ACCREDITATION
AGRÉMENT
CANADA
Qmentum

Accreditation Report

Perth and Smith Falls District Hospital

Smith Falls, ON

On-site survey dates: October 16, 2017 - October 19, 2017

Report issued: November 8, 2017

About the Accreditation Report

Perth and Smith Falls District Hospital (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. As part of this ongoing process of quality improvement, an on-site survey was conducted in October 2017. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

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

Confidentiality

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

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

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

A Message from Accreditation Canada

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

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

Your Program Manager or Client Services Coordinator is available if you have questions or need guidance.

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

We look forward to our continued partnership.

Sincerely,

Leslee Thompson
Chief Executive Officer

Table of Contents

Executive Summary

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

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

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

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

Accreditation Decision

Perth and Smith Falls District Hospital's accreditation decision is:

Accredited with Exemplary Standing

The organization has attained the highest level of performance, achieving excellence in meeting the requirements of the accreditation program.

About the On-site Survey

- **On-site survey dates: October 16, 2017 to October 19, 2017**

- **Locations**

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

  1. Great War Memorial
  2. Perth and Smiths Falls District Hospital

- **Standards**

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

  System-Wide Standards

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

  Service Excellence Standards

  5. Biomedical Laboratory Services - Service Excellence Standards
  6. Critical Care - Service Excellence Standards
  7. Diagnostic Imaging Services - Service Excellence Standards
  8. Emergency Department - Service Excellence Standards
  9. Medicine Services - Service Excellence Standards
  10. Obstetrics Services - Service Excellence Standards
  11. Perioperative Services and Invasive Procedures - Service Excellence Standards
  12. Point-of-Care Testing - Service Excellence Standards
  13. Reprocessing of Reusable Medical Devices - Service Excellence Standards
  14. Transfusion Services - Service Excellence Standards

- **Instruments**

  The organization administered:

  1. Governance Functioning Tool (2016)
  2. Canadian Patient Safety Culture Survey Tool
  3. Worklife Pulse
  4. Client Experience Tool

Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
Population Focus (Work with my community to anticipate and meet our needs)	43	0	0	43
Accessibility (Give me timely and equitable services)	67	0	0	67
Safety (Keep me safe)	542	3	14	559
Worklife (Take care of those who take care of me)	109	0	0	109
Client-centred Services (Partner with me and my family in our care)	250	0	8	258
Continuity (Coordinate my care across the continuum)	48	0	0	48
Appropriateness (Do the right thing to achieve the best results)	864	1	23	888
Efficiency (Make the best use of resources)	47	0	5	52
Total	**1970**	**4**	**50**	**2024**

Overview by Standards

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

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

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

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

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	49 (98.0%)	1 (2.0%)	0	35 (97.2%)	1 (2.8%)	0	84 (97.7%)	2 (2.3%)	0
Leadership	49 (98.0%)	1 (2.0%)	0	96 (100.0%)	0 (0.0%)	0	145 (99.3%)	1 (0.7%)	0
Infection Prevention and Control Standards	40 (100.0%)	0 (0.0%)	0	31 (100.0%)	0 (0.0%)	0	71 (100.0%)	0 (0.0%)	0
Medication Management Standards	78 (100.0%)	0 (0.0%)	0	64 (100.0%)	0 (0.0%)	0	142 (100.0%)	0 (0.0%)	0
Biomedical Laboratory Services **	71 (100.0%)	0 (0.0%)	0	105 (100.0%)	0 (0.0%)	0	176 (100.0%)	0 (0.0%)	0
Critical Care	50 (100.0%)	0 (0.0%)	0	92 (100.0%)	0 (0.0%)	23	142 (100.0%)	0 (0.0%)	23
Diagnostic Imaging Services	62 (100.0%)	0 (0.0%)	5	69 (100.0%)	0 (0.0%)	0	131 (100.0%)	0 (0.0%)	5
Emergency Department	71 (100.0%)	0 (0.0%)	0	99 (100.0%)	0 (0.0%)	8	170 (100.0%)	0 (0.0%)	8

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Medicine Services	45 (100.0%)	0 (0.0%)	0	77 (100.0%)	0 (0.0%)	0	122 (100.0%)	0 (0.0%)	0
Obstetrics Services	71 (100.0%)	0 (0.0%)	2	87 (100.0%)	0 (0.0%)	1	158 (100.0%)	0 (0.0%)	3
Perioperative Services and Invasive Procedures	111 (100.0%)	0 (0.0%)	4	109 (100.0%)	0 (0.0%)	0	220 (100.0%)	0 (0.0%)	4
Point-of-Care Testing **	38 (100.0%)	0 (0.0%)	0	46 (100.0%)	0 (0.0%)	2	84 (100.0%)	0 (0.0%)	2
Reprocessing of Reusable Medical Devices	85 (100.0%)	0 (0.0%)	3	40 (100.0%)	0 (0.0%)	0	125 (100.0%)	0 (0.0%)	3
Transfusion Services **	75 (100.0%)	0 (0.0%)	0	69 (100.0%)	0 (0.0%)	0	144 (100.0%)	0 (0.0%)	0
Total	**895 (99.8%)**	2 (0.2%)	14	1019 (99.9%)	1 (0.1%)	34	1914 (99.8%)	3 (0.2%)	48

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

Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Safety Culture			
Accountability for Quality (Governance)	Met	4 of 4	2 of 2
Patient safety incident disclosure (Leadership)	Met	4 of 4	2 of 2
Patient safety incident management (Leadership)	Unmet	5 of 6	1 of 1
Patient safety quarterly reports (Leadership)	Met	1 of 1	2 of 2
Patient Safety Goal Area: Communication			
Client Identification (Biomedical Laboratory Services)	Met	1 of 1	0 of 0
Client Identification (Critical Care)	Met	1 of 1	0 of 0
Client Identification (Diagnostic Imaging Services)	Met	1 of 1	0 of 0
Client Identification (Emergency Department)	Met	1 of 1	0 of 0
Client Identification (Medicine Services)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client Identification (Obstetrics Services)	Met	1 of 1	0 of 0
Client Identification (Perioperative Services and Invasive Procedures)	Met	1 of 1	0 of 0
Client Identification (Point-of-Care Testing)	Met	1 of 1	0 of 0
Client Identification (Transfusion Services)	Met	1 of 1	0 of 0
Information transfer at care transitions (Critical Care)	Met	4 of 4	1 of 1
Information transfer at care transitions (Emergency Department)	Met	4 of 4	1 of 1
Information transfer at care transitions (Medicine Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Obstetrics Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Perioperative Services and Invasive Procedures)	Met	4 of 4	1 of 1
Medication reconciliation as a strategic priority (Leadership)	Met	4 of 4	2 of 2
Medication reconciliation at care transitions (Critical Care)	Met	5 of 5	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Emergency Department)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Medicine Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures)	Met	5 of 5	0 of 0
Safe Surgery Checklist (Obstetrics Services)	Met	3 of 3	2 of 2
Safe Surgery Checklist (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
The “Do Not Use” list of abbreviations (Medication Management Standards)	Met	4 of 4	3 of 3
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management Standards)	Met	4 of 4	1 of 1
Concentrated Electrolytes (Medication Management Standards)	Met	3 of 3	0 of 0
Heparin Safety (Medication Management Standards)	Met	4 of 4	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
High-Alert Medications (Medication Management Standards)	Met	5 of 5	3 of 3
Infusion Pumps Training (Critical Care)	Met	4 of 4	2 of 2
Infusion Pumps Training (Emergency Department)	Met	4 of 4	2 of 2
Infusion Pumps Training (Medicine Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Obstetrics Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Perioperative Services and Invasive Procedures)	Met	4 of 4	2 of 2
Narcotics Safety (Medication Management Standards)	Met	3 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Client Flow (Leadership)	Met	7 of 7	1 of 1
Patient safety plan (Leadership)	Met	2 of 2	2 of 2
Patient safety: education and training (Leadership)	Met	1 of 1	0 of 0
Preventive Maintenance Program (Leadership)	Met	3 of 3	1 of 1
Workplace Violence Prevention (Leadership)	Met	5 of 5	3 of 3

