



ACCREDITATION CANADA



Driving Quality Health Services

Accreditation Report

Prepared for:
Norfolk General Hospital

Simcoe, ON

On-site Survey Dates:
March 22, 2009 - March 25, 2009

December 9, 2009



ACCREDITATION CANADA
AGRÉMENT CANADA

Accredited by ISQua

Final Accreditation Report

About this Report

This Report documents updated information and action taken by Norfolk General Hospital to address areas for improvement identified in its Forecast Report issued in April 2009. It also shows the final accreditation decision.

The Report is based on information obtained from the organization. Accreditation Canada relies on the accuracy of this information to conduct the on-site survey and to prepare the Report. Any alteration of this Report compromises the integrity of the accreditation process and is strictly prohibited.

Confidentiality

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

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

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About the Qmentum Accreditation Program

Accreditation is a cornerstone of quality improvement and patient safety initiatives, enabling an organization to regularly and consistently assess and improve its services.

Accreditation Canada's Qmentum program offers a customized process aligned with organizational needs and priorities. Organizations complete self-assessment questionnaires, collect indicator and instrument data, and undergo an on-site survey during which peer surveyors assess their services against national standards of excellence. Qmentum also offers ongoing support from and liaison with Accreditation Specialists who work with each organization to address critical issues, assist with action planning, and monitor progress.

Accreditation results, and the accreditation decision, are documented as follows:

- ***On-Site Report:***
At the conclusion of the on-site survey, surveyors provide the organization with an On-site Report summarizing their findings. The organization reviews the results and starts working on areas identified for improvement.
- ***Forecast Report:***
Following the on-site survey, Accreditation Canada issues a Forecast Report, containing more detailed on-site survey findings, a summary of indicator and instrument data, and a forecast of the final accreditation decision.
- ***Final Report:***
The Final Report is issued six months after the Forecast Report. It shows updated data, based on action(s) the organization has taken to address areas identified for improvement in the Forecast Report, and the final accreditation decision.

The findings in these Reports guide the organization as it incorporates the principles of accreditation into its programs and improves the quality of care and services provided to clients and the community.

An important adjunct to the Accreditation Reports is the Quality Performance Roadmap, available to the organization through a designated online portal. The Roadmap allows organization teams to review accreditation requirements and results in detail, and develop action plans, submit evidence, and monitor improvements.

Accreditation Summary

Norfolk General Hospital

On-site survey dates	March 22 to 25, 2009
Forecast Report issued	April 20, 2009
Forecast of the accreditation decision	Accreditation with Condition

Final Report issued	December 9, 2009
Accreditation Decision	Accreditation

Accreditation History

Previous on-site survey dates	March 5 to 8, 2006
Accreditation Decision	Accreditation
Previous on-site survey dates	March 23 to 26, 2003
Accreditation Decision	Accreditation
Previous on-site survey dates	March 1 to 3, 2000
Accreditation Decision	Accreditation
Previous on-site survey dates	March 2 to 4, 1997
Accreditation Decision	Accreditation
Previous on-site survey dates	January 6 to 7, 1994
Accreditation Decision	Accreditation
Previous on-site survey dates	February 1 to 2, 1991
Accreditation Decision	Accreditation
Previous on-site survey dates	March 2 to 3, 1988
Accreditation Decision	Accreditation

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Previous on-site survey dates Accreditation Decision	February 27 to 28, 1985 Accreditation
Previous on-site survey dates Accreditation Decision	August 19 to 20, 1982 Accreditation
Previous on-site survey dates Accreditation Decision	March 3 to 4, 1980 Accreditation
Previous on-site survey dates Accreditation Decision	April 4 to 5, 1978 Accreditation
Previous on-site survey dates Accreditation Decision	November 11 to 12, 1975 Accreditation
Previous on-site survey dates Accreditation Decision	December 12 to 13, 1972 Accreditation
Previous on-site survey dates Accreditation Decision	September 9 to 10, 1969 Accreditation
Previous on-site survey dates Accreditation Decision	November 11 to 12, 1966 Accreditation
Previous on-site survey dates Accreditation Decision	August 8 to 9, 1963 Accreditation
Previous on-site survey dates Accreditation Decision	March 3 to 4, 1962 Accreditation
Previous on-site survey dates Accreditation Decision	June 6 to 7, 1959 Accreditation
Previous on-site survey dates Accreditation Decision	November 11 to 12, 1958 Accreditation
Previous on-site survey dates Accreditation Decision	February 2 to 3, 1955 Accreditation
Previous on-site survey dates Accreditation Decision	April 4 to 5, 1954 Accreditation

Previous on-site survey dates
Accreditation Decision

January 1, 1951 to January 2, 1952
Accreditation

Organization's Commentary

The following comments were provided to Accreditation Canada post survey.

