-complexity patient population by matching physician shifts to patient volumes and aligning them with the ED's zonal layout.

A multidisciplinary approach to elder care in the emergency department is noteworthy, as evidenced by the establishment of the Geriatric Assessment Team (GAT). A geriatric emergency medicine (GEM) nurse practitioner recently joined the team of allied health professionals who care for elderly patients in the ED, including a GEM RN, an occupational therapist, a physical therapist, and a social worker. By leveraging each team member's unique skill set and expertise, the patient's specific needs are targeted to support a safe transition home and avoid admissions.

NHH has demonstrated its commitment to organization-wide patient flow. This has become more evident and widespread over the past two to three years. A whole-hospital-system approach is taken to ensure that all leaders within the organization recognize that patient flow is everyone’s priority. Creating standard work for discharge planning, timing, process, and responsibility is a natural next step for an organization clearly committed to improving patient flow and adept at applying standard work to support consistent processes.

An overcapacity protocol exists for the organization that specifically outlines where unconventional spaces can be opened on specific wards, including designated hallway spaces, and is supported by established patient criteria. The team continually monitors when the need to open flex spaces will occur and is attuned to any changes in flow, capacity, and trends.

A home-first approach to discharge planning is being established, and continuing work is needed to ensure that all members of the care team appreciate its significance. Continued strengthening of partnerships with community organizations and committing to this philosophy are integral to supporting patient flow.

There is work underway to establish internal surge plans within the emergency department to manage patient flow and optimize space usage during surges. However, ED-specific plans do not currently exist. It is well established that maintaining assessment spaces for emergency department patients while stable, admitted patients awaiting placement on the ward receive temporary care in the hallway or other non-conventional spaces prevents ED overcrowding from impeding flow and ensures that complete and appropriate initial assessments can occur.

The teams proactively identify patients early in their ED journey who will require multidisciplinary involvement. This includes ISAR screening for frailty, which prompts referral to the Geriatric Assessment Team (GAT) and early identification of patients likely to require admission, thereby enabling earlier completion of the Best Possible Medication History (BPMH) by the pharmacy technician within the ED. Both initiatives are noteworthy examples of proactive efforts to improve patient care.

The teams are supported by organizational policy in transferring information using the Situation, Background, Assessment, and Recommendation (SBAR) format. This electronic tool exists within Epic and can be used to support consistent, standardized sharing of information. However, it is unclear whether the tool is consistently used to support standardization and reduce variation. NHH is encouraged to consider implementing a standard auditing process to ensure that a Transfer of Accountability consistently occurs in an optimized manner.

Table 13: Unmet Criteria for Emergency Department

Criteria Number	Criteria Text	Criteria Type
2.1.10	There are established protocols to identify and manage overcrowding and surges in the emergency department.	HIGH
2.1.12	Protocols are followed to manage clients when access to inpatient beds is not available.	NORMAL

Service Excellence for Emergency Department

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

The organization does not have a policy that informs for whom, by whom and when suicide screening should occur . There is guidance recommending screening for certain CEDIS complaints in patients presenting to the emergency department. This isn't formally outlined in a standard operating procedure. Staff working in the ED lack clarity on when the screen should occur throughout the patient's journey. This was evidenced during the tracer when a patient was not screened at triage, and for whom it would have been appropriate given the presenting concerns.

NHH is encouraged to implement universal mental health screening for all patients presenting to the emergency department, regardless of presenting concern, so that those at risk of suicide are consistently identified. This could include a simple question at triage or during the primary nurse assessment that enquires about mental health concerns. This could be as simple as a single screening question of all patients, "Do you or have you recently had concerns about your mental health?" and if the patient answers in the affirmative, following up with a question about whether the patient is experiencing suicidal ideation. If the patient answers positively, the primary care nurse would implement a Columbia Suicide Screening. Asking about mental health should be normalized and akin to asking if a patient has a headache or chest pain.

The organization is encouraged to invest in clinical quality improvement training for interested frontline staff in the ED. Quality improvement projects could be driven by ideas from the point of care and supported by the corporation, with patient and family involvement in the process. Such an approach will help ensure that improvements are relevant to the people providing and receiving hands-on care. It will be important to ensure evaluation of QI initiatives occurs so that the effectiveness of change ideas is understood.

Table 14: Unmet Criteria for Service Excellence for Emergency Department

There are no unmet criteria for this section.