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Compliance (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Hand-Hygiene Education and Training (Infection Prevention and Control Standards)	Met	1 of 1	0 of 0
Infection Rates (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Critical Care)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Diagnostic Imaging Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Emergency Department)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Medicine Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Obstetrics Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Critical Care)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Medicine Services)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Suicide Prevention (Emergency Department)	Met	5 of 5	0 of 0
Venous Thromboembolism Prophylaxis (Critical Care)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Medicine Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2

Summary of Surveyor Team Observations

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

Perth and Smiths Falls District Hospital is commended on its strong commitment to quality and safety, as reflected by the outstanding results from this accreditation survey. Throughout the survey, the dedication of the board, leaders and point of care staff and physicians was evident. This commitment to quality was also reflected in the positive feedback surveyors heard from patients, families and community members.

The organization is lead by a board of directors that is strongly committed to excellence and ensures the hospital maintains a positive financial position through increased efficiencies and strategic changes in program and service delivery. The board strives to achieve good governance and embarks on its own initiatives to enhance board performance. The board has lead the strategic planning process involving broad consultation with stakeholders.

The senior leaders promote and model a “can do” attitude, recognizing the contributions of all team members and nurturing a values-based culture. Many staff cited appreciation for their leaders who are visible, accessible and supportive.

The organization benefits from and contributes to a number of provincial networks. Community partners praised the organization’s collaborative approach, willingness to share resources, and contributions that complement the role and services of other agencies. It was noted that the organization’s leaders often play a significant role in regional planning with other members of the Local Health Integration Network. Recent changes to the stroke program reflect the organization’s willingness to redefine its role and transfer some program components to a larger facility in order to achieve better patient outcomes.

Over the past three years, the organization has made patient- and family-centred care a high priority. The results are remarkable. The Patient and Family Advisory Council has become a significant and valued partner, with members embedded in many aspects of the organization’s planning, evaluation and quality improvement activities. Council members participate on two board committees and the Ethics Committee. They play an important advisory role related to selected policies, facility renovations, patient information material and other improvements to enhance the care experience of patients and families. In particular, the Council played a major role in the development of the exceptional new patient information guide. The commitment to patient- and family-centred care and the Council are highly visible, including the new logo, developed by the Council, reflecting patients and families as the “Heart of Care.”

Teamwork is very strong at Perth and Smiths Falls District Hospital. Staff help and rely upon each other to provide excellent care and services. Many staff described a sense of family and recognize the importance of the work they do in serving their local community. Staff demonstrate resilience and an ability to innovate and problem solve. They appreciate the organization’s investment in staff development and desire to provide a safe, respectful work environment. A number of initiatives have been undertaken to enhance physician engagement and stabilize physician resources.

The hospital has recently completed a renewal of the Smiths Falls site, which has significantly enhanced the care environment. The building at the Perth site is old and efforts are being made to make improvements, subject to available resources. The organization recognizes the need to update and/or replace some management information systems, with a new health information system being the highest priority.

The quality of care at Perth and Smiths Falls appears to be very good. The organization has adopted many evidence-based practices and in particular has worked hard to ensure Required Organizational Practices (ROPs) are consistently implemented. Key performance indicators are monitored and initiatives are underway to continuously improve results. The organization has developed a quality improvement plan and a patient safety plan. The patient safety plan focuses on medication reconciliation, other aspects of medication safety, hand hygiene, patient information at discharge, 30 day readmission rates, and meeting the needs of complex, frail and vulnerable patients.

A number of program enhancements have been made, with particular successes related to the Baby Friendly Initiative, Centralized Intake Assessment Centre (CIAC) for hip replacement, expanded mammography program, transfer of accountability (bedside shift change), and enhanced scope of practice for registered practical nurses (RPNs) and pharmacists. Significant improvements have been achieved related to medication safety. The organization is commended for its recent successful lab certification.

The organization has identified many opportunities for improvement. Perth and Smiths Falls District Hospital is working strategically and diligently to provide exceptional care and, in partnership with others, achieve optimal health for the people in the communities it serves.

Detailed Required Organizational Practices

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

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

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Safety Culture	
Patient safety incident management A patient safety incident management system that supports reporting and learning is implemented.	· Leadership 15.4

Detailed On-site Survey Results

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

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

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

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

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

See Appendix B for a list of priority processes.

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

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

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

Priority Process Results for System-wide Standards

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

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

Priority Process: Governance

Meeting the demands for excellence in governance practice.

Unmet Criteria		High Priority Criteria
Standards Set: Governance		
10.5	The governing body regularly hears about quality and safety incidents from the clients and families that experience them.	!
13.9	The governing body prepares an annual report of its achievements.	

Surveyor comments on the priority process(es)

The organization is governed by an enthusiastic and dedicated board of directors, consisting of 12 community members, the President and Vice President of Medical Staff and 3 members of the senior leadership team (the CEO, VP Patient Care Services, and Chief of Staff). The board has established four board committees to assist its work. The board uses the Ontario Hospital Association (OHA) Guide to Good Governance and various OHA governance tools and other resources. Bylaws define board roles and processes. The board may wish to consider developing a more explicit and simple document that outlines its governance model and reflects its move away from the previous Carver governance model, remnants of which are still apparent, for example in the policy related to CEO Leadership and Monitoring.

The board oversees the strategic planning process and regularly reviews key performance metrics included in the balanced scorecard.

The board has added patient advisors to two board committees and is considering adding a member of the Patient and Family Advisory Council to the board. Patient stories are communicated by the CEO at the beginning of each board meeting. The board is encouraged to explore having these stories communicated directly by patients and family members.

The board has self-identified the need to enhance its board evaluation processes, specifically feedback regarding the contributions of individual board members. The board may wish to consider developing an annual report of its own activities and achievements which would complement the annual report of the organization's achievements.

Priority Process: Planning and Service Design

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization is finalizing a new strategic plan for 2018-2021. This plan was developed in consultation with community partners, employees, medical staff the Patient and Family Advisory Council, the Local Health Integration Network (LHIN) and other stakeholders. Operational plans will be developed to align with the strategic plan.

The organization has made a strong commitment to patient and family-centred care. The new Patients and Families The Heart of Care logo was developed with input from the Patient and Family Advisory Council and is prominently displayed. The Council is actively engaged in many activities, including policy review, development of the patient information booklet, renovations to the Emergency Department, food selections and various quality improvements.

Community partners noted that the organization values partnerships and collaboration to meet the needs of clients across various agencies. Partners expressed appreciation for the support (for example, staff training) and shared resources provided by the organization. The organization has established a respectful relationship with the LHIN and other hospitals within the LHIN. As illustrated by recent changes to the stroke program, the organization is prepared to make program changes which result in improved efficiency and patient outcomes.