Organization Commentary

Self assessments

Norfolk General Hospital completed the self assessment process in the summer months of 2008. The new process involved increased staff participation and acted as a baseline assessment for the organization. Once the self assessment was completed each accreditation team reviewed the roadmap in detail and entered evidence and action plans to address all red and yellow flags in the Accreditation portal. In certain situations, it was very difficult to understand why a red or yellow flag was in the Roadmap when compared to the actual numerical results in the survey report. In order to clarify this situation Accreditation Canada should clearly state how a red or yellow flag is determined.

Survey Visit

The on-site survey visit was completed from March 23-25, 2009. Three Accreditation Canada surveyors and one intern visited our organization. Over the three day period of the survey they made visits to the clinical programs/services and met with members of the Board of Directors and Senior Administration staff. The process included an increase in front line staff involvement and comments from staff were positive. Staff enjoyed the opportunity to showcase to the surveyors the role that they plan as a part of the NGH team and were appreciative of the feedback from the surveyors.

Survey Finding - On-site Report

The On-site report was received following the debriefing session on March 25, 2009. This report indicated that NGH had met 1199 standards' criteria and showed 69 unmet criteria with 148 non applicable. The highlights of the Required Organizational Practices (ROP) indicate the 3 ROP's were not met within the Managing Medication Survey, 1 ROP not met in the Obstetrical Survey, 1 ROP for Critical Care and 5 references to the Medication Reconciliation ROP (surgery (2), Obstetrics (2), Critical Care (1) for a total of 10 unmet ROP's. It was our understanding that the test for compliance to the Medication Reconciliation Required Organizational Practice requires that Medication Reconciliation (on admission) will be implement in one unit and Medication Reconciliation (on discharge) will be implemented in one unit. On this basis, Norfolk General Hospital has met this test for compliance in that Medication Reconciliation is implemented in the ED for all admitted patients and on the Medical Unit for all in-patient discharges. The plan to roll out facility wide was documented for all are areas. This was somewhat confusing for staff and Directors to address since we had met the accreditation standard for Medication Reconciliation. After discussion with the Accreditation Specialist it was confirmed that Norfolk General Hospital had met this ROP. The inconsistency in the interpretation of the compliance for medication reconciliation needs to be addressed

For each of the other 5 ROP's, plans are in place to implement initiatives to ensure compliance with the standards by October of 2009

Comments within the on-site report associated with contacting patients and family at the end of service were a concern to the various services. Norfolk General Hospital partners with NRC Picker for Patient Satisfaction information and rely on the data that is obtained through this survey to identify opportunities for improvement and quality care activities. Comments from our clients is reviewed and acted upon. This report is available to all Directors/managers who share the content with their staff and develop improvement goals based on identified issues within the various dimensions of care. This

report enables the hospital to compare our positive response rates to those of other Community Hospitals in Ontario. Norfolk General Hospital has implemented the Health Outcomes for Better Information and Care (HOBIC) assessment which on admission and discharge assesses the patient for the ability to care for themselves (Therapeutic Self Care). This assessment provides meaningful real time information to the care team on admission and on discharge about how patients will be able to maintain their well-being once they are responsible for their own care. It is a way to measure how we have been able to address and self care issues during the hospital stay and made every effort to ensure that care needs are continued to the next sector. Reports are generated within the organization so that front line nurses, Directors, Senior Leadership and patients can see evidence of the changes and opportunities for on-going support.

Not all hospitals have the ability to meet all criteria. Selected criteria which are not achievable should be noted as “not applicable” rather than “non-compliant”. For example, there is a criteria for the Intensive Care Unit which states “An Intensivist or Critical Care Specialist is available daily to consult with admitting physicians in open intensive care units”. The Norfolk General Hospital was assessed as non-compliant with respect to this criteria. However, the Intensive Care Unit at the Norfolk General Hospital has only six beds and is not large enough to recruit an Intensivist or Critical Care Specialist.

Leading Practices

Recognizing innovation and creativity in Canadian health care delivery

Leading practices are commendable or exemplary organizational practices that demonstrate high quality leadership and service delivery. Accreditation Canada considers these practices worthy of recognition as organizations strive for excellence in their specific field, or commendable for what they contribute to health care as a whole. They may have been identified as a leading practice in a particular geographic region, or for a particular service delivery area or health issue.