Inpatient Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

Northumberland Hills Hospital met the majority of Accreditation Canada's inpatient service standards, demonstrating a strong commitment to safe, high-quality, and patient-centered care. Patients and families consistently reported positive experiences, citing clear and respectful communication, compassionate care delivery, and meaningful involvement in care decisions, particularly in palliative care contexts. The effective use of whiteboards in patient rooms was observed and supported timely communication, transparency, and collaboration between patients, families, and the interprofessional care team.

Staff engagement was evident across the unit. A hospitalist shared positive reflections regarding her experience working within the organization, and members of the multidisciplinary team reported feeling valued and supported in their roles, contributing to a positive care environment.

Clinical documentation and risk assessment practices were consistently completed and well embedded in daily care processes. Patient charts reflected comprehensive completion of Braden Scale assessments, falls risk assessments, venous thromboembolism (VTE) prophylaxis, medication reconciliation, and Best Possible Medication Histories (BPMH). The use of a closed-loop medication administration system, in conjunction with verification of two patient identifiers, demonstrates strong adherence to medication safety best practices and supports a well-established culture of patient safety. Documentation indicates that information transfer at transitions of care occurs through the electronic health record. An opportunity for improvement is noted in ensuring the quality and completeness of transferred information aligns with the Required Organizational Practice through a standardized auditing tool.

Table 15: Unmet Criteria for Inpatient Services

There are no unmet criteria for this section.

Service Excellence for Inpatient Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

NHH demonstrates a strong commitment to service excellence within its inpatient services and demonstrates a clear understanding of the community and population it serves. Strong partnerships with community agencies support continuity of care, support smoother transitions, and contribute to addressing broader social and health related needs of patients and families.

Patient and family-centred care is further supported through access to inclusive, non-denominational spaces that respect diverse spiritual, cultural, and personal beliefs. This approach promotes psychological safety and emotional well-being for patients, families, and staff. The organization also demonstrates a commitment to learning and professional development by supporting educational opportunities for staff and learners, contributing to a culture of continuous improvement.

The effective use of technology is evident across inpatient services. Technology serves as an enabler to support clinical decision making, communication, and workflow efficiency. Strong controls are in place to safeguard the electronic patient record, with appropriate privacy, security, and access management measures that align with legislative and organizational requirements. These practices support patient safety and confidentiality.

To further strengthen service excellence, opportunities exist to formalize and consistently apply performance appraisal processes across inpatient services. Establishing clear, structured appraisals that identify development goals, particularly for emerging leaders, would support succession planning, leadership capacity, and staff engagement.

While Quality Improvement activities are occurring, there is an opportunity to enhance the evaluation, documentation, and spread of successful QI initiatives. Measuring impact and sharing learning across units would embed a culture of continuous quality improvement throughout the inpatient program.

Table 16: Unmet Criteria for Service Excellence for Inpatient Services

There are no unmet criteria for this section.

Mental Health and Addictions Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

The Mental Health and Addictions team demonstrates a strong commitment to delivering high-quality, person-centered care grounded in equity, accessibility, and community partnership. Care is consistently delivered through an equity lens, with staff intentionally tailoring approaches to meet the diverse needs of the population served. Clients have access to services through multiple options including in person, telephone, and virtual options ensuring timely and appropriate entry points into care.

All clients are assessed using an evidence-based, standardized tool, supporting consistent clinical decision making and continuity across the care journey. Peer support is embedded within the service model, offering clients meaningful opportunities for shared experience and recovery-oriented engagement. Client feedback is routinely collected through the Qualtrics platform, and the team is actively exploring just-in-time feedback mechanisms to further strengthen responsiveness and real-time quality improvement. Required Organizational Practices including two client identifiers, medication reconciliation, and information transfer at transitions of care are met in innovative and client-appropriate ways that reflect the unique needs of this population.

Partnerships are a notable strength. The program maintains strong, collaborative relationships with three police services and the Canadian Mental Health Association. The Mental Health Engagement and Response Team (MHEART), which pairs a social worker with police, exemplifies an integrated, community-based approach to crisis response. The ACTT (Assertive Community Treatment Tam) is deeply embedded in the community and often maintains long-term therapeutic relationships with clients, supporting stability and continuity over many years.

Staff consistently report feeling safe in both office and community settings. Emergency code alarms are accessible at each workspace, and police or colleagues are readily available to support community visits when needed. This reflects a well-established culture of safety and teamwork.

Table 17: Unmet Criteria for Mental Health and Addictions Services

There are no unmet criteria for this section.

Service Excellence for Mental Health and Addictions Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

The Mental Health and Addictions program demonstrates strong alignment with the Service Excellence standard through a client-centered, accessible approach to care. An interprofessional team model is well established and effectively supports clients through a variety of access points and program options, enabling responsive and coordinated service delivery across the continuum of care.

The physical environment supports accessibility and inclusion. A universally accessible washroom has recently been added, reflecting the organization’s commitment to reducing barriers and enhancing dignity for clients, families, and staff.

Ethical practice is embedded within the program. Ethics consultations are readily available, and staff demonstrate strong awareness of this resource. Evidence indicates that ethics consults have been appropriately accessed to support decision making in complex or challenging client situations, reinforcing a culture of ethical reflection and accountability.

Performance management processes indicate some variability, with performance appraisals noted as sporadic. However, staff consistently report receiving ongoing, meaningful feedback, and describe leadership as highly engaged in their professional growth and development. This reflects a strengths based leadership approach and a supportive work environment that prioritizes learning and development.

Quality Improvement activities are informed by data and evidence. This is demonstrated through the Mental Health Quality Performance Committee (QPC), which uses performance indicators to identify areas for improvement. Improvement initiatives are measured and monitored. There is an opportunity to develop a mature quality improvement framework that supports service excellence.

Table 18: Unmet Criteria for Service Excellence for Mental Health and Addictions Services

There are no unmet criteria for this section.

Obstetrics Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

The culture of collaboration and teamwork on the obstetrical ward is remarkable. All team members spoke about the value each discipline brings to the department, and their respect for one another was evident.

During periods of shortage, an agreement with privileged midwifery providers was in place to cover unfilled nursing shifts and maintain continuity of care for patients. The teams work, train, and problem-solve together, all in the best interest of their patients.

During the tracer, a cesarean section occurred where the patient-centred approach to care and positive teamwork were on full display. The appreciation of the benefits of prolonged skin-to-skin time for mom and baby during the OR stay post-delivery was shared by all team members. It was impressive to witness that this has become the standard of care provided at NHH. It can serve as a model for other obstetrical units.

A robust surge protocol has been established for the obstetrical services program. It ensures capacity remains within the hospital to care for obstetrical patients when demand for services surges. As a result, redirection of out-of-catchment patients has been greatly minimized, ensuring that any obstetrical patient presenting for care can be safely cared for at NHH.

Table 19: Unmet Criteria for Obstetrics Services

There are no unmet criteria for this section.

Service Excellence for Obstetrics Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

The level of support that the interdisciplinary obstetrical team has received for educational initiatives, including NRP, ALARM, ACORN, and other learning opportunities, is truly impressive. Learning together across disciplines has built a remarkable culture of teamwork and collaboration and ensured that team members feel valued and supported.

The team has effectively identified factors contributing to an increased cesarean section rate and is diligent in monitoring progress to reduce the primary and overall c-section rate. However, they are encouraged to evaluate the effectiveness of, and compliance with, each of the strategies employed to ensure proper evaluation of its safety improvement strategies.

Table 20: Unmet Criteria for Service Excellence for Obstetrics Services

There are no unmet criteria for this section.

Perioperative Services and Invasive Procedures

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

The perioperative program at NHH is supported by a collaborative interdisciplinary team committed to people-centred care and providing high-quality, safe perioperative care. Anesthesia assistants are a recent, positive addition to the team mix and have been successfully integrated. The addition of a fourth operating room will enable NHH to more effectively meet local surgical needs, including expanded urological procedures such as lithotripsy. This will be a major change for the program and one that will require expanded human resources but is exciting for all involved.

There is sound medication management in the perioperative area. There is an Omnicell in the operating room area that stocks pre-assembled anesthesia medication packs containing commonly used drugs. The anesthetist signs out and returns the medications from the Omnicell cabinet. The number of drugs available in the operating room anesthesia carts is minimized, and single-use vials are used exclusively.

There is insufficient evidence that a Transfer of Accountability (TOA) consistently occurs upon admission to the postoperative inpatient unit. The teams are supported by organizational policy in transferring information using the Situation, Background, Assessment, and Recommendation (SBAR) format. This electronic tool exists within the Epic system and can be used to support consistent, standardized sharing of information. However, it is unclear whether the tool is consistently used to support standardization and reduce variation. NHH is encouraged to consider implementing a standard auditing process to ensure that a Transfer of Accountability consistently occurs in an optimized manner.