Priority Process: Resource Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization has well established resource management processes and has had a balanced budget for the past four years. The budget planning cycle is largely determined by the Local Health Integration Network (LHIN). Oversight of spending and compliance with the budget involves managers, senior leaders, the audit and finance committee and the board. There is an external audit process.

A Fiscal Advisory Committee composed of union representatives, a non-union representative and the President of Medical Staff provides a forum for senior leaders to inform and consult with others as part of the budget planning process. The budget process includes analysis of data including activity and spending trends, anticipated retirements and other relevant information.

Appropriate policies such a signing authorities exist. Variance analyses are done as required.

Priority Process: Human Capital

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The Human Resource team is limited to two individuals that have done an amazing job at leading human capital at the organization. The team is supported by consultants for negotiations, pay equity, compensation framework, management coaching and complex labour relations issues. As well, there is legal counsel support available.There is a flow chart that portrays this information.

There are good relations with unions at the organization. Currently there are negotiations that are underway that the team is hopeful will result in a positive outcome. There is a clear process in place for on-boarding new staff. A performance review is completed at the end of 6 months and then every 3 years. Upon review of staff files it is apparent that there is more of a focus on performance reviews over the last few years. Prior to that time performance reviews were not done consistently. Exit interviews are offered for staff.

Better Safe Than Sorry program is completed by staff members annually. There is documentation to support that staff are completing the annual reviews. A Human Resources/Talent Management plan has been developed with several indicators that monitor several processes that reflect how the organization is performing. This tool is in the process of ongoing development.

Priority Process: Integrated Quality Management

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
15.3 A strategy to prevent the abuse of clients is developed and implemented.	!
15.4 A patient safety incident management system that supports reporting and learning is implemented. 15.4.1 A patient safety incident management system is developed, reviewed, and updated with input from clients, families, and team members, and includes processes to report, analyze, recommend actions, and monitor improvements.	ROP **MAJOR**

Surveyor comments on the priority process(es)

The organization demonstrates a strong commitment to quality, safety and continuous improvement. Teams are supported in identifying areas for improvement, making changes and evaluating results using Plan, Do, Study, Act (PDSA) cycles and other improvement methods. Some capacity for lean methodology has been developed and process mapping is used as part of the review of critical incidents and prospective analysis.

The organization has adopted numerous evidence-based practices including those related to Required Organizational Practices (ROPs).

A risk management framework has been developed which identifies and addresses key organizational risks.

A quality improvement plan has been developed and specifies measures, targets, target justification and planned improvement initiatives. This plan includes a large number of initiatives, many of which are required to meet accountabilities from the LHIN and/or Ministry. Given the size of this organization there is some risk that this ambitious plan will overextend limited staff resources and compromise results. The Patient Safety Plan is more focused and identifies six goals and related actions, measures and timelines.

Storyboards are posted throughout the organization in pubic spaces, profiling the measurement of results and the organization's commitment to measurement and transparency. A balanced scorecard is used to monitor and report key results.

The organization demonstrates a "can do" attitude, which results in an impressive agility to implement improvements. The Patient and Family Advisory Council is increasingly engaged in various quality improvement initiatives. The organization is encouraged to further explore ways to partner with patients and families on quality improvement teams.

Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization has established core values and a code of conduct which are reviewed with staff at orientation and the annual Better Safe Than Sorry education session. The values and code of conduct are used as a framework for performance management.

An enthusiastic Ethics Committee is composed of a cross section of staff and a member of the Patient and Family Advisory Council. The Committee meets bi-monthly and as required to respond to ethics consults. In addition to ethics consults, the Committee plays a role in promoting staff awareness and understanding of ethics, policy review and review of research proposals (which also undergo review by the originating institution's research ethics board). Ethics consults involve both clinical ethics and organizational ethics issues such as smoking,

The organization has access to an ethicist at the Kingston Hospital but has not thus far accessed this resource.

The ethics framework is broadly available to assist staff in identifying and working through ethics issues. There is an information pamphlet about the Ethics Consultation Services.

The organization is commended for its approach to ethics, particularly the inclusion of a patient advisor on the Ethics Committee. The organization is encouraged to support further education of the Ethics Committee members and to build ongoing education into the Ethics Committee meeting process.

Priority Process: Communication

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization has committed to effective internal and external communications. Despite having limited dedicated internal resources to support the communications function, the organization has developed a variety of communications tools, including an excellent patient information guide that was developed in partnership with the Patient and Family Advisory Council. Internal newsletters (Connections) profile organizational changes and activities, educate staff and celebrate employee achievements. A Communications Strategy and Community Engagement Framework has been developed. Subject to available staff resources, the organization plans to enhance its website and use of social media.

Some of the organization's information management systems do not meet current needs and require replacement when funds are available. In particular, a new health information system will be the focus of a major fundraising campaign.

Policies and practices are in place to protect patient confidential and privacy. Staff receive ongoing education related to privacy and confidentiality as required by provincial legislation and organizational policies. Staff demonstrate awareness of the importance of patient privacy and this is considered when planning renovations such as changes to the patient registration space in the Emergency Department.

Priority Process: Physical Environment

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization functions on two sites. The Smiths Falls site has undergone a major renewal beginning in 2008. This refurbishment is almost complete, with 5% of the heating and ventilation (HVAC) system improvements still pending. The Perth site is an old physical plant, where reoccurring floods remain a problem but is being addressed. Many areas of the Perth site require major renovations to better support patient care and efforts are being made to address these deficiencies, subject to available funding. With financial support from the community, patient rooms at Perth are being renovated. A new medication room in the Perth Emergency Department is a welcome addition.

Renovations are done in consultation with staff with strong involvement of Infection Prevention and Control. The Patient and Family Advisory Council is involved in the redesign of the registration area in the Smiths Falls Emergency Department.

The buildings generally appear to be clean, although old flooring and building materials pose challenges in some areas especially at the Perth site. Back-up generators are in place.

Security focuses on safety of both patients and staff. There are no dedicated security staff during daytime hours and the organization relies on local police services, which are very responsive. Recent changes in security camera monitors at Smiths Falls have been made to address staff concerns after hours.

The hospitals are non-smoking zones. Some recycling programs are in place in conjunction with community programs.

Priority Process: Emergency Preparedness

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The interprpfessional team demonstrated that there has been extensive work done with external partners to ensure that the organization is prepared in the event of a disaster. The team shared a mock exercise
that was held earlier this year that involved several internal and external stakeholders. A post scenario gap analysis was completed and then shared with staff. There were tremendous learnings for all that participated.

There is a schedule in place to hold codes, most of the codes are to be reviewed annually or more frequently. However, there are a number that are scheduled every 3 years. The team may want to increase the frequency of these mock codes as three years is a long time for staff to go without practice.

The Committee members were able to describe participation with the Ontario Fire Marshall and the evacuation process that occurs annually. Mock code reds are held monthly and the results are shared. Team members shared that front line staff are ad hoc members of the committee based on the area of focus. It may be of benefit to include more front line staff on a regular basis.

Priority Process: Patient Flow

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Survey day was a good day to see the units in action. Capacity pressures created flow issues and led to direct surveyor observation of cooperative processes and problem solving. This included both sites and the whole team as needed.
The daily huddles early in the day and as needed allow all team members to be aware of evolving demands and priorities of the day.
During the episodes of care, staff members at all levels, highlighted the tools and processes in place (with rationale), that positively impact flow and care.

Priority Process: Medical Devices and Equipment

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

It is evident that this is a committed team with members at both sites. The department runs smoothly with staff ready and able to do multiple functions and assist each other when work flow permits. All sterilization is consolidated to one site which is positive and no flash sterilization is performed.