Leading Practices

- are creative and innovative
- demonstrate efficiency in practice
- are linked to Accreditation Canada standards
- are adaptable by other organizations

Norfolk General Hospital is commended for the following:



There is an outbreak management binder for enteric and respiratory outbreaks. This kit includes several original forms and checklists of activities to complete. It is very thorough and comprehensive. It has been recognized by the regional infection prevention and control program for this area. The infection control practitioner will be presenting this new kit at the CHICA conference in Newfoundland. (Infection Prevention and Control)

1 Results Overview

This section of the Report shows an overview of the organization's results, displayed according to three significant components of the accreditation program: quality dimensions, required organizational practices, and standards sections.

1.1 Overview by Quality Dimensions

Accreditation Canada standards and criteria can be categorized into eight quality dimensions.

The following table summarizes the percentage of criteria associated with each quality dimension that were met by the organization, as well as the national compliance rate from January 1 to June 30, 2009 for all Accreditation Canada organizations.

Quality Dimension	Organization compliance rate %		National compliance rate * %
	Forecast Results	Final Results	
Population Focus <ul style="list-style-type: none"> Working with communities to anticipate and meet needs 	91	91	90
Accessibility <ul style="list-style-type: none"> Providing timely and equitable services 	97	97	97
Safety <ul style="list-style-type: none"> Keeping people safe 	94	98	90
Worklife <ul style="list-style-type: none"> Supporting wellness in the work environment 	97	97	93
Client-centred Services <ul style="list-style-type: none"> Putting clients and families first 	98	98	96
Continuity of Services <ul style="list-style-type: none"> Experiencing coordinated and seamless services 	97	100	96
Effectiveness <ul style="list-style-type: none"> Doing the right thing to achieve the best possible results 	94	95	91
Efficiency <ul style="list-style-type: none"> Making the best use of resources 	98	98	94

* Percentage of Accreditation Canada organizations surveyed from January 1 to June 30, 2009 that are in compliance with the criteria associated with each quality dimension.

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1.2 Overview by Required Organizational Practice (ROP)

Required Organizational Practices are essential practices that Accreditation Canada requires organizations to have in place to enhance patient and client safety and minimize risk.

This section shows two tables. The first summarizes the safety areas addressed by each ROP, and shows the organization's compliance status and the percentage of Accreditation Canada organizations nationally that met the ROP from January 1 to June 30, 2009.

To help organizations identify specific areas for action related to ROPs, the second table shows detailed requirements for unmet ROPs, and the standards sections in which they appear.

Following the on-site survey and receipt of the Forecast Report, organizations have opportunities to submit evidence of action taken to address areas identified for improvement. ROPs that continue to be rated unmet may be a result of the organization submitting incomplete or insufficient evidence, or because it has chosen to focus on other areas.

1.2a Overview by ROP Safety Areas

Safety Areas For Required Organizational Practices	Status at the Time of Forecast Report	Status at the Time of Final Report	Organizations that met the ROP %
Culture			
Adopts client safety as a written, strategic priority or goal	Met	Met	91
Produces quarterly reports on client safety, including recommendations from adverse incidents	Met	Met	89
Has a reporting and follow-up system for sentinel events, adverse events, and near misses	Met	Met	89
Discloses adverse events to clients and families	Met	Met	86
Conducts one client safety-related prospective analysis per year	Met	Met	71
Communication			
Educates clients and families about their roles in promoting safety	Met	Met	71
Ensures effective information transfer at transition points	Unmet	Met	92

Safety Areas For Required Organizational Practices	Status at the Time of Forecast Report	Status at the Time of Final Report	Organizations that met the ROP %
Communication			
Uses verification processes and other checking systems for high-risk activities	Unmet	Met	90
Conducts medication reconciliation at admission	Unmet	Met	41
Conducts medication reconciliation at transfer	Unmet	Met	43
Uses two client identifiers before administering medications	Met	Met	86
Identifies abbreviations, symbols, and dose designations that are not to be used	Unmet	Met	54
Medication Use			
Stores concentrated electrolytes away from client service areas	Met	Met	92
Standardizes and limits number of medication concentrations	Unmet	Met	97
Provides training on infusion pumps	Met	Met	78
Evaluates and limits availability of heparin products	Met	Met	89
Evaluates and limits availability of narcotic (opioid) products	Unmet	Met	97
Worklife/Workforce			
Delivers client safety training and education at least annually	Met	Met	91
Develops and implements client safety plan	Met	Met	88
Defines roles, responsibilities, and accountabilities for client care and safety	Met	Met	65
Has a preventive maintenance program for medical devices, equipment, and technology	Met	Met	79