The Safe Surgical Checklist is universally adopted for all surgical procedures performed in the operating room. It was observed that team members remained actively engaged in activities, did not follow the script exactly as outlined, and may not have been actively engaged. The organization may wish to consider a renewed focus on ensuring team members consistently and rigorously follow the outlined checklist so that all components are addressed every time. This also requires an approach in which all team members stop what they are doing, remain silent when not speaking to the prescribed points, and actively listen and engage in the process.

During the tracer, a patient's case almost had to be cancelled because the patient had taken a GLP-1 medication within the past week, which increases the risk of aspiration. The communication of the risk to the patient was professional and appropriate. Through shared decision making, the team pivoted to provide care with alternative analgesia rather than a general anesthetic to accommodate the patient. This demonstrated a patient-centred approach to care while maintaining patient safety and was impressive to witness. With the increasing prevalence of GLP-1 medication use in society at large, the organization may wish to emphasize the importance of discontinuing these medications before surgery through preoperative clinics, patient-oriented communication materials, and other means.

Table 21: Unmet Criteria for Perioperative Services and Invasive Procedures

There are no unmet criteria for this section.

Service Excellence for Perioperative Services and Invasive Procedures

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

Volatile anesthetics and nitrous oxide are potent greenhouse gases, with desflurane being the most potent inhaled anesthetic. The American Society of Anesthesiologists and other anesthesia professional associations recommend avoiding inhaled anesthetics and using intravenous and regional anesthesia when clinically appropriate, while avoiding desflurane and nitrous oxide when inhaled anesthetics are used. NHH is commended for already phasing out desflurane several years ago. It continues to use Nitrous Oxide, albeit infrequently. A quality improvement project could help align the team with best practices and further minimize the use of anesthetic gases. The team of anesthetists is well-positioned to support this work, as they use multiple modes of anesthesia delivery, including spinal anesthesia and ultrasound-guided nerve blocks. This should be supported by the capacity for nurses to manage patient-delivered analgesia via epidural placement for post-operative pain control.

The surgical program at NHH championed Early Recovery After Surgery (ERAS) for its bowel surgeries. With the program's success, it has been moved from the balanced scorecard to everyday operations.

Given the program's success, the teams are encouraged to identify other surgeries amenable to ERAS principles, such as gynecological surgeries, to optimize surgical care for patients served at NHH.

The organization does not have a policy that informs for whom, by whom, and when, suicide screening should occur. There is guidance recommending screening for certain CEDIS complaints in patients presenting to the emergency department, but not in patients presenting as outpatients elsewhere in the organization, including those presenting for day surgery.

NHH is encouraged to implement universal mental health screening for all patients presenting for surgical services, regardless of presenting concern, so that those at risk of suicide are consistently identified. This could include a question at their initial assessment that enquires about mental health concerns, which could be as simple as a single screening question of all patients, “Do you or have you recently had concerns about your mental health?” and if the patient answers in the affirmative, following up with a question about whether the patient is experiencing suicidal ideation. If the patient answers positively, a complete Columbia Suicide Screening should occur, and appropriate referrals be made. Asking about mental health should be normalized and akin to asking if a patient has a headache or chest pain.

Table 22: Unmet Criteria for Service Excellence for Perioperative Services and Invasive Procedures

There are no unmet criteria for this section.

Point-of-Care Testing

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

The organization has a well-established point of care testing program for its two services, glucometer and amniocentesis testing. Quality testing programs and standard operating procedures are updated regularly with oversight engaged by the Medical Director. Staff training both within the lab and the units is well supported by the hospital.

Table 23: Unmet Criteria for Point-of-Care Testing

There are no unmet criteria for this section.

Rehabilitation Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

Rehabilitation Services demonstrate alignment with Accreditation Canada standards, with a strong focus on safety, quality, and responsiveness to patient needs, including those exhibiting responsive behaviors. Staff articulated a clear understanding of Gentle Persuasive Approaches (GPA) principles and their application in daily practice. This initiative was introduced based on staff injury occurring due to responsive behaviors. All staff in the unit are trained, and the initiative is spreading into other departments within the organization, such as the float pool. Awareness of the organization's disclosure policy was evident, and leadership was able to describe the process for disclosure when safety incidents occur.

Safety incidents are routinely reviewed through the departmental Quality and Operations group. An opportunity for improvement is noted in ensuring the quality and completeness of transferred information aligns with the Required Organizational Practice through a standardized auditing tool.

Data trending is actively used to identify Quality Improvement opportunities, particularly related to falls and responsive behaviors. These indicators are formally included on the departmental scorecard and are visibly displayed on the Clinical Quality Board within the unit, supporting staff awareness, engagement, and real time monitoring of performance.

Improvement initiatives are measured and evaluated, with progress tracked over time and opportunities for further improvement clearly identified. This structured approach supports continuous improvement and enhances the safety and effectiveness of rehabilitation services.

An opportunity exists to further strengthen organizational learning by formalizing the process for sharing results and associated learnings beyond the Rehabilitation Services department. Establishing a consistent approach to disseminating outcomes and incorporating formal evaluation of spread initiatives would support scalability and reinforce a culture of continuous quality improvement across the organization.

Table 24: Unmet Criteria for Rehabilitation Services

There are no unmet criteria for this section.

Service Excellence for Rehabilitation Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

NHH demonstrates strong commitment to service excellence through the intentional design and use of physical spaces that support rehabilitation outcomes for diverse patient populations, including those recovering from stroke. Rehabilitation environments are well planned, functional, and aligned with patient needs, contributing positively to safety, recovery, and overall experience.

The recently opened outpatient stroke rehabilitation program is a notable strength. Staff clearly articulate pride and ownership in this service and consistently identify it as an essential component of stroke recovery. The outpatient model enhances continuity of care following acute hospitalization and supports patient centered rehabilitation by enabling individuals to receive specialized stroke services close to home. This approach reflects best practice in accessibility, community-based care, and patient engagement.

In addition, NHH operates a six-bed palliative care unit that effectively supports acute, palliative, and hospice patients. The flexibility of this space is a key asset, allowing it to respond to system pressures during periods of high acute care surge while maintaining a strong focus on comfort and quality of life for palliative patients. Staff are appropriately trained in the use of infusion pumps, enabling safe delivery of pain and symptom management therapies, even when patient acuity increases.

Overall, the rehabilitation and palliative environments demonstrate thoughtful planning, workforce preparedness, and adaptability. These elements collectively support high-quality, patient centered care and align well with Accreditation Canada’s expectations for service excellence for Rehabilitation services.

Table 25: Unmet Criteria for Service Excellence for Rehabilitation Services

There are no unmet criteria for this section.

Reprocessing of Reusable Medical Devices

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

NHH demonstrates strong compliance with the Reprocessing of Reusable Medical Devices standard, supported by recent infrastructure investments, skilled staff, and a culture of quality and safety. The department has undergone significant enhancements, including the installation of new washer equipment and a fully upgraded endoscopy reprocessing area. These improvements support safe, standardized, and efficient reprocessing practices across the organization.

Staff within the department are knowledgeable, highly skilled, and express pride in their work environment and equipment. The implementation of an instrument tracking system further strengthens traceability, accountability, and patient safety throughout the reprocessing lifecycle. Staff demonstrated confidence in their understanding of reprocessing workflows, including those specific to endoscopy, reflecting the effectiveness of ongoing education and training opportunities.

The organization provides numerous educational opportunities to ensure staff remain competent and comfortable with all reprocessing processes. Education is inclusive of endoscopy reprocessing and supports both onboarding and continuous professional development. There is no immediate-use sterilization within the hospital, reducing risk and reinforcing adherence to best practices and planned reprocessing workflows.

The physical design of the department supports infection prevention and workflow integrity. The decontamination area is physically separate from clean and sterile areas and requires assigned, controlled access, minimizing the risk of cross contamination.

A strong culture of quality improvement is evident. Staff are encouraged to identify and participate in quality improvement initiatives, and several initiatives are currently underway as the team continues to optimize the use of new equipment and systems.

Leadership within the department is a clear strength. Leadership is visible, engaged, and regularly present within the department. Staff reported receiving ongoing feedback and recognition, contributing to morale, engagement, and a supportive work environment.

Overall, NHH demonstrates strong alignment within the standard through effective leadership, modernized infrastructure, staff competence, and a commitment to continuous quality improvement, ensuring safe and reliable reprocessing practices that support patient safety.

Table 26: Unmet Criteria for Reprocessing of Reusable Medical Devices

There are no unmet criteria for this section.

Transfusion Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the table at end of this section.

Assessment Results

Transfusion services are well established and predominantly provided within the ambulatory care unit and Emergency for trauma cases. Quality standards and standard operating procedures are in place and reviewed and updated on a regular basis. There is a strong internal and external reporting quality program in place.

Table 27: Unmet Criteria for Transfusion Services

There are no unmet criteria for this section.