Staff shared improvements to the physical environment which have occurred since the last survey. Staff were able to share knowledge and rationale for the changes.

The team has identified and initiated process or equipment improvements
and are also part of larger organizational change initiatives that impact quality and processes positively. One upcoming change will be a move from linens to disposable wraps. The organization has carefully considered many aspects of this change, including staff education, planned participation of leader with team, the new product provider, and their efforts to minimize environmental impacts.

Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Clinical Leadership

- Providing leadership and direction to teams providing services.

Competency

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

Episode of Care

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

Decision Support

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

Impact on Outcomes

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

Medication Management

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

Organ and Tissue Donation

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

Infection Prevention and Control

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

Diagnostic Services: Imaging

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

Diagnostic Services: Laboratory

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

Point-of-care Testing Services

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

Transfusion Services

- Transfusion Services

Standards Set: Biomedical Laboratory Services - Direct Service Provision

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

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

The lab has been accredited by the Ontario Lab Accreditation process and the team is very proud of this as it is an example of the excellent services that are provided. The lab has multiple Standard Operating Procedures that are reviewed and updated on an as need basis. This is done more frequently than once per year. The team works together to ensure that the updated information is disseminated to others in the lab.

The current hours of operation are different at the two sites. The Perth site has an on-call staff member available over night and the specimens are sent via taxi to the Smiths Falls site. In the event that something is needed at the Perth site there is an on-call staff member available. This change was as the result of reviewing needs and also finding efficiencies in lab services.

There are many quality improvement initiatives that the lab is involved in. One of these initiatives was a change in the start time for lab collection for inpatient services. This improvement has made a change in the time that lab results are available to physicians that round at 0900. Other measures that are tracked include turn around times and lab staff compliance feedback. These results are updated monthly and are posted in the staff lounge.

Standards Set: Critical Care - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The unit is an open model ICU but has supports available from other facilities in the event that a higher level of care is needed. Staff reviewed the quality indicators and were able to articulate the differences in the graphs. There is a strong sense of providing high quality care and the dedication of the staff members is very evident.

Staff discussed the staffing model and the differences on the various shifts. They were pleased to share that all of the vacancies had been filled and that staffing was good. There is a 'sharing' of staff between units based on the needs of the patients. Staff are comfortable in sharing any issues or concerns with the leadership team.

Priority Process: Competency

The staff in the ICU are certified in Advanced Cardiovascular Life Support (ACLS), Electrocardiography (ECG) interpretation and other specialized courses. Staff have a definite focus on providing quality care to their patients and families. There in ongoing training through the corporate Better Safe than Sorry

Program as well as the Keep your Finger on the Pulse program that staff felt provided them with the necessary information to ensure safe practices are maintained.

Performance reviews are completed on a regular basis and ongoing feedback is provided to staff. Regular rounding occurs with staff and patients and this has had a positive impact on staff morale. There is a very good sense of team work and collaboration.

Staff are aware of how to escalate a concern if required. There is good knowledge of the workplace violence policy and the processes to follow in the event of an incident. There was a discussion in the unit with interprofessional team members about the Medical Assistance in Dying (MAID) processes and the ethical issues that this care creates. It was a very important conversation and staff were very comfortable voicing their feelings.

Priority Process: Episode of Care

The ICU is an open model unit and has limitations on the types of patients and the level of acuity of the patients that they can provide care to. There are standardized order sets that are followed for all patients. The level of care that is provided is very good and the nurses have a great sense of pride in their ability to provide patient focused care.

Patients and families are actively engaged in the care that is required. A patient that I spoke to was very complimentary of the care that she had received. A thorough assessment is completed on any admissions to the ICU. A good transfer of information is received at the time of admission, transfer and discharge from the ICU.

End of life discussions are reviewed with the patient and family on admission to the ICU. Due to the fact that the acuity level of patients is not that high any patient that does require ventilation greater than 48 hours will be transferred to another facility. The staff are very good in collaborating with other team members to ensure that these patients are identified and transferred as appropriate. All of the Required Organizational Practices for ICU have been met. Staff were very pleased with the training that they received on the infusion pumps and felt that the drug library was an excellent safety tool to ensure that errors would be reduced.

Safer Healthcare Now! bundles are followed with zero incidents. There is a great sense of pride in the work that is provided in the unit. The team work and collaboration is very evident. Patients and their families are encouraged to participate in care planning while they are in the ICU and once it is determined that they are appropriate for transfer or discharge.

Priority Process: Decision Support

Patient charts are kept up to date and are inclusive of all of the information collected on each patient. Staff did discuss that due to the fact that they are a small community, patient confidentiality and privacy needs to be maintained. All standards were met.

Priority Process: Impact on Outcomes

The team shared that the Patient and Family Advisory Committee has been involved in reviewing and providing feedback on protocols. There are processes in place that the staff shared related to safety incidents and the electronic tool that is used to capture this information. Staff talked about what they would do in the event of an error, how it is reported and the disclosure to patients and their family.

Quality improvement indicators have been identified and are tracked. They include Safer Healthcare Now! initiatives as well as total number of ventilators and staff education.

Priority Process: Organ and Tissue Donation

Staff did indicate that there have been a couple of cases in which corneas were retrieved. There is a hospital policy on the process to follow in the event that a potential donor has been identified. Typically these patients would remain in the Emergency Department until the transport team arrived.

Standards Set: Diagnostic Imaging Services - Direct Service Provision

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

The organization has met all criteria for this priority process.

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

Diagnostic Imaging functions on two sites, with ultrasound, X-ray, bone mineral densitometry (BMD) and CT done at Smiths Falls, and ultrasound, X-ray, echocardiography and mammography done at Perth. The department at Smiths Falls is spacious and well designed. The space at Perth is crowded and poorly laid out, except for the new mammography room. Discussions are underway to examine ways to better use the available space at Perth, within available resources. Equipment is generally good and up to date. There are challenges with the lack of interoperability between the PACS system and the system in Ottawa, given the increasing number of patient referrals from Ottawa because of better access at Smiths Falls and Perth.

Efforts are made to ensure appropriate utilization of tests, with communication if necessary between the radiologist and referring physician. Unfunded BMD tests are reviewed. If new technology is approved (for example MRI), it will be important for the organization to ensure appropriate utilization of both MRI and CT tests, which could be expected to decrease.

Falls screening is done at registration. The organization should ensure consistent use of coloured bracelets for all patients at risk of falls, as a visual reminder in addition to information in the client's registration form.

The presence of on-site radiologists is appreciated and results in a very good response to emergency patients. After hours coverage is provided remotely by Real Time.

The department is committed to quality and safety. A number of quality indicators are monitored, including wait times and no show rates. Efforts have been made to reduce no shows, particularly in CT. Satisfaction surveys of referring physicians and patients are used for continuous improvement. A quality board profiles a few indicators and other information. The manager is exploring other ways to communicate and utilize real time information to engage and support staff in daily improvement.

Staff expressed a high level of satisfaction working in this department, and noted particularly the strong sense of teamwork. The interaction between staff and clients was observed to be very professional and caring.

Standards Set: Emergency Department - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The role of leadership is evident in the department. Two examples include the mock disaster held involving many staff, community partners and volunteers. This went well by all accounts and was very valuable to identify gaps and strengths, while at the same time building solid relationships. The second example would be the recent addition of an RPN to the staffing complement in ER. The team acknowledged and appreciated the role of leadership in this decision which they have found to be very helpful.