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Safety Areas For Required Organizational Practices	Status at the Time of Forecast Report	Status at the Time of Final Report	Organizations that met the ROP %
Infection Control			
Ensures policies and procedures meet infection control guidelines	Met	Met	98
Delivers hand hygiene education and training.	Met	Met	97
Tracks and shares information on Infection rates	Met	Met	75
Monitors processes for reprocessing equipment	Met	Met	88
Administers the influenza vaccine	Met	Met	92
Administers the pneumococcal vaccine	Met	Met	95
Evaluates compliance with hand hygiene practices	Met	Met	72
Falls Prevention			
Implements a falls prevention strategy	Met	Met	63
Risk Assessment			
Implements interventions to prevent pressure ulcers	Met	Met	83
Monitors clients for risk of suicide	Not applicable	Not applicable	88

1.2b Overview of Unmet ROPs by Standards Section and Criterion

The organization is required to submit, through the Organization Portal, evidence of the action it has taken to meet the following ROPs in each of the identified standards sections.

Unmet Required Organizational Practice	Standards section and criterion #
Communication	
The team reconciles medications with the client at referral or transfer, and communicates information about the client’s medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.	<ul style="list-style-type: none"> · Surgical Care Services 11.4
The team reconciles the client’s medications upon admission to the organization, with the involvement of the client.	<ul style="list-style-type: none"> · Surgical Care Services 7.10

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1.3 Overview by Standards Section

The following table shows the percentage of high priority criteria in the identified standards section with which the organization has complied.

Standards Section	Organization compliance rate %		National compliance rate * %
	Forecast Results	Final Results	
Sustainable Governance	100	100	94
Effective Organization	100	100	88
Infection Prevention and Control	98	100	94
Managing Medications	90	99	94
Critical Care Services	90	100	85
Diagnostic Imaging Services	100	100	92
Emergency Department Services	97	100	88
Long Term Care Services	100	100	89
Medicine Services	90	97	84
Obstetrics/Perinatal Care Services	86	100	92
Operating Rooms	97	100	95
Reprocessing and Sterilization of Reusable Medical Devices	97	100	94
Surgical Care Services	88	94	87

* Percentage of Accreditation Canada organizations surveyed from January 1 to June 30, 2009 that are in compliance with the specified high priority criteria.

2 Status of Unmet, High Priority Criteria (from Forecast Report)

This section lists the high priority criteria from each standards section that were rated unmet at the time of the Forecast Report, and their current status. This table excludes the ROP data that is displayed in the previous section.

Following the on-site survey and receipt of the Forecast Report, organizations have opportunities to submit evidence of action taken to address areas identified for improvement. Criteria that continue to be rated unmet may be a result of the organization submitting incomplete or insufficient evidence, or because it has chosen to focus on other areas.

Infection Prevention and Control	Organization compliance status (Final Report)	National compliance rate * %
12.16 The organization tracks devices sent for sterilization so they can be recalled in the event of a breakdown or failure in the sterilization system.	Met	93
Managing Medications	Organization compliance status (Final Report)	National compliance rate * %
7.4 Medications for client service areas are stored in labelled, unit dose packaging.	Met	87
7.5 Unit dose oral medications remain in the manufacturer’s or pharmacy’s packaging until they are administered.	Met	92
10.13 The organization monitors compliance with its policies and processes for prescribing medications.	Met	91
18.5 Service providers seek an independent double check before administering high-alert/high-risk medications.	Unmet	83
Critical Care Services	Organization compliance status (Final Report)	National compliance rate * %
11.7 Following transition or end of service, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning.	Met	67

* Percentage of Accreditation Canada organizations surveyed from January 1 to June 30, 2009 that are in compliance with the specified high priority criteria.

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Emergency Department Services		Organization compliance status (Final Report)	National compliance rate * %
3.4	The interdisciplinary team communicates regularly to coordinate services, roles, and responsibilities.	Met	89
Medicine Services		Organization compliance status (Final Report)	National compliance rate * %
11.6	Following transition or end of service, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning.	Met	59
16.3	The team compares its results with other similar interventions, programs, or organizations.	Met	70
16.4	The team uses the information it collects about the quality of its services to identify successes and opportunities for improvement, and makes improvements in a timely way.	Unmet	76
Obstetrics/Perinatal Care Services		Organization compliance status (Final Report)	National compliance rate * %
9.6	The team documents the amount of administered medication.	Met	96
11.5	Following transition or end of service, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning.	Met	70
16.6	The team follows the organization's policy and process to disclose adverse events to clients and families.	Met	93
Operating Rooms		Organization compliance status (Final Report)	National compliance rate * %
3.4	The surgical suite has three levels of increasingly restricted access: accessible areas, semi-restricted areas, and restricted areas.	Met	86
12.11	The team is able to track all reprocessed or sterilized items so they can be recalled in the event of a breakdown or failure in the sterilization system.	Met	86

* Percentage of Accreditation Canada organizations surveyed from January 1 to June 30, 2009 that are in compliance with the specified high priority criteria.