Priority Process: Competency

Team members have the expected competencies such as ACLS and Better Safe than Sorry. Individually they shared that they receive support for additional education in their professional areas of interest. When additional expertise is needed to support a patient, it was shared that other staff members, such as the oncology nurses, "are only a call away". The department describes itself as inter-professional team where all professions work side by side as colleagues without hierarchy.

When workload is heavy, nurses shared that they receive support to have additional staffing added when needed for workload. One nurse simply said, "they trust us" (leadership).

Priority Process: Episode of Care

The team was aware of processes from beginning to end of ER visit. Staff took an active role in advocating as needed for patients, using all information they are aware of the patient and family. This meant that even on a busy day when beds are short, patient care needs remained the priority and an admission was appropriate versus a discharge with a likely return to ER and worsened condition.

Priority Process: Decision Support

The ER team is aware of decision support tools, processes and policy.
For example, the ER encounter record which is completed by nurses and available for team members to view, contains triggers and space for required screening such as falls risk assessment, and suicidal ideation. These assist to guide placement in the department, safety and care in ER.

Priority Process: Impact on Outcomes

Quality Improvement (QI) activities were evident with large , eye catching, data and information shown graphically on the department wall for staff, patients and families to see at a glance.
Other QI ideas have spread down to ER such as the idea of college students creating videos for hospital and patient use and awareness. Students receive school credit and the hospital receives the product. In the ER this approach was used for information on wait times.

Priority Process: Organ and Tissue Donation

Organ donation does not take place at this time. Should there be a situation where this is desired a policy is in place.

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

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

The organization has met all criteria for this priority process.

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

The 2 infection control professionals are familiar and knowledgeable about both sites. They are fortunate to also work with a past Infection control leader who now does occupational health and safety. The 3 staff members create a strong team.

Efforts on hand hygiene are welcome to see and are innovative. The team targets all involved such as staff, volunteers, students and visitors. On admission, patients receive their own personal hand sanitizer which was a decision based on patient feedback and suggestion. The Infection Prevention and Control (IPAC) group has worked hard on education. There is dedicated time at orientation and ongoing updates afterward. Pamphlets shared included one for families on hand hygiene which also highlights precautions; pamphlets for staff on Sharps Injury Prevention, N95 respirators and Personal Protective Equipment (PPE); and wallet cards for staff on PPE, hand hygiene and precautions.

Patients and staff shared that both hospitals are well kept and that housekeepers are very responsive to needs. This includes terminal clean needs and attention to isolation precautions. Housekeeping also plays a key role in sharps safety and disposal. Incidents are very low in this area.

The team works collaboratively with other sites and professionals in the LHIN and/or provincially to ensure best practice, continuous learning and a strong working relationship which strengthens work in this area.

Standards Set: Medication Management Standards - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Medication Management	

The organization has met all criteria for this priority process.

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

Advances in Medication Management are clearly evident since the last survey. All involved should be proud of the role they have played to create this success.

Examples include: Pharmacy departments which are closer to patient areas and, have a standard layout at both sites; staff who now work at both sites; renovated Medication rooms on the units done as funding available; improved equipment from fridges to med carts; and, the initial work now in place for unit dosing to name a few. The Pharmacy Manager has an organized, deliberate approach which keeps the work focused and manageable.

QI activities are conducted by many on the team and include required audits. Communications boards keep the team up to date on work elements and celebrate successes or milestones for the team.

As the Pharmacy Manager leads medication management improvements forward, this is supported clinically by the Staff Development lead. There is a high level of focus on education which reinforces medication management at the point of care. Staff also acknowledge the amount of education and support provided.

Clearly medication management is supported by all stakeholders and this is very positive.

Standards Set: Medicine Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The collaboration and input of patients and family members is evident on the unit. Recent positive outcomes include the Paliative Care room, the room by room renovation process, and the new extra chairs for each room, suggested by patients and families to support the Move to Improve initiative.

Priority Process: Competency

Staff shared many opportunities for education which included the day long mandatory annual education; lunch and learn sessions; or specific opportunities they identify such as being supported to take the courses on Indigenous Culture or Palliative Care.

Priority Process: Episode of Care

Care on the unit was described as "nothing could be better"; "excellent care" and "if I had to be in the hospital, I'd want to be here". This appreciation and respect on the units was easily seen.
Family members coming and going spoke with staff to receive or share information which supports care and collaboration.
During the survey with pressure on beds, staff attitudes remained positive and decision making was collaborative with team involvement as to who might move where, to create space for admissions. It was a 'can do' attitude from all involved on a busy day.

Priority Process: Decision Support

Staff awareness of information and documentation requirements that support care needs was evident. The unit noted the value of the patient record system that has 29 mandatory questions for completion. If these are not completed the system does not allow you to progress with the admission. At the same time team members on this unit took the initiative to create an admission checklist, which further supported awareness of admission steps and was a tool to share information at shift change if the admissions process had unfinished areas.

Priority Process: Impact on Outcomes

Teams are open to change and new approaches for care improvement. When bedside reporting was initiated, team members participated cautiously, and kept an open mind. Now with the passage of time, team members note improvements they see with this approach such as being able to see patients sooner, and a quicker start overall to the day. Other processes the staff find valuable are the post discharge phone calls to support patients; and the posting of letters with feedback.

Standards Set: Obstetrics Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The labour and delivery unit is a level one unit with four labour, delivery, recovery and post partum room. There are two obstetricians that provide 24/7 coverage for the patients and their families. In the event that a patient requires a higher level of care they would be assessed to determine if they should be transferred to another facility or deliver at the hospital and then transfer post delivery. Following the birth of the baby 'rooming in' 24/7 is the expectation.

There are established partnerships that are very helpful to ensure that care continues once patients and their baby are discharged. These partnerships include Public Health and Leeds, Grenville and Lanark District Health Unit.

There is a mixture of staff in the unit ranging from new graduate to more senior staff. The team functions very well together and is supportive of each other. The staff indicated that they feel very supported by leadership and that following any incidents team huddles are held and staff are provided with any resources that they require.

Priority Process: Competency

Staff that work in the unit have all participated in the MOREob Program and are trained in neonatal resuscitation, fetal health surveillance and the Baby Friendly Initiative. The orientation process is comprehensive and the new graduate that I spoke with felt very supported.

The team works very well together and is supportive of each other. The new graduate indicated that leadership and her peers have all made her feel very comfortable and that she is receiving the necessary exposure to ensure that she is providing safe patient care. Staff felt that they were recognized formally and informally for the work that they provide. There was a strong sense of pride in the care that is provided to patients and their families.

Staff are aware of the workplace violence policy and understand the process to follow in the event of an incident.

Priority Process: Episode of Care

The labour and delivery unit is a level 1 unit with four beds and functions as a labour, delivery, recovery and post partum unit. There are two obstetricians that deliver 300 babies per year. There is a 34% C-section rate for the unit. The team functions at a high level of skilled nurses. The admission health assessment and routine monitoring is very comprehensive. There is a paper chart for this information.

There are booked C-sections as well as urgent sections. Both are done in the main operating room. The operating room staff are responsible for the mother and the C-section while the labour and delivery staff are responsible for the baby.

Rounding at the bedside happens at every shift change. The white boards in the rooms are updated every shift. The staff ensure that the patient and family are actively engaged in the delivery process. Consent for the administration of medications at birth for the baby are given following verbal consent from the mother. All Required Organizational Practices are met in the department. The staff are comfortable in meeting all of these practices.

There are processes in place for patients if their clinical status changes. Staff are comfortable and confident to relay this information to the obstetricians. Patients are closely monitored for any excessive bleeding and there is a 'tray' that contains all of the medications that would need to be administered. Staff stated that following the completion of MOREob that they are very comfortable in dealing with any obstetrical emergency.

The staff have established good working relationships with external partners related to care and support for the newborn and mother. Public Health was in to assess a patient pre-discharge to ensure that she had the necessary supports available to her. Skin to skin is encouraged for all patients and their newborn. This is done for vaginal and C-section deliveries. The team is satisfied with their breast feeding rates and the supports that are in place at the hospital as well as in the community.

Priority Process: Decision Support

The patient chart is a combination of paper and electronic documentation. Some of the information is charted in either place. There is the opportunity to consolidate this process to ensure that duplication, omission or loss of paper work does not occur. Staff indicated that they have recently converted from a 'guidelines' model to policies and procedures with care plans in place. They are happy with this change and feel that it has provided more autonomy for the staff. Charts are audited on a monthly basis and feedback is provided to staff.

Priority Process: Impact on Outcomes

The labour and delivery staff participate in BORN data collection. There is a large depository for pregnancy, birth and post natal information. As well, the team is well on their way towards the Baby Friendly Initiative. This requires a great deal of work. The hospital recently received the Certificate of Participation from the Breastfeeding Council.

Protocols and guidelines are in place to ensure that safe practice is provided to patients and their families. High risk activities are identified and there are mitigating strategies. In the event of a patient incident, staff were aware of the process that needs to be completed to ensure that information is collected and then learnings are shared more broadly.

Breast feeding rates, C-section rates and hand hygiene are a few of the indicators that are tracked and monitored by the team.

Standards Set: Perioperative Services and Invasive Procedures - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

There is active involvement from the Patient and Family Advisory Council with regards to the peri-operative services. Goals and objectives are established with input from staff and patients/families. There are indicators on the balanced scorecard that are tracked and shared with the staff. The team consists of RN, RPN and physicians and functions very effectively. The area was busy this morning with an urgent transfer and a busy list but the team did very well.

Partnerships exist with the colleges and universities in the area as well as with vendors. Both of these partners support learning and education for staff and physicians.

Recently there have been changes to the pre-operative area that were identified as an issue by patients and their families. Patient privacy was the area of concern and that issue has been resolved. It would be difficult at times to maintain confidentiality and privacy due to the small community as well as proximity of patients in the space that is available.

Priority Process: Competency

There are numerous opportunities for staff for education and re- certification. Staff talked about an education day that is held once a year that is based on feedback from the front line team. There are lunch and learn sessions that are sponsored by different vendors and the staff are appreciative of this. There is an orientation process for new staff that are hired as well as supporting them in the operating room training courses and other educational opportunities that are identified.

Priority Process: Episode of Care

The peri-operative area is very busy and well organized. The volumes of patients that are flowing through the department is high but a sense of order is maintained. The staff are all very qualified and rotate between the different areas of peri-operative, operating room and recovery room. The transfer of information from one location to the next is seamless. The team functions very well together as an interprofessional team.

There are clear processes in place with regards to obtaining consent and then pre-checks that are done prior to the patient entering the operating room. All of the patients are treated respectfully and their privacy is maintained. Pre-operative information is provided in the pre-op clinic and then is repeated and confirmed once the patient arrives on the day of the surgery. Information about the surgery is clarified and any questions are answered at that time.

Medication reconciliation is done during the admission process and medications are confirmed with the patient. In the cataract area the eye drops that are required are clearly explained to the patient and family prior to discharge with labels and instructions. Follow up phone calls are made to patients post discharge on day one or two to follow up on any concerns that they may have.

The operating room is run very well. There are standardized processes in place to ensure the safe delivery of care to patients. The rooms are prepared in advance of the patient arrival. Once the patient has arrived in the operating room the surgical safety checklist is completed. Staff felt confident that in the event of any concerns they would speak up and stop the process to ensure that the correct care would be provided. Patients are treated very respectfully throughout the procedure. The team functions very well.

The recovery room nurses receive a thorough transfer of information from the operating room nurse and an assessment of the patient's status is completed. The anesthetist also provides a report on any medications that were given as well as any concerns that may have developed intra-operatively. Once the patient is fully awake further instructions (both written and verbal) are provided to the patient. The information that is gathered from the patient and provided to the patient is all documented.

Staff felt very well supported. There are educational opportunities for staff that choose to attend any courses. Lunch and learn sessions are held to ensure that there knowledge level remains current.

Priority Process: Decision Support

Staff in the peri-operative area use paper charting. All information related to the care that is provided is documented in the chart. All of the standards are met.

Priority Process: Impact on Outcomes

There are goals and objectives that were established with input from staff, patients and families. All possible processes are identified and put in place to help reduce any errors. The staff provided an example in which a medication error was made and the process that followed. Disclosure to the patient and family as well as the identification of steps that would help to further reduce the possibility of the error reoccurring. There were very good learnings that took place and the staff that were involved felt very supported.

The team does participate in some research activities. There are learnings that occur from this participation. The staff talked about the process for identifying high risk activities and the work that has been done to help reduce the potential for errors. Quality improvement indicators have been identified and the results are posted in the unit. Staff are involved in this process. There are multiple standardized protocols that are followed by staff for patients that are having cataracts, orthopedics or gynecology surgery. These protocols are shared with the patients throughout the peri-operative and post-operative stages.

Feedback from patients was very positive. The multiple interactions that I witnessed were very positive with information sharing and teaching were being done. The nurses talked about spending time with the patients to help put them at ease even though they had a busy schedule.

Priority Process: Medication Management

There are very safe medication practices in the operating room. All of the standards are met.

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

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

The organization has met all criteria for this priority process.

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

The lab recently underwent the process of purchasing new glucometers. The CobasIT was purchased and has greatly improved the ability to educate staff and to complete routine re-certification audits. Monthly audits are completed by the lab staff on all of the glucometers in the hospital to ensure accuracy. With this new system there is a 'bar code' access so that all staff and patients are identified correctly. The wireless docking stations transfer the lab result into Meditech via an interface. This ensures that lab results are captured and recorded in the patient record.

The Point of Care Committee was having difficulty getting established so the manager was able to have a standing item on the agenda of the Medical Quality Assurance Committee. This group is comprised of various members of the interprofessional team including physicians. This is an excellent example of using an existing committee to ensure that scope of services are defined and also oversees Point of Care testing.

Standards Set: Transfusion Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Transfusion Services	

The organization has met all criteria for this priority process.

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

The manager of lab services meets with the Canadian Blood Services annually to review transfusion rates and discards. The Perth site was recognized for a low rate of discards at less than 3%. The are standards in place that require an order for blood prior to the staff completing a cross match for blood products. There is a philosophy of administering only one unit of blood rather than two and repeating the hemoglobin before a second unit will be ordered.

The Medical Quality Assurance Committee is the forum in which transfusion information is shared. In the event of a blood transfusion adverse event there is a process that is followed that includes repeating the original sample of blood as well as completing multiple forms that are required.

There is an Emergency Blood Management National Advisory Committee that shares provincial planning information to all labs across the province. The hospital does provide home transfusions of IVIG. This is in partnership with a third party that is responsible for the training for patients including a checklist that is shared with the hospital.