Reprocessing and Sterilization of Reusable Medical Devices		Organization compliance status (Final Report)	National compliance rate * %
3.3	The physical space prevents cross-contamination of sterilized and contaminated devices or equipment, isolates incompatible activities, and clearly separates different work areas.	Met	61
Surgical Care Services		Organization compliance status (Final Report)	National compliance rate * %
8.5	Prior to a procedure, the team discusses organ donation with the client, and provides an opportunity for the client to consent to organ donation.	Met	35
11.6	Following transition or end of service, the team contacts clients, families, or referral organizations or teams to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning.	Met	61

* Percentage of Accreditation Canada organizations surveyed from January 1 to June 30, 2009 that are in compliance with the specified high priority criteria.

3 Performance Measures (Instruments and Indicators)

As part of the accreditation process, organizations collect performance measurement data. These measures consist of both instruments and indicators, and are valuable components of evaluation and quality improvement.

This section compares the organization’s performance measurement data with national data submitted by Accreditation Canada organizations. It can be used by the organization for benchmarking or other purposes.

3.1 Instrument Results

Instruments are questionnaires completed by a representative sample of board members, clients, staff, leadership, or other stakeholders.

Governance Functioning Tool

The Governance Functioning Tool is an opportunity for governing body members to assess their internal structures and processes, provide their perceptions and opinions, and identify areas for improvement.

The organization’s governing body members completed the Governance Functioning Tool between September 28 and October 24, 2008. This table compares the results to national results obtained from January 1 to June 30, 2009.

Number of survey respondents = 6 respondents

Governance Structures and Processes	% Agree		% Neutral		% Disagree	
	Organization	National	Organization	National	Organization	National
1 We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	67	86	0	0	33	14
2 We have explicit criteria to recruit and select new members.	83	80	0	0	17	20
3 Our renewal cycle is appropriately managed to ensure continuity on the governing body.	83	94	0	0	17	6
4 The composition of our governing body allows us to meet stakeholder and community needs.	100	95	0	0	0	5
5 Clear written policies define term lengths and limits for individual members, as well as compensation.	100	95	0	0	0	5
6 We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations.	100	92	0	0	0	8

Governance Structures and Processes	% Agree		% Neutral		% Disagree	
	Organization	National	Organization	National	Organization	National
7 Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	83	96	0	0	17	4
8 We review our own structure, including size and sub-committee structure.	83	93	0	0	17	7
9 We have sub-committees that have clearly-defined roles and responsibilities.	100	97	0	0	0	3
10 Our roles and responsibilities are clearly identified and distinguished from those delegated to the CEO and/or senior management. We do not become overly involved in management issues.	100	96	0	0	0	4
11 We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decision-making.	67	92	0	0	33	8
12 Disagreements are viewed as a search for solutions rather than a “win/lose”.	100	96	0	0	0	4
13 Our meetings are held frequently enough to make sure we are able to make timely decisions.	100	99	0	0	0	1
14 Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	100	97	0	0	0	3
15 Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	100	97	0	0	0	3
16 Our governance processes make sure that everyone participates in decision-making.	100	95	0	0	0	5
17 Individual members are actively involved in policy-making and strategic planning.	100	90	0	0	0	10
18 The composition of our governing body contributes to high governance and leadership performance.	83	96	0	0	17	4
19 Our governing body’s dynamics enable group dialogue and discussion. Individual members ask for and listen to one another’s ideas and input.	100	97	0	0	0	3

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Governance Structures and Processes	% Agree		% Neutral		% Disagree	
	Organization	National	Organization	National	Organization	National
20 Our ongoing education and professional development is encouraged.	83	92	0	0	17	8
21 Working relationships among individual members and committees are positive.	83	99	0	0	17	1
22 We have a process to set bylaws and corporate policies.	100	98	0	0	0	2
23 Our bylaws and corporate policies cover confidentiality and conflict of interest.	100	98	0	0	0	2
24 We formally evaluate our own performance on a regular basis.	83	84	0	0	17	16
25 We benchmark our performance against other similar organizations and/or national standards.	60	73	0	0	40	27
26 Contributions of individual members are reviewed regularly.	33	61	0	0	67	39
27 As a team, we regularly review how we function together and how our governance processes could be improved.	83	79	0	0	17	21
28 There is a process for improving individual effectiveness when non-performance is an issue.	50	61	0	0	50	39
29 We regularly identify areas for improvement and engage in our own quality improvement activities.	50	82	0	0	50	18
30 As a governing body, we annually release a formal statement of our achievements that is shared with the organization's staff as well as external partners and the community.	83	87	0	0	17	13
31 As individual members, we receive adequate feedback about our contribution to the governing body.	17	69	0	0	83	31
32 We have a process to elect or appoint our chair.	67	94	0	0	33	6
33 Our chair has clear roles and responsibilities and runs the governing body effectively.	100	98	0	0	0	2

Patient Safety Culture Survey

The Patient Safety Culture Tool asks staff to provide their perceptions about the culture of patient safety with the organization. It identifies areas of strength, areas for improvement, and mechanisms to monitor changes.

The organization's staff completed the Patient Safety Culture Tool between June 17 and 30, 2008. This table compares the results to national results obtained from January 1 to June 30, 2009.

Number of survey respondents = 129 respondents

A. Patient Safety: Activities to avoid, prevent, or correct adverse outcomes which may result from the delivery of health care	% Disagree		% Neutral		% Agree	
	Organization	National	Organization	National	Organization	National
1 Patient safety decisions are made at the proper level by the most qualified people	27	9	20	13	53	77
2 Good communication flow exists up the chain of command regarding patient safety issues	31	14	25	16	44	70
3 Reporting a patient safety problem will result in negative repercussions for the person reporting it	60	75	29	13	11	12
4 Senior management has a clear picture of the risk associated with patient care	37	16	23	22	40	62
5 My unit takes the time to identify and assess risks to patients	16	7	18	13	66	80
6 My unit does a good job managing risks to ensure patient safety	18	5	17	11	65	84
7 Senior management provides a climate that promotes patient safety	26	11	33	18	42	72
8 Asking for help is a sign of incompetence	90	89	6	5	5	6
9 If I make a mistake that has significant consequences and nobody notices, I do not tell anyone about it	90	92	8	4	2	4
10 I am sure that if I report an incident to our reporting system, it will not be used against me	20	18	31	18	49	64
11 I am less effective at work when I am fatigued	8	13	11	10	80	77
12 Senior management considers patient safety when program changes are discussed	17	10	39	25	44	64
13 Personal problems can adversely affect my performance	24	32	25	18	51	50

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A. Patient Safety: Activities to avoid, prevent, or correct adverse outcomes which may result from the delivery of health care	% Disagree		% Neutral		% Agree	
	Organization	National	Organization	National	Organization	National
14 I will suffer negative consequences if I report a patient safety problem	75	83	21	10	4	7
15 If I report a patient safety incident, I know that management will act on it	24	11	35	17	41	72
16 I am rewarded for taking quick action to identify a serious mistake	39	36	42	33	19	31
17 Loss of experienced personnel has negatively affected my ability to provide high quality patient care	38	42	26	24	36	33
18 I have enough time to complete patient care tasks safely	37	28	32	21	31	51
19 I am not sure about the value of completing incident reports	46	69	23	16	31	15
20 In the last year, I have witnessed a co-worker do something that appeared to me to be unsafe for the patient in order to save time	49	56	17	17	35	27
21 I am provided with adequate resources (personnel, budget, and equipment) to provide safe patient care	43	28	25	20	32	52
22 I have made significant errors in my work that I attribute to my own fatigue	81	80	14	11	5	9
23 I believe that health care error constitutes a real and significant risk to the patients that we treat	7	14	20	14	73	72
24 I believe health care errors often go unreported	22	32	19	24	58	44
25 My organization effectively balances the need for patient safety and the need for productivity	34	16	36	25	30	59
26 I work in an environment where patient safety is a high priority	22	8	27	12	51	79
27 Staff are given feedback about changes put into place based on incident reports	40	24	28	22	32	54
28 Individuals involved in patient safety incidents have a quick and easy way to report what happened	34	13	27	19	39	68

A. Patient Safety: Activities to avoid, prevent, or correct adverse outcomes which may result from the delivery of health care	% Disagree		% Neutral		% Agree	
	Organization	National	Organization	National	Organization	National
29 My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures	26	24	28	23	46	53
30 My supervisor/manager seriously considers staff suggestions for improving patient safety	18	14	25	19	57	67
31 Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts	57	69	29	17	15	14
32 My supervisor/manager overlooks patient safety problems that happen over and over	66	71	25	14	9	14
33 On this unit, when an incident occurs, we think about it carefully	15	8	26	15	59	77
34 On this unit, when people make mistakes, they ask others about how they could have prevented it	21	15	24	22	56	63
35 On this unit, after an incident has occurred, we think about how it came about and how to prevent the same mistake in the future	14	8	24	13	62	78
36 On this unit, when an incident occurs, we analyze it thoroughly	27	14	30	22	43	64
37 On this unit, it is difficult to discuss errors	48	66	22	18	30	16
38 On this unit, after an incident has occurred, we think long and hard about how to correct it	19	13	35	21	46	66

B. These questions are about your perceptions of overall patient safety	% Good/ Excellent		% Acceptable		% Poor/ Failing	
	Organization	National	Organization	National	Organization	National
39 Please give your unit an overall grade on patient safety	44	72	44	24	13	4
40 Please give the organization an overall grade on patient safety	24	64	51	30	25	6

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C. These questions are about what happens after a Major Event	% Disagree		% Neutral		% Agree	
	Organization	National	Organization	National	Organization	National
41 Individuals involved in major events contribute to the understanding and analysis of the event and the generation of possible solutions	14	7	36	23	50	70
42 A formal process for disclosure of major events to patients/families is followed and this process includes support mechanisms for patients, family, and care/service providers	20	8	41	27	39	65
43 Discussion around major events focuses mainly on system-related issues, rather than focusing on the individual(s) most responsible for the event	22	17	35	32	43	51
44 The patient and family are invited to be directly involved in the entire process of understanding: what happened following a major event and generating solutions for reducing re-occurrence of similar events	24	12	43	32	33	56
45 Things that are learned from major events are communicated to staff on our unit using more than one method (e.g. communication book, in-services, unit rounds, emails) and / or at several times so all staff hear about it	28	13	22	18	49	69
46 Changes are made to reduce re-occurrence of major events	13	6	34	17	53	76

Worklife Pulse

The Worklife Pulse Tool enables an organization to take the ‘pulse’ of its worklife quality. The Tool provides a snapshot of the work environment, as well as individual and organizational outcomes. Findings may be used to identify strengths and gaps in the work environment, engage stakeholders in discussions of opportunities for improvement, plan interventions to improve worklife quality, and develop a clearer understanding of how worklife influences the organization’s capacity to meet its strategic goals.

The organization’s staff completed the Worklife Pulse Tool between June 17 and 30, 2008. This table compares the results to national results obtained from January 1 to June 30, 2009.

Number of survey respondents = 275 respondents

How would you rate your work environment	% Disagree		% Neutral		% Agree	
	Organization	National	Organization	National	Organization	National
1 I am satisfied with communications in this organization.	41	23	33	20	26	57
2 I am satisfied with communications in my work area.	25	18	27	16	48	66
3 I am satisfied with my supervisor.	15	11	31	17	54	72
4 I am satisfied with the amount of control I have over my job activities.	27	13	20	17	54	70
5 I am clear about what is expected of me to do my job.	8	5	15	8	78	87
6 I am satisfied with my involvement in decision making processes in this organization.	32	22	32	25	36	53
7 I have enough time to do my job adequately.	46	32	27	19	27	49
8 I feel that I can trust this organization.	39	16	28	25	33	58
9 This organization supports my learning and development.	20	12	28	20	52	68
10 My work environment is safe.	23	11	29	15	48	74
11 My job allows me to balance my work and family/personal life.	32	15	23	18	45	68

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Individual Outcomes	% Not Stressful		% A bit Stressful		% Quite or Extremely Stressful	
	Organization	National	Organization	National	Organization	National
12 In the past 12 months, would you say that most days at work were...	10	21	39	43	52	36

	% Very Good/ Excellent		% Good		% Fair/ Poor	
	Organization	National	Organization	National	Organization	National
13 In general, would you say your health is...	62	62	32	32	6	6
14 In general, would you say your mental health is...	62	68	32	27	6	5
15 In general, would you say your physical health is...	57	59	36	33	8	8

	% Very Satisfied		% Somewhat Satisfied		% Not Satisfied	
	Organization	National	Organization	National	Organization	National
16 How satisfied are you with your job?	81	89	15	9	5	2

	% < 10		% 10 - 15		% > 15	
	Organization	National	Organization	National	Organization	National
17 In the past 12 months, how many days were you away from work because of your own illness or injury? (counting each full or partial day as 1 day)	91	87	3	6	6	7
18 During the past 12 months, how many days did you work despite an illness or injury because you felt you had to (counting each full or partial day as 1 day)?	85	85	8	8	7	7

	% Never/ Rarely		% Sometimes		% Often/ Always	
	Organization	National	Organization	National	Organization	National
19 How often do you feel you can do your best quality work in your job?	8	4	31	16	61	80

	% Disagree		% Neutral		% Agree	
	Organization	National	Organization	National	Organization	National
20 Overall, I am satisfied with this organization.	28	12	32	22	40	66
21 Working conditions in my area contribute to patient safety.	17	8	30	18	53	74

3.2 Indicator Results

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

Medication Reconciliation at Admission

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

Medication Reconciliation at Admission					
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% Formal medication reconciliation at admission	Notes received from the Organization

RED	Norfolk General Hospital (Emergency Department Services)	Emergency Department Services	01/01/2009 31/03/2009	67	
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Threshold for Flags
 RED: < 75/100
 YELLOW: >= 75/100 AND < 90/100
 GREEN: >= 90/100

Health Care Associated Infection Rates

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

Health Care Associated Infection Rates - C. difficile					
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection / 1000 patient days	Notes received from the Organization
GREEN	Norfolk General Hospital (Infection Prevention and Control)	NGHIPC	01/07/2008 30/09/2008	0.3	July: 1 case, 3397 patient days - 0.29 cases/1000 patient days August: 2 cases, 3226 patient days - 0.62 cases/1000 patient days September: 0 cases, 3240 patient days - 0 cases/1000 patient days

Threshold for Flags

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

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Health Care Associated Infection Rates - MRSA					
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection + colonization / 1000 patient days	Notes received from the Organization
GREEN	Norfolk General Hospital (Infection Prevention and Control)	NGHIPC	01/04/2008 30/06/2008	0.91	April: 1 case, 3386 patient days - 0.29 cases/1000 patient days May: 4 cases, 3424 patient days, - 1.16 cases/1000 patient days June: 4 cases, 3031 patient days, - 1.31 cases/1000 patient days

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

Surgical Site Infection

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

Surgical Site Infection - Colorectal Surgery					
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics	Notes received from the Organization
RED	Norfolk General Hospital (Infection Prevention and Control)	NGHIPC	01/01/2008 31/03/2008	64	
RED	Norfolk General Hospital (Infection Prevention and Control)	NGHIPC	01/04/2008 30/06/2008	55	

Threshold for Flags

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

Surgical Site Infection - Hysterectomy					
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics	Notes received from the Organization
RED	Norfolk General Hospital (Infection Prevention and Control)	NGHIPC	01/01/2008 31/03/2008	75	
YELLOW	Norfolk General Hospital (Infection Prevention and Control)	NGHIPC	01/04/2008 30/06/2008	88	

Threshold for Flags

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

4 Follow Up Required

The organization has earned Accreditation. To ensure ongoing quality improvement, the organization should show progress on the unmet criteria identified in this Report before the next on-site survey.

Evidence of action taken should be submitted through the Organization Portal.

Closing Thoughts from the President and CEO

Congratulations on reaching this important milestone on your accreditation journey. We salute and celebrate your achievements, and look forward to continuing to work with you as accreditation increasingly strengthens and supports your quality improvement and patient safety initiatives.

Your ongoing efforts to incorporate Accreditation Canada standards and tools into your programs and services have been, and will continue to be, of great benefit to your organization, your staff, the people you serve, and your community. Please contact your Accreditation Specialist, or use the Organization Portal, if you have questions or require additional information in this process.

Thank you for your commitment and dedication to improving quality health care through accreditation.

Wendy Nicklin
President and CEO
Accreditation Canada

Appendix A - Accreditation Decision Guidelines

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

1. population focus
2. accessibility
3. safety
4. worklife
5. client-centred services
6. continuity of services
7. effectiveness
8. efficiency

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

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

Accreditation Canada High Priority Criteria

Accreditation Canada recognizes High Priority Criteria in several key areas:

- Quality Improvement
- Safety
- Risk
- Ethics

Required Organization Practices (ROPs)

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

Based on the above, the three accreditation decisions for 2009 Qmentum surveys are:

Option 1: Accreditation

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

- (a) 10% or less of high priority criteria unmet per standard section, and
- (b) compliance with all of the Required Organizational Practices, and
- (c) compliance with collection of all the performance measures

Option 2: Accreditation with Condition: Report or Focused Visit

An organization will receive Accreditation with Condition: Report or Focused Visit if any of following criteria is

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met:

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

The condition and time frame for submission of the report or visit is based on the nature of the recommendations.

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

Option 3: Non Accreditation

An organization will not be accredited if the following conditions exist:

- (a) More than 30% of high priority criteria unmet per standard section and
- (b) More than 20% of unmet criteria for the organization