Instrument Results

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

Governance Functioning Tool (2016)

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

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

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

- **Data collection period: July 13, 2017 to July 14, 2017**
- **Number of responses: 1**

Governance Functioning Tool Results

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1. We regularly review and ensure compliance with applicable laws, legislation, and regulations.	0	0	100	94
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	0	0	100	95
3. Subcommittees need better defined roles and responsibilities.	100	0	0	72
4. As a governing body, we do not become directly involved in management issues.	0	0	100	81
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	94

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
6. Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	96
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	0	100	96
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	0	0	100	95
9. Our governance processes need to better ensure that everyone participates in decision making.	0	0	100	64
10. The composition of our governing body contributes to strong governance and leadership performance.	0	0	100	91
11. Individual members ask for and listen to one another's ideas and input.	0	0	100	95
12. Our ongoing education and professional development is encouraged.	0	0	100	92
13. Working relationships among individual members are positive.	0	0	100	97
14. We have a process to set bylaws and corporate policies.	0	0	100	95
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	99
16. We benchmark our performance against other similar organizations and/or national standards.	0	0	100	76
17. Contributions of individual members are reviewed regularly.	0	100	0	69
18. As a team, we regularly review how we function together and how our governance processes could be improved.	0	0	100	80
19. There is a process for improving individual effectiveness when non-performance is an issue.	0	100	0	62
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	0	0	100	85

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
21. As individual members, we need better feedback about our contribution to the governing body.	0	100	0	50
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	0	0	100	84
23. As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	95
24. As a governing body, we hear stories about clients who experienced harm during care.	0	0	100	78
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	0	0	100	90
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	0	0	100	88
27. We lack explicit criteria to recruit and select new members.	100	0	0	77
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	0	0	100	88
29. The composition of our governing body allows us to meet stakeholder and community needs.	0	0	100	93
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	93
31. We review our own structure, including size and subcommittee structure.	0	100	0	88
32. We have a process to elect or appoint our chair.	0	0	100	89

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

Overall, what is your assessment of the governing body's impact over the past 12 months, in terms of driving improvements to:	% Poor / Fair	% Good	% Very Good / Excellent	%Agree * Canadian Average
	Organization	Organization	Organization	
33. Patient safety	0	0	100	81

Overall, what is your assessment of the governing body's impact over the past 12 months, in terms of driving improvements to:	% Poor / Fair	% Good	% Very Good / Excellent	%Agree * Canadian Average
	Organization	Organization	Organization	
34. Quality of care	0	0	100	82

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

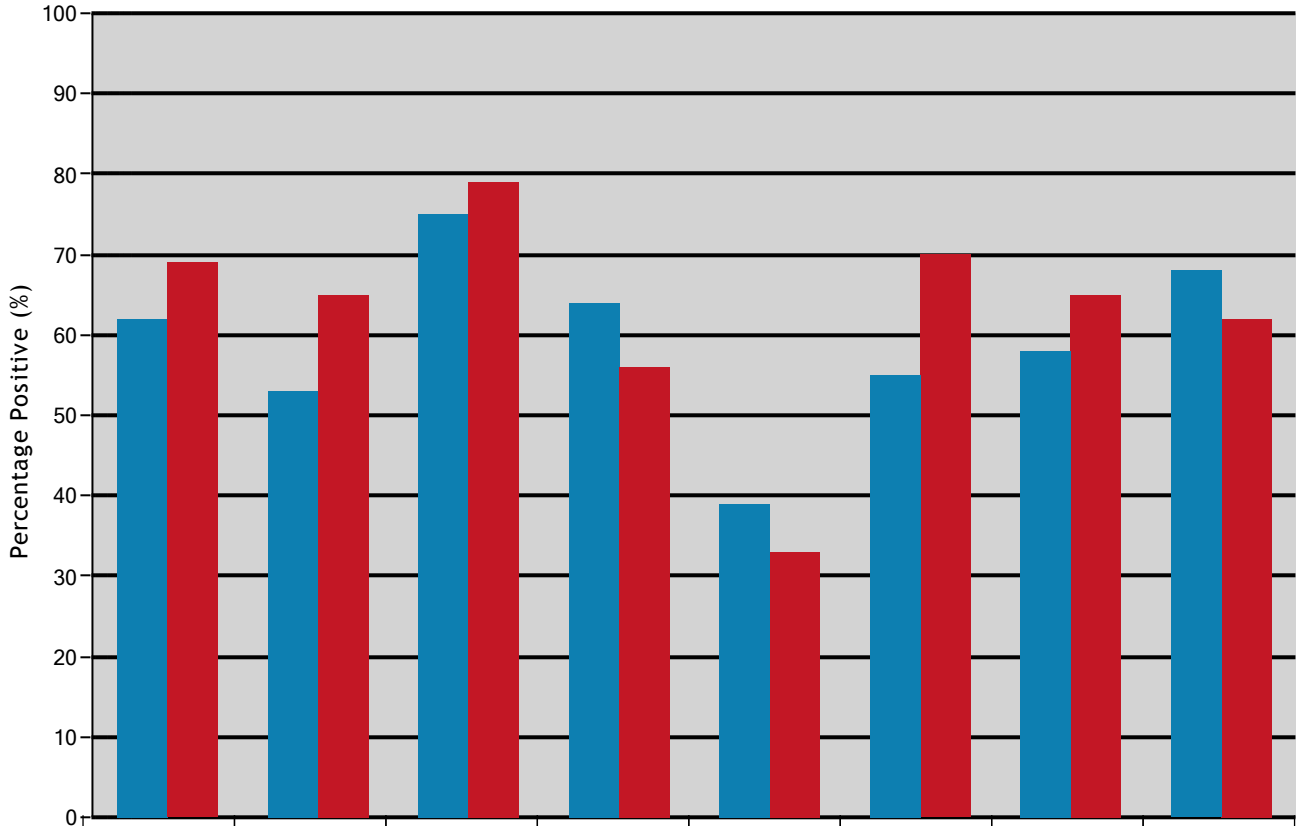
Canadian Patient Safety Culture Survey Tool

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

Results from the Patient Safety Culture Tool allow the organization to identify strengths and areas for improvement in a number of areas related to patient safety and worklife. Accreditation Canada provided the organization with detailed results from its Patient Safety Culture Tool prior to the on-site survey through the client organization portal. The organization then had the opportunity to address areas for improvement. During the on-site survey, surveyors reviewed progress made in those areas.

- **Data collection period: October 14, 2016 to November 18, 2016**
- **Minimum responses rate (based on the number of eligible employees): 152**
- **Number of responses: 154**

Canadian Patient Safety Culture Survey Tool: Results by Patient Safety Culture Dimension



	Organizational (senior) leadership support for safety	Supervisory leadership for safety	Unit learning culture	Enabling Open Communication I: judgment-free environment	Enabling Open Communication II: job repercussions of error	Incident follow up	Stand-alone items	Overall Perceptions of Client Safety
	62%	53%	75%	64%	39%	55%	58%	68%
	69%	65%	79%	56%	33%	70%	65%	62%

Legend

Perth and Smith Falls District Hospital

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2017 and agreed with the instrument items.

Worklife Pulse

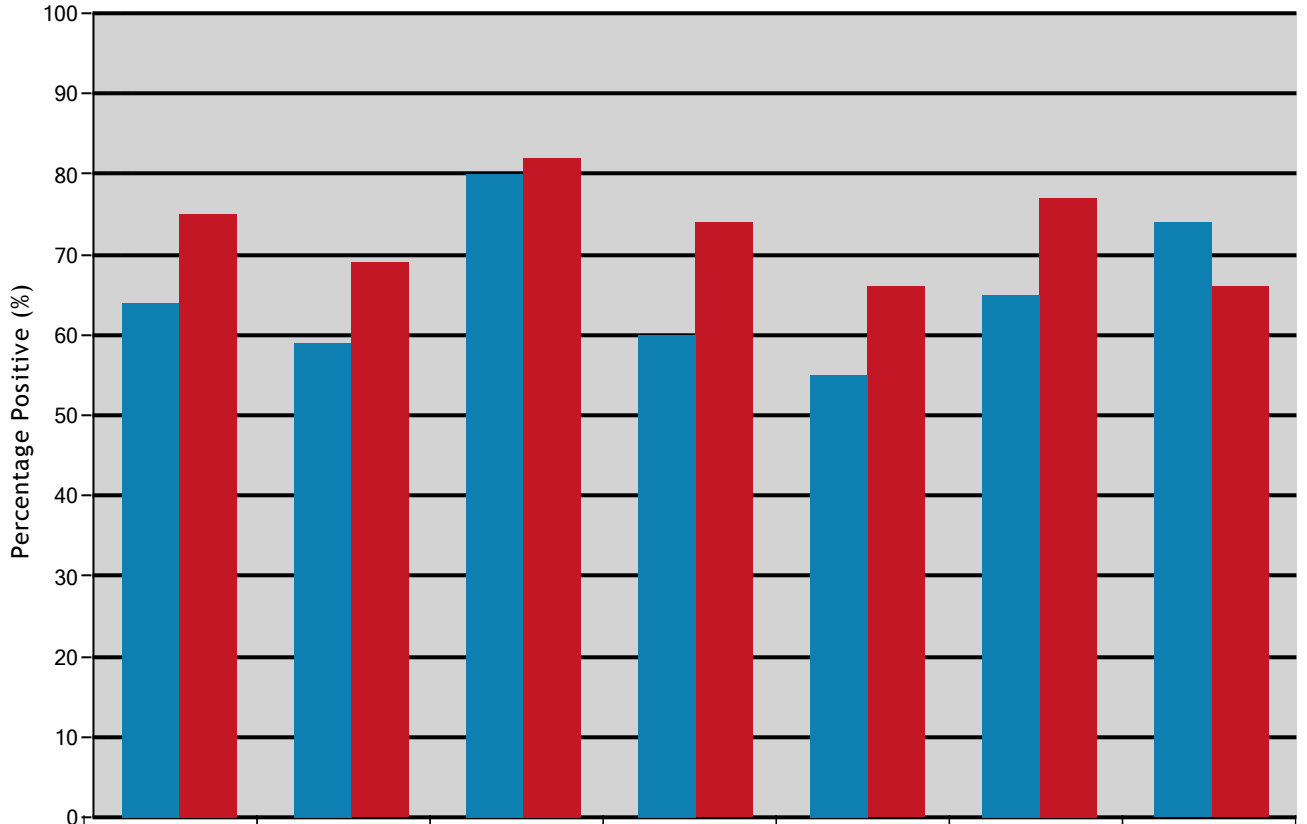
Accreditation Canada helps organizations create high quality workplaces that support workforce wellbeing and performance. This is why Accreditation Canada provides organizations with the Worklife Pulse Tool, an evidence-informed questionnaire that takes a snapshot of the quality of worklife.

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

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

- **Data collection period: June 19, 2016 to July 15, 2016**
- **Minimum responses rate (based on the number of eligible employees): 166**
- **Number of responses: 179**

Worklife Pulse: Results of Work Environment



	Job	Training and Development	Coworkers	Immediate Supervisor	Senior Management	Safety and Health	Overall Experience
	64%	59%	80%	60%	55%	65%	74%
	75%	69%	82%	74%	66%	77%	66%

Legend

Perth and Smith Falls District Hospital

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2017 and agreed with the instrument items.

Client Experience Tool

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

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

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

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

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

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

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

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

Organization's Commentary

After the on-site survey, the organization was invited provide comments to be included in this report about its experience with Qmentum and the accreditation process.

• Do the findings accurately capture the successes and challenges of the organization?
o Yes, we believe the findings are accurate and captures the essence of how our organization operates on a daily basis.

• What has the organization learned through assessing its level of compliance against the Accreditation Canada standards?
o The organization learned that accreditation preparation is an ongoing process since much of the work like our PFCC initiatives take time to evolve and require strong foundations upon which to build. This cannot be accomplished in a short period of time preceding an accreditation.
o We have also learned that accreditation is the chance to celebrate success and the hard work of every one of our team members.

• Are there any actions currently underway to address the identified areas for improvement?
o Yes we are working on the patient abuse prevention strategy and framework.
o The Board of Directors at the October 24, 2017 meeting, discussed ways to have patient stories told directly to the board by patients. This would be in addition to the current practice of relaying patient stories and journeys at every meeting.
o The Board of Directors is in the midst of creation of quarterly summary of board activities and outcomes that would be shared broadly with stakeholders. There was discussion that this could form the basis for an improved annual general report.

• What are the organization's immediate and long term actions to improve its quality of care and diminish any risks that may exist?
o The organization is committed to ongoing quality and safety improvement and are considering the recent accreditation process as the impetus to push ourselves to the next level of safety and quality.

Appendix A - Qmentum

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

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

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

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

Action Planning

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

Evidence Review and Ongoing Improvement

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

Appendix B - Priority Processes

Priority processes associated with system-wide standards

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

Priority processes associated with population-specific standards

Priority Process	Description
Chronic Disease Management	Integrating and coordinating services across the continuum of care for populations with chronic conditions

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

Priority processes associated with service excellence standards

Priority Process	Description
Blood Services	Handling blood and blood components safely, including donor selection, blood collection, and transfusions
Clinical Leadership	Providing leadership and direction to teams providing services.
Competency	Developing a skilled, knowledgeable, interdisciplinary team that can manage and deliver effective programs and services.
Decision Support	Maintaining efficient, secure information systems to support effective service delivery.
Diagnostic Services: Imaging	Ensuring the availability of diagnostic imaging services to assist medical professionals in diagnosing and monitoring health conditions
Diagnostic Services: Laboratory	Ensuring the availability of laboratory services to assist medical professionals in diagnosing and monitoring health conditions
Episode of Care	Partnering with clients and families to provide client-centred services throughout the health care encounter.
Impact on Outcomes	Using evidence and quality improvement measures to evaluate and improve safety and quality of services.
Infection Prevention and Control	Implementing measures to prevent and reduce the acquisition and transmission of infection among staff, service providers, clients, and families
Living Organ Donation	Living organ donation services provided by supporting potential living donors in making informed decisions, to donor suitability testing, and carrying out living organ donation procedures.
Medication Management	Using interdisciplinary teams to manage the provision of medication to clients

Priority Process	Description
Organ and Tissue Donation	Providing organ and/or tissue donation services, from identifying and managing potential donors to recovery.
Organ and Tissue Transplant	Providing organ and/or tissue transplant service from initial assessment to follow-up.
Point-of-care Testing Services	Using non-laboratory tests delivered at the point of care to determine the presence of health problems
Primary Care Clinical Encounter	Providing primary care in the clinical setting, including making primary care services accessible, completing the encounter, and coordinating services
Public Health	Maintaining and improving the health of the population by supporting and implementing policies and practices to prevent disease, and to assess, protect, and promote health.
Surgical Procedures	Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge