ACCREDITATION AGRÉMENT CANADA
Qmentum

Accreditation Report

Norfolk General Hospital

Simcoe, ON

On-site survey dates: March 8, 2020 - March 12, 2020

Report issued: April 14, 2020

About the Accreditation Report

Norfolk General Hospital (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. As part of this ongoing process of quality improvement, an on-site survey was conducted in March 2020. 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

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Executive Summary

Norfolk General 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

Norfolk General 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: March 8, 2020 to March 12, 2020**

- **Location**

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

  1. Norfolk General 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 Services - Service Excellence Standards
  7. Diagnostic Imaging Services - Service Excellence Standards
  8. Emergency Department - Service Excellence Standards
  9. Inpatient Services - Service Excellence Standards
  10. Long-Term Care Services - Service Excellence Standards
  11. Obstetrics Services - Service Excellence Standards
  12. Perioperative Services and Invasive Procedures - Service Excellence Standards
  13. Point-of-Care Testing - Service Excellence Standards
  14. Reprocessing of Reusable Medical Devices - Service Excellence Standards
  15. Transfusion Services - Service Excellence Standards

- **Instruments**

  The organization administered:

  1. Worklife Pulse
  2. Canadian Patient Safety Culture Survey Tool
  3. Governance Functioning Tool (2016)
  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)	44	1	0	45
Accessibility (Give me timely and equitable services)	72	3	1	76
Safety (Keep me safe)	587	6	22	615
Worklife (Take care of those who take care of me)	116	0	1	117
Client-centred Services (Partner with me and my family in our care)	296	4	1	301
Continuity (Coordinate my care across the continuum)	53	0	2	55
Appropriateness (Do the right thing to achieve the best results)	904	30	11	945
Efficiency (Make the best use of resources)	56	0	0	56
Total	**2128**	**44**	**38**	**2210**

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	94 (97.9%)	2 (2.1%)	0	143 (97.9%)	3 (2.1%)	0
Infection Prevention and Control Standards	40 (100.0%)	0 (0.0%)	0	29 (100.0%)	0 (0.0%)	2	69 (100.0%)	0 (0.0%)	2
Medication Management Standards	69 (100.0%)	0 (0.0%)	9	62 (100.0%)	0 (0.0%)	2	131 (100.0%)	0 (0.0%)	11
Biomedical Laboratory Services **	72 (100.0%)	0 (0.0%)	0	105 (100.0%)	0 (0.0%)	0	177 (100.0%)	0 (0.0%)	0
Critical Care Services	59 (98.3%)	1 (1.7%)	0	104 (100.0%)	0 (0.0%)	1	163 (99.4%)	1 (0.6%)	1
Diagnostic Imaging Services	64 (97.0%)	2 (3.0%)	2	67 (98.5%)	1 (1.5%)	1	131 (97.8%)	3 (2.2%)	3
Emergency Department	72 (100.0%)	0 (0.0%)	0	106 (100.0%)	0 (0.0%)	1	178 (100.0%)	0 (0.0%)	1

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Inpatient Services	57 (95.0%)	3 (5.0%)	0	77 (95.1%)	4 (4.9%)	4	134 (95.0%)	7 (5.0%)	4
Long-Term Care Services	53 (94.6%)	3 (5.4%)	0	93 (93.9%)	6 (6.1%)	0	146 (94.2%)	9 (5.8%)	0
Obstetrics Services	66 (94.3%)	4 (5.7%)	3	86 (97.7%)	2 (2.3%)	0	152 (96.2%)	6 (3.8%)	3
Perioperative Services and Invasive Procedures	113 (99.1%)	1 (0.9%)	1	109 (100.0%)	0 (0.0%)	0	222 (99.6%)	1 (0.4%)	1
Point-of-Care Testing **	38 (100.0%)	0 (0.0%)	0	48 (100.0%)	0 (0.0%)	0	86 (100.0%)	0 (0.0%)	0
Reprocessing of Reusable Medical Devices	79 (94.0%)	5 (6.0%)	4	31 (81.6%)	7 (18.4%)	2	110 (90.2%)	12 (9.8%)	6
Transfusion Services **	71 (100.0%)	0 (0.0%)	5	68 (100.0%)	0 (0.0%)	1	139 (100.0%)	0 (0.0%)	6
Total	**951 (97.8%)**	21 (2.2%)	24	1114 (98.0%)	23 (2.0%)	14	2065 (97.9%)	44 (2.1%)	38

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

Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Safety Culture			
Accountability for Quality (Governance)	Met	4 of 4	2 of 2
Patient safety incident disclosure (Leadership)	Met	4 of 4	2 of 2
Patient safety incident management (Leadership)	Met	6 of 6	1 of 1
Patient safety quarterly reports (Leadership)	Met	1 of 1	2 of 2
Patient Safety Goal Area: Communication			
Client Identification (Biomedical Laboratory Services)	Met	1 of 1	0 of 0
Client Identification (Critical Care Services)	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 (Inpatient 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 (Long-Term Care Services)	Met	1 of 1	0 of 0
Client Identification (Obstetrics Services)	Met	1 of 1	0 of 0
Client Identification (Perioperative Services and Invasive Procedures)	Met	1 of 1	0 of 0
Client Identification (Point-of-Care Testing)	Met	1 of 1	0 of 0
Client Identification (Transfusion Services)	Met	1 of 1	0 of 0
Information transfer at care transitions (Critical Care Services)	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 (Inpatient Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Long-Term Care 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	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Critical Care Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Emergency Department)	Met	1 of 1	0 of 0
Medication reconciliation at care transitions (Inpatient Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Long-Term Care Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures)	Met	4 of 4	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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Concentrated Electrolytes (Medication Management Standards)	Met	3 of 3	0 of 0
Heparin Safety (Medication Management Standards)	Met	4 of 4	0 of 0
High-Alert Medications (Medication Management Standards)	Met	5 of 5	3 of 3
Infusion Pumps Training (Critical Care Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Emergency Department)	Met	4 of 4	2 of 2
Infusion Pumps Training (Inpatient Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Long-Term Care 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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Worklife/Workforce			
Patient safety: education and training (Leadership)	Met	1 of 1	0 of 0
Preventive Maintenance Program (Leadership)	Met	3 of 3	1 of 1
Workplace Violence Prevention (Leadership)	Met	5 of 5	3 of 3
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Compliance (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Hand-Hygiene Education and Training (Infection Prevention and Control Standards)	Met	1 of 1	0 of 0
Infection Rates (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Critical Care Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Inpatient Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Long-Term Care Services)	Met	5 of 5	1 of 1
Falls Prevention Strategy (Obstetrics Services)	Met	2 of 2	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Perioperative Services and Invasive Procedures)	Met	2 of 2	1 of 1
Pressure Ulcer Prevention (Critical Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Inpatient Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Long-Term Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
Suicide Prevention (Emergency Department)	Met	5 of 5	0 of 0
Suicide Prevention (Long-Term Care Services)	Met	5 of 5	0 of 0
Venous Thromboembolism Prophylaxis (Critical Care Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Inpatient 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.

Norfolk General Hospital (NGH) is a collaborative organization, as evidenced by the approach taken in 2015 to increase its collaboration with West Haldimand General Hospital. This started as plan for sharing a president and CEO and expanded to a shared full senior team and other positions.

In 2018, NGH collaborated with West Haldimand General Hospital in a comprehensive joint strategic planning process that resulted in a strategic plan to lead the shared direction for both organizations.

NGH and West Haldimand General Hospital have enhanced their shared governance activities by establishing joint board committees. The NGH Board of Directors is commended for recognizing and supporting this collaborative strategic approach. All of this will position NGH well in the evolution and planning of Ontario Health Teams.

NGH's clearly articulated strategic priorities are high reliability health care, exceptional experience, and exceptional environment.

The strategic planning process in 2018 included an extensive community needs assessment that helped identify areas of focus for community needs.

The NGH board has adopted a process to ensure it has a well-developed skill mix in its membership. The board also has a solid process to onboard new board members and provide regular education to support board members in their roles. The board is commended for its efforts to develop board and board member evaluation which have led to improvements (e.g., board orientation, consent agenda process). The board is strongly encouraged to update the 2013 bylaws and board policy and procedures. The board members are acknowledged for learning about ethical decision making. The goal is for the board to use the ethics framework and criteria in board discussions and decision making.

NGH has highly engaged relationships with its community partners, and there is strong collaboration between NGH and multiple sectors across the system. NGH is seen as a partner that takes progressive steps to understand how it can work with others. Its partners see NGH as creative and an equal partner in improving health care services. The partners encourage NGH to continue to focus on communication strategies.

The strong value that NGH places on partnership will be an asset for its future role in developing an Ontario Health Team.

To help ensure the strategic plan is fulfilled, leadership is encouraged to operationalize the strategic plan at the unit, department, and program levels. This will enable everyone in the organization to understand how their work contributes to the strategic directions.

Leadership has embraced the importance of leader standard work through their experience with Studer and the High Reliability Organization frameworks. This work and learnings need to continue. The leaders are commended for their focus on continuous quality improvement and the well-developed integrated quality management framework.

NGH makes continual efforts to focus on opportunities for recruitment and retention. While there is evidence of support for succession planning and talent management, the organization needs to ensure that there are adequate investments to address the need.

The organization is encouraged to consider opportunities to maximize scope of practice, specifically for registered nurses, registered practical nurses, and personal support workers.

NGH values the importance of recognizing team members. The organization is encouraged to explore new ways of recognition, with input from team members.

With respect to the delivery of care and services, the organization is focused on providing quality of care while also understanding its limitations.

Attention is given to ensuring standardization, as seen in the organization's use of standardized patient order sets.

The organization is encouraged to streamline its communication processes for patients and families. It is also encouraged to increase the functionality of its electronic health record to enhance comprehensive and standard documentation.

Patient feedback highlights the caring and compassionate care provided by NGH staff. Patient-centred care and engagement is evident throughout the organization. There are advisors on some committees, but this involvement is still in the early stages. The organization is encouraged to involve patients and families at multiple levels of planning and decision making.

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		
1.5	There is a process to develop the governing body's by-laws and policies and update them regularly.	
3.1	The ethics framework and evidence-informed criteria are used by the governing body to guide decision making.	!

Surveyor comments on the priority process(es)

The board composition has a good balance of skills and abilities.

The bylaws were last updated in 2013 and the board is strongly encouraged to develop a work plan to update the bylaws.

The board is commended for adopting the ethics framework and being educated on its use. It is encouraged to incorporate the ethics framework and criteria into board discussions and decision making.

The Governance Functioning Tool results led to improvements in the orientation of new board members (e.g., "peer pairing," moving to a consent agenda process for board meetings). Board members find the well-developed process for individual board member evaluation valuable.

The board values providing educational opportunities for its members, and encourages them to continue to seek opportunities for learning, including regularly accessing the Ontario Hospital Association’s information and education on good governance.

In 2018, the board developed a joint strategic plan with West Haldimand General Hospital. The process included broad stakeholder involvement and a community needs assessment. The strategic plan has clear mission, vision, and values statements. In addition, the strategic priorities identify where the organization is to be focused.

Priority Process: Planning and Service Design

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
4.10 Goals and objectives at the team, unit, or program level align with the strategic plan.	

Surveyor comments on the priority process(es)

NGH uses an expansive community needs assessment to plan services. An excellent example is its evaluation of the need for obstetrics and gynaecology services and its use of this information to plan for infrastructure improvements and program enhancements.

NGH serves a large per capita migrant population and has enhanced its translation services to better serve this population.

There is some inconsistency at the team, unit, or program levels with how their goals and objectives align with the strategic plan.

Community partners see NGH as a strong partner, with leaders and staff who are creative, progressive thinkers, and value the perspectives of their partners.

The organization is encouraged to spread the use of project management discipline throughout the organization to ensure that changes to operational plans are achieved.

NGH is encouraged to consider how it could improve formal opportunities for patient and family engagement earlier in the planning and service design process. The Patient and Family Advisory Council (PFAC) is having challenges with membership, structure, and understanding of roles and responsibilities. It would be advantageous for the organization to put additional focus on revitalizing the PFAC.

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)

NGH has a well-defined resource management structure that includes input and oversight at all levels of the organization.

The annual process includes benchmarking through the use of the HIT tool and through the BIG database. The process uses financial and utilization indicators to evaluate financial performance and monitor progress.

The organization is commended for its process to include patient safety and quality of care in its resource allocation decision making. It is evident at all levels that quality and safe patient care are priority criteria for decision making.

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 an innovative team that seeks new opportunities to support worklife at NGH. The team is commended for its flexible approach to recruitment that has been extended to physicians and volunteers.

NGH supports learners for all levels of needs. This includes a wealth of placement students from all disciplines and staff who have access to education and training to meet their ongoing development needs. Being a learning organization, NGH has seen benefits in its ability to recruit new talent.

Recruitment and retention are a challenge for NGH. However, it is committed to ensuring that its values lead the efforts. This is highlighted by the recruitment process where criteria are used to “hire for attitude.” The performance management approach is also an example of how it uses a just culture to support staff.

NGH values supporting staff wellness and safety. There is a well-defined and effective return to work program. The staff safety initiatives that use peer advocates (e.g., the “got your back” project to address musculoskeletal injuries) are seen as a success throughout the organization.

There are likely more opportunities to support team member wellness. NGH is encouraged to create formal structures to address health and wellness opportunities and include front-line team members.

The organization’s dedication to succession planning and a formal talent management process has created opportunities for new job opportunities at NGH.

Compliance with the performance appraisal policy is inconsistent. The team is encouraged to review the policy and process and consider new ways to document meaningful staff performance engagement with direct reports.

The team is encouraged to assess skill mix across the organization and ensure staff are working to their full scope.

Over the past few years there has been leadership turnover at the manager and director levels and this has created opportunities for novice leaders. The organization is encouraged to ensure that formal and informal leadership development support is provided to these new leaders to support their success.

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	
16.3 The organization's leaders require, monitor, and support service, unit, or program areas to monitor their own process and outcome measures that align with the broader organizational strategic goals and objectives.	!

Surveyor comments on the priority process(es)

NGH is commended for its strong quality improvement culture that is evident throughout the organization, and the commitment of resources for improvement initiatives (e.g., front-line staff time to be involved). Leaders are engaged in leading improvement opportunities and seeking best practices to influence improvement plans.

The organization has a well-documented integrated quality management plan that uses a framework for quality improvement and risk management processes and activities.

The leaders have been thoughtful about prioritizing quality improvement activities and ensuring they are aligned with the strategic priorities. The leaders are strongly encouraged to ensure that front-line team members understand how quality improvement and the strategic priorities are linked. This could be done with consistent use of huddle boards across the organization, as an effective way to recognize staff for their role in helping to meet the strategic priorities.

The organization considers its strategic priority of being a high reliability organization as a written patient safety priority. However, patients, families, and team members are not clear on this connection. The organization is encouraged to seek ways to document more clearly that the high reliability organization priority is the same as a patient safety priority.

The organization has a patient safety incident program. It is encouraged to increase patient and family involvement when the program is reviewed and revised.

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)

NGH has an active and highly engaged interdisciplinary Ethics Committee. Membership includes staff, leadership, an ethicist, PFAC members, and community members.

PFAC was consulted and its changes were considered as the team renewed the ethics framework. The organization has adopted a revised ethics framework and there is ongoing education. An ethicist is available 24 hours a day and the team has built the organization's internal capacity to manage ethical dilemmas.

The team reviews trends and has focused its education sessions on areas identified for improvement. For example, staff indicate that they are aware of the focus on substitute decision making and they find this to be helpful. The organization is encouraged to continue to explore opportunities to share case studies and engage front-line staff and physicians.

The board is aware of the ethics framework and has reviewed case studies. The board is encouraged to use the framework when difficult decisions need to be made.

There is a comprehensive code of conduct that all staff and physicians sign, and a process to manage non-compliance with the code of conduct.

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 is proud of its regular partnership meetings with a wide variety of stakeholder partners. These are valuable venues for shared communication.

NGH is commended for the recently developed integrated communication plan between NGH and West Haldimand General Hospital. It is encouraged to share the plan broadly, including with patients and families.

The organization uses a hybrid paper and electronic clinical documentation system. It is encouraged to continue to assess and plan to advance the electronic medical record.

The organization has developed a comprehensive patient and family guide that provides information to patients and families when they are admitted to hospital.

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)

All the standards are met. The biggest challenge is maintaining adequate humidity and temperature throughout the facility. The current system has been modified to operate most efficiently.

The air handler has been changed and three new boilers are being installed. The generators are new and can meet 100 percent of the facility requirements.

The facility team is actively involved in environmental initiatives and has received awards for its efforts.

Staff who have completed the safety certification course conduct monthly workplace inspections, to keep the workplace environment safe.

Several areas of the building still have asbestos. These areas are routinely monitored for safety and corrective asbestos abatement has been instituted.

The facility has not yet completed a comprehensive energy audit. It is encouraged to do so to achieve the financial savings.

Many repairs and updates are ongoing with HERD funding.

Although the entrances to the hospital are wheelchair accessible, there do not appear to be many accessible washrooms. The organization is encouraged to make more of its washrooms accessible.

Priority Process: Emergency Preparedness

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
14.8 An emergency communication plan is developed and implemented.	

Surveyor comments on the priority process(es)

NGH is commended for its review and revision of its emergency responses, including its pandemic plan. It has a well-defined incident management structure (IMS). The organization is encouraged to develop an emergency communication plan and include it in the IMS. In addition, it is encouraged to consider highlighting business continuity in each of the emergency response codes.

The organization is encouraged to develop a regular schedule for mock codes. There have been mock exercises at its off-site location and long-term care facility over the last two years and the debriefing highlighted emergency preparedness strengths and opportunities for learning.

The emergency preparedness oversight team (leadership) is encouraged to seek input from patients and families on the exercises that are held.

Priority Process: People-Centred Care

Working with clients and their families to plan and provide care that is respectful, compassionate, culturally safe, and competent, and to see that this care is continuously improved upon.

Unmet Criteria		High Priority Criteria
Standards Set: Critical Care Services		
17.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Inpatient Services		
16.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Long-Term Care Services		
17.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from residents and families.	!
Standards Set: Obstetrics Services		
18.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Perioperative Services and Invasive Procedures		
25.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!

Surveyor comments on the priority process(es)

NGH clearly identifies the importance of enhancing patient experience in its strategic plan. Many clinical teams have started to collaborate formally with patient and family representatives in their care teams. This work is in the early stages and the organization is strongly encouraged to continue on this path.

The organization had good engagement with the community, patients, and families when developing the strategic plan in 2018. It is encouraged to continue with regular engagement and collaboration with patients and families. Specifically, it is encouraged to consider opportunities for patient and family engagement earlier in the planning and service design process. The PFAC is having challenges with its

membership, structure, and understanding of roles and responsibilities. It would be advantageous for the organization to put additional focus on revitalizing the PFAC.

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)

A comprehensive patient flow policy has been developed. Staff meet daily to review the discharges and the number of available beds. Policies have been developed to have beds available to repatriate patients and admit surgical patients. There are areas in the hospital to which patients can be moved if necessary. The hospital is consistently recognized as a champion in repatriating patients. As a result, partners are open to accepting patients for care that is not available locally.

In collaboration with emergency medical services, the transport of high-risk patients not suitable for care locally has been established.

Because of a concise and comprehensive policy that is regularly reviewed and modified, patient flow does not appear to be an ongoing problem. There is no hallway medicine.

Priority Process: Medical Devices and Equipment

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

Unmet Criteria		High Priority Criteria
Standards Set: Reprocessing of Reusable Medical Devices		
8.1	The reprocessing area is equipped with hand hygiene facilities at entrances to and exits from the reprocessing areas, including personnel support areas.	!
8.2	The reprocessing area's designated hand-washing sinks are equipped with faucets supplied with foot-, wrist-, or knee-operated handles, electric eye controls, automated soap dispenser and single-use towels.	
15.1	There is a quality improvement program for reprocessing services that integrates the principles of quality control, risk management, and ongoing improvements.	
15.3	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities with input from stakeholders.	
15.4	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives with input from stakeholders.	!
15.5	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from stakeholders.	
15.6	Quality improvement activities are designed and tested to meet objectives.	!
15.8	There is a process to regularly collect indicator data and track progress.	
15.9	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
15.10	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
15.11	Information about quality improvement activities, results, and learnings is shared with stakeholders, teams, organization leaders, and other organizations, as appropriate.	

15.12	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from stakeholders.	

Surveyor comments on the priority process(es)

Biomedical services are provided under contract by staff from Hamilton Health Sciences who are on-site three days per week and who are always available in an emergency. The staff actively participate in the process of evaluating new equipment and giving their opinions and insights on products. Because of their association with an academic centre a large inventory of replacement parts is available if the parts are not available locally.

The endoscopy suite is located in a separate area, removed from the OR, where scopes are processed. Clean and dirty areas are located in the same room but on opposite sides.

All staff working in the reprocessing department have their CSAO certificate that is valid for five years, when it needs to be renewed with an ongoing evaluation process. All documentation is done manually in the medical devices reprocessing and stored in binders. It is suggested that the organization consider developing a computerized system where all the information could be documented and stored. Quality improvement projects could then be developed by reviewing the stored data.

Areas for improvement:

• Have hand hygiene dispensers readily available upon exit from the medical devices reprocessing department.

• Ensure better separation of the contaminated and clean areas in endoscopy and the OR to prevent cross-contamination of equipment.

• Have more disposable anaesthetic supplies (e.g., masks, circuits, laryngeal masks) available, to decrease some of the workload and required documentation by the medical devices reprocessing staff.

• Install hands-free faucets.

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:

Point-of-care Testing Services

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

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

Transfusion Services

- Transfusion Services

Standards Set: Biomedical Laboratory Services - Direct Service Provision

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

Surveyor comments on the priority process(es)
Priority Process: Episode of Care
Priority Process: Diagnostic Services: Laboratory
The laboratory is well organized, bright, and clean. There are good processes in place. The team continually looks for ways to improve processes. The team's greatest challenge is recruitment, and it is working on a plan to increase student interest in a career in laboratory services. The team works well together and is committed to providing good laboratory services. The clinical teams find that the laboratory is very responsive.

Standards Set: Critical Care 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.	
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 critical care unit is rated as a level 2 advanced unit. The unit is able to care for most critically ill patients who require ventilation. The unit operates on a hybrid model. It is not a closed unit.

Several internists and anaesthesiologists are involved in the care of the patients. A cardiologist who is able to insert temporary pacemakers is also available to provide care.

Strong alliances have been formed with infection prevention and control and community partners to provide care to patients once they are discharged.

A framework is in place to provide outreach critical care within the organization. It is called the critical care response team and is staffed by an intensive care unit nurse, a respiratory therapist, and an internist. Patients are seen and evaluated as to whether they can be managed on the floor or whether they need to be admitted to the intensive care unit. Trigger criteria have been developed to initiate patient assessment by the critical care response team.

A surge capacity plan is in place. There are several beds in the unit that are not routinely used and can be used as required. Strong alliances have been formed with external partners to transfer patients for care if no intensive care space is available.

Priority Process: Competency

Staff who are hired to work in the critical care unit are expected to have the critical care course. If they do not have the course, they are expected to obtain the required education and training. Also, all staff are expected to have advanced cardiovascular life support, paediatric advanced life support, and trauma certification.

Paediatric cases are usually referred to external partners. Staffing is usually on a two-to-one basis with one nurse staffing a patient if the patient is being ventilated. The area usually has three nurses during the day and three during the night. The area was renovated several years ago, and most of the equipment and monitoring equipment are up to date.

Priority Process: Episode of Care

Families are strongly encouraged to participate in the care of the patient. If approved by the patient, families are constantly informed as to the patient's progress and the goals for care. If the organization cannot meet the patient's needs, alternative arrangements can be made.

All staff have received training in identifying ethical instances and the route to follow to obtain a fair resolution of the problem.

Support is provided to families during transition and following the death of a patient.

Because of the location of the intensive care unit, critically ill patients need to be transferred with monitoring to the x-ray department to undergo a CT scan. Patients are transferred to another facility for bone scans or nuclear medicine tests.

Quality improvement initiatives relevant to the department have been developed and extensive data have been obtained to improve and manage safe patient care.

Priority Process: Decision Support

Standard information is obtained by the intake staff. Nursing assessments are done electronically. Physician assessments are done manually, with some available electronically. A Dragon dictation system is available for physicians so they can immediately dictate their assessment which is available electronically on the chart.

Patients presenting to the emergency department are asked whether they would like access to MyChart. Information is provided as to how patients can access their chart and any investigational results.

In collaboration with the IT department, various safety measures have been implemented to protect the information that is electronically gathered.

The staff work as a team to help each other out with patient care when required.

Priority Process: Impact on Outcomes

The team has developed standardized order sets for use in the intensive care unit. Many best practice order sets have been obtained from a reference library. These have been reviewed by the local staff, with alterations made and eventually approved by the Medical Advisory Committee (MAC) and put into practice. This allows a standardized approach to care.

Patients are assigned to different most responsible providers who provide care. This causes rounding to occur at different times during the day and significantly impairs the ability to have a true interdisciplinary round on a daily basis. On weekends, patients usually are cared for by the on-call physician for the intensive care unit.

It is strongly suggested that some type of hybrid coverage be developed to improve the care and rounding of patients and to provide nurses with one individual to readily contact about concerns that may arise.

Priority Process: Organ and Tissue Donation

Policies and procedures have been developed for organ and tissue donation. The unit actively participates in finding patients who may meet the criteria to be potential donors. Clinical triggers have been established to identify these potential tissue and organ donors. Once the triggers have been activated the Trillium coordinator is contacted. This individual speaks to the family, obtains consent, and proceeds with the required process.

The hospital's physicians do not feel comfortable determining neurological death. Cases have occurred were patients were transferred to tertiary centres so assessment could occur and organs could be harvested.

On occasion the transplant team has brought their own staff and procured the organs on-site.

Standards Set: Diagnostic Imaging Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Diagnostic Services: Imaging		
15.2	The team has a safety manual adapted for diagnostic imaging services.	!
15.6	Universal fall precautions, applicable to the setting, are identified and implemented to ensure a safe environment that prevents falls and reduces the risk of injuries from falling.	!
17.1	The team collects information and feedback from clients, families, staff, service providers, organization leaders, and other organizations about the quality of its services to guide its quality improvement initiatives.	
Surveyor comments on the priority process(es)		
Priority Process: Diagnostic Services: Imaging		

The diagnostic imaging team is highly engaged and committed to quality improvement and safety in the department.

The team is commended for its successful CT replacement that included excellent project management discipline, including comprehensive risk assessment in the planning.

Policy and procedures are being reviewed and updated. The diagnostic imaging team is encouraged to continue to work toward the Institute for Quality Management in Healthcare evaluation as this will support policy review and development.

Over the past year the team and leadership assessed the use of after-hours modalities. As a result, improvements were made to on-call hours and criteria for after-hours services, which had a positive impact on improving efficiency and worklife balance.

In addition, a diagnostic imaging operational review was conducted and the team is looking at improvement opportunities arising from this assessment. The team is encouraged to align its annual goals and objectives with the strategic plan and ensure that staff understand that alignment.

There is no safety manual specific to diagnostic imaging, but there is a variety of information on safety throughout the department. The Institute for Quality Management in Healthcare work will help greatly in developing a safety manual and ensuring there are consistent policies, procedures, and guidelines for all areas.

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 emergency department is fortunate to have a PFAC member who attends all meetings in the department. This person has been valuable in providing a patient's perspective regarding care and other aspects of the department.

A decontamination room is ready to use as necessary. The emergency department has not participated in any disaster mocks for some time, although it has completed a tabletop code orange scenario.

The department is well equipped to provide the level of service that the community expects from the emergency department. Both paediatric and adult patients are well cared for.

Patients presenting to the emergency department are provided with information about available community services and how to access them.

Priority Process: Competency

Team members working in the emergency department are required to have certain qualifications, including a nursing degree, CPR training, advanced cardiovascular life support, paediatric advanced life support, and completion of a trauma course. Also, the organization strongly suggests that staff in the department have a critical care certificate or an emergency department certificate, and encourages them to obtain these qualifications within a certain period of time.

Three staff work the day shift and three work the night shift. There is also an overlap of one staff member from 1 p.m. to 9 p.m. daily. The staffing model has been reviewed and appears to be adequate.

There is a comprehensive orientation for new team members in the emergency department. The overall hospital orientation includes ethical decision-making, infusion pump safety, and information technology.

There is education and training on occupational health and safety regulations and organizational policies. Importantly, education and training are provided on how to identify, reduce, and manage risk to patients and staff.

A process is in place on how to report and follow through on concerns about workplace violence.

Staff are familiar with certain ethical dilemmas that may occur in the emergency department. Individuals to contact for further advice and management of the situation are clearly laid out.

Priority Process: Episode of Care

All patients presenting to the emergency department are initially assessed by the triage nurse. A Canadian Triage and Acuity Scale score is assigned to each patient and appropriate initial care and placement occurs. Those with higher acuity scores are brought in immediately for assessment and treatment. Those with lower acuity scores are asked to wait in the waiting area where they are instructed to let the staff know if there is any worsening in their condition. Both paediatric and adult patients are similarly assessed. Staff performing this initial assessment receive additional training.

Information is provided to the patient and accompanying family members as to what type of care and further patient investigation is required. The emergency department, in cooperation with the Local Health Integration Network, has established a program to try to avoid unnecessary admissions by using community partners to manage patients. A program has been developed where patients being discharged from the emergency department or from the inpatient units are contacted three days after discharge to see if they are following the instructions provided. The department will assess whether this reduces the number of repeat visits. Mental health and addiction resources are available in the community to manage these difficult patients.

All patients who are admitted undergo a standardized nursing evaluation. Medication reconciliation occurs on initial evaluation of the patient and is performed by the nurse, the physician, or both.

Standardized order sets have been developed for common conditions that are most frequently seen in the emergency department. This has standardized treatment and contributed to best care and outcomes for patients.

Staff have received training on how to identify and manage end-of-life patients. For those requiring admission, a standardized order set has been developed for these patients. They can be admitted to the palliative care ward.

Priority Process: Decision Support

All nursing documentation is done electronically, while physician documentation is mixed. Some physicians choose to write out the patient history while others dictate their findings via the Dragon dictation system. This information is then generated electronically and is available for all to read. Nurses receive training in electronic documentation during orientation. The majority of orders are done electronically; however, there are locums covering some shifts who do not have total electronic data access and therefore their orders are usually paper generated.

Patients are able to access their chart electronically. During arrival and registration, they are asked if they would like to access MyChart to obtain their information. If they initially express no interest but later request this service, they can arrange it through medical records.

In collaboration with the IT department, several monitoring and safety features have been implemented to maintain privacy and security.

Priority Process: Impact on Outcomes

The emergency department is very active in developing quality improvement plans and monitoring and making changes based on the data collected. Certain indicator data have been agreed upon to be monitored and closely followed on a quarterly basis. Data on wait time for services, length of stay, the number of patients who leave without being seen, and times to admission are tracked.

Guidelines and protocols are regularly reviewed. Order sets are developed by the physicians and are approved at the MAC.

Risks to staff are identified and minimized when possible. There are no security staff in the hospital; it has to rely on the availability of the local police for help when a violent patient presents. It is suggested that leadership reconsider this to provide a safe working environment in light of increases in the number of violent patients.

Priority Process: Organ and Tissue Donation

All standards in this area are met.

Refer to critical care, organ and tissue donation section for comments.

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 organization has an active and committed Infection Prevention and Control Committee that meets quarterly and is chaired by the pathologist. Many of the members have completed additional courses to have their designation as infection control practitioners (ICPs). The practitioners ensure that the environment is safe for staff, patients, and visitors.

Hand-hygiene audits are performed regularly and the results are posted. The staff had to deal with a recent respiratory syncytial virus outbreak on one of the inpatient units and was therefore able to test its preparedness in managing such an outbreak.

Several quality improvement plan projects have been initiated and the frequency of catheter urinary tract infections has decreased.

The organization encourages all staff to get the flu vaccine.

There is no on-site microbiology laboratory. Specimens are sent out to public health or to Brantford.

When an outbreak or infection is identified, the ICP initiates the protocol and all stakeholders are informed. The ICP also declares when the outbreak has ended.

Standards Set: Inpatient Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.5	Service-specific goals and objectives are developed, with input from clients and families.	
2.4	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.	
2.8	A universally-accessible environment is created with input from clients and families.	
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
9.2	A comprehensive geriatric needs assessment is completed, when appropriate, in partnership with the client and family.	!
9.3	The inpatient services team works with the emergency department team to initiate the geriatric needs assessment, where appropriate, for clients who enter into the organization through the emergency department.	!
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
16.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

The clinical leaders are very engaged and knowledgeable. They are committed to improving patient safety and care.

The organization works with the community to collect information about the community and determine services required. The population is aging and the team is encouraged to work with patients and families to develop a plan to improve accessibility. For example, there are no wheelchair accessible washrooms.

The General Practice Committee, which is a subcommittee of the MAC, discusses clinical practice. PFAC members are included in these discussions and this is viewed positively.

Skill mix level is discussed at the clinical team level but not with patients and families. Job design and roles and responsibilities and assignments are not discussed with patients. The team is encouraged to involve PFAC in these discussions.

While there are some goals for the units, there is variation in the level of staff involvement in the development and monitoring of the goals and objectives. The team is encouraged to engage all staff and involve patients and families in the development of unit goals and objectives aligned with the strategic plan.

Priority Process: Competency

Comprehensive skills and patient safety annual education sessions are held and staff find these very informative and useful in their practice.

Staff generally feel safe at work. There is no formal security on-site except in situations where they are required for specific patients. The organization is encouraged to complete a staff safety audit to identify and address areas of concern.

Priority Process: Episode of Care

Patients and families describe the team as caring, compassionate, and focused on providing the best care possible. Patients feel that the nurses are very busy and are working short at times; however, they indicate that the staff are responsive to their needs.

There is a process for patients and families to bring forward a complaint, but it is not well known or documented. The organization is encouraged to develop clear information packages about how to voice a complaint or offer a compliment.

Most patients are seniors. Specific geriatric assessments are not available, but staff complete a thorough admission assessment for each patient. As the population continues to age, the team is encouraged to consider specific geriatric assessment expertise and protocols.

There is a process to access translation services through a staff list at the switchboard. As the community becomes more diverse, the team is encouraged to use translation services alternatives.

Change of shift and bedside transfer of accountability is done, with a goal to complete it at the bedside. Nursing identified that since all the rooms are ward rooms privacy is an issue. The team is encouraged to explore how bedside transfer of accountability could be completed while maintaining confidentiality.

Regular interdisciplinary rounds are held where discharge planning is discussed. The outcomes of the

discussion are shared with the rest of the team verbally. The team is encouraged to document the discharge care plan in the chart so all staff are knowledgeable about the plan. Patients are informed about the discharge plan after the meeting. The team is encouraged to develop a formal process to include patients in the development of the discharge plan.

There are good patient pamphlets such as the patient handbook, Patient and Visitor Safety at NGH, and falls prevention.

Priority Process: Decision Support

There is a comprehensive interdisciplinary health record.

Priority Process: Impact on Outcomes

The clinical educator is energetic and committed to evidence-based practice and ongoing education. Recently, the organization invested in a service that provides a clinical skills and education platform. Each year a skills fair focused on new skills and a safety fair focused on patient safety (e.g., hand hygiene, pump training) are provided.

Policies and procedures are updated based on evidence and patients and families provide input.

Indicators include hand-hygiene rates, falls, and readmission for chronic obstructive pulmonary disease and heart failure. The team is encouraged to involve staff, patients, and families in identifying and monitoring indicators and determining their role in making improvements.

Standards Set: Long-Term Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.3	Service-specific goals and objectives are developed, with input from residents and families.	
2.3	An appropriate mix of skill level and experience within the team is determined, with input from residents and families.	
2.8	A universally-accessible environment is created with input from residents and families.	
Priority Process: Competency		
3.1	Required training and education are defined for all team members with input from residents and families.	!
3.14	Education and training are provided on how to identify palliative and end-of-life care needs.	!
3.16	Resident and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
Priority Process: Episode of Care		
10.3	A pleasant dining experience is facilitated for each resident.	
Priority Process: Decision Support		

The organization has met all criteria for this priority process.

Priority Process: Impact on Outcomes		
17.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from residents and families.	
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

The team tracks indicators. However, no specific departmental service goals and objectives are developed with input from staff or patients and families.

The team has recently created a Complex Continuing Care Committee that includes a member of the PFAC. This committee will provide an opportunity for the team to develop and monitor goals and

objectives and quality and patient safety indicators.

The team is encouraged to develop a process to align the unit goals with the strategic plan and patient input. PFAC members have provided input into initiatives such as signage and decorations in palliative care to make it more homelike.

Patients and families are not involved in discussions about skill mix or roles and responsibilities. The team is encouraged to explore mechanisms to broaden patient and family feedback.

Priority Process: Competency

The team has access to specialized geriatric services through phone and Ontario Telemedicine Network consultation. Gentle persuasive approach and non-violent crisis management training are available. Behavioural Supports Ontario consultations are also available to help manage responsive behaviours. The team indicates that they feel safe at work and that they are encouraged to report any incidents of harm.

There has been an increase in the age of patients and behaviours associated with dementia and mental health. The team is encouraged to provide ongoing education related to specialized geriatrics. In addition, the team is planning to address the need for formal palliative care training.

Not all staff work to their full scope of practice. The team is encouraged to review the scope of practice for all staff and make changes as appropriate. The orientation for personal support workers was recently enhanced.

Priority Process: Episode of Care

The interdisciplinary complex continuing care team is passionate about improving the lives of the patients. The organization has implemented a hospitalist model that has been successful. The hospitalists work closely with the team to meet the needs of the patients.

A process to lodge complaints or offer compliments is outlined in the patient handbook; however, it is not clear to patients and families. The organization is encouraged to consult with patients and families about how to make the complaint process more transparent. While there is a separate pamphlet that outlines the process, staff and patients are not aware of it.

The hospitalist assesses patients' mental status, including for depression and suicide. The nursing care plan to manage depression is not documented and the team is encouraged to document the plan in the nursing care plan. The hospitalists work to reduce the use of antipsychotics as appropriate.

Physiotherapy and activation are provided. There is limited reactivation for the slow stream rehabilitation and alternate level of care patients. It was noted during the on-site survey that several alternate level of care and transition patients were in bed or a chair with their pajamas on. As part of the patients' rehabilitation and to help reduce the incidence of pressure ulcers, the team is encouraged to determine

how patients could be dressed and out of bed more often. Staff note that a shortage of positioning chairs makes it more difficult to get patients up.

During the on-site survey, patients were not encouraged to come to the dining room for meals. The organization is encouraged to consider how this could be part of the rehabilitation/activation plan.

Belt or chair restraints are often used. The team is encouraged to consider alternatives to restraints, including more activation and opportunities to wander safely.

There are several recreational activities and a monthly calendar with daily activities is posted. There are several one-on-one activities and programs supported by volunteers such as the Nuts and Bolts program. The team is encouraged to explore and support activities that are focused on managing delirium and dementia.

An interdisciplinary team meets on a regular basis to discuss discharge plans. The social worker discusses the plans with the patients and families. Families find the whiteboards in the rooms helpful. The team is encouraged to individualize the information and at the same time respect patient privacy.

A few safety issues identified during the on-site survey include an open door to the supply area that has potentially hazardous solutions. Since there are confused patients wandering the unit, the team needs to ensure that the door is closed at all times. Also, apple sauce is used to mix crushed medication and the container is used for several doses and left on the counter, which creates a potential infection control issue. The team is encouraged to implement an alternative to this practice.

Patients indicate that the physicians and staff are very caring. They are pleased with the food and some of the activities that are offered.

The team is committed and dedicated to providing the best care possible.

Priority Process: Decision Support

There is a comprehensive and complete health record. Staff are aware of the ethics framework.

Priority Process: Impact on Outcomes

Each year a skills fair focused on new skills and a safety fair focused on patient safety, such as hand hygiene and pump training, are provided.

Policies and procedures are updated based on evidence and patients and families provide input.

Indicators are developed to align with being a high reliability organization, including hand-hygiene rates and falls. The quality board is well organized. Team members are encouraged to review the board and discuss their role in making improvements, and to consider a process to include patient and family feedback.

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

The medication management team is interdisciplinary and high functioning. The new pharmacy leader is making positive changes. Nursing and pharmacy work closely together to improve patient safety and they have made significant progress in improving medication management processes.

The Pharmacy and Therapeutics Committee reviews annual audits of Required Organizational Practices related to medication safety. The use of dangerous abbreviations remains an issue and this will be reviewed at MAC. It is suggested that the team explore alternatives to manage those who continue to use dangerous abbreviations.

The team takes a proactive approach to identify medications that may become or are in short supply. This is viewed positively.

A new clinical interdisciplinary practice team has been formed to support staff with education and implementation of evidence-based practice.

The pharmacy area is well organized, but very small and congested. The organization is encouraged to explore how to expand the pharmacy department to meet increased demand. There is an area in the pharmacy that includes a medication and a staff refreshment area. The team is encouraged to ensure there is a barrier between these two distinct purposes.

In complex continuing care, the print and the area to sign off on the 30-day medication administration record (MAR) are very small. The team is encouraged to explore options to make the MAR more readable.

High-alert medications are labelled on the storage containers in the pharmacy and the computers on the dispensing carts on the units identify a medication as high alert. However, medication packaging on the units is not identified as high alert. The team is encouraged to explore opportunities to increase awareness of high-alert medications.

The team indicates that there is outdated technology that is not integrated. For example, the organization uses SMART pumps but these are at capacity and no additional parameters can be added. The team is

looking to replace these in the near future.

Two patient identifiers are used for medication administration. However, in some areas there is variability in taking the MAR or label to the bedside to compare the two identifiers. The team is encouraged to conduct observation audits to ensure all staff are consistently applying good practices.

Some staff are not aware of when to complete an incident report. For example, staff indicate that an incident report is not needed if a medication is missed. The team is encouraged to report all incidents and near misses.

The team's patient safety improvements are well underway and contributing to NGH being a high reliability organization.

Standards Set: Obstetrics Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.3	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.	
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		
17.1	A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families.	!
17.2	Strategies are developed and implemented to address identified safety risks, with input from clients and families.	!
17.4	Safety improvement strategies are evaluated with input from clients and families.	!
18.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		
Priority Process: Competency		

There is a comprehensive orientation program and staff are mentored. Standard education requirements and competencies are required, including maternal/newborn, neonatal resuscitation program, fetal surveillance, and breastfeeding.

There is a collaborative approach to providing care and there are plans to enhance the team's

interpersonal relationships and collaboration.

General position profiles with defined roles and responsibilities are available. Specialty competencies are only outlined in job postings and the team is encouraged to modify the position profiles to highlight the required specialty competencies.

The team recently joined the Maternal Newborn Child Youth Network that provides access to educational programs and this is viewed positively.

Priority Process: Episode of Care

The team is very caring and compassionate in its care. Patients are partners in care and their learning needs are individualized. Patient information that is collected is comprehensive and easy to follow. Transfer of accountability is well done both in written and verbal form.

There is good access to epidural services. The team is also exploring the feasibility of pain management alternatives such as nitrous oxide and water therapy.

For C-sections, the team works closely with the OR staff to ensure integrated care is delivered. A registered respiratory therapist is available. The team is pleased with the plan to add hours to this position. Prior to and during the C-section that was observed, all staff and physicians showed compassion for and provided reassurance to the patient and family.

The team works with patients and families on initiatives to improve the environment. For example, in response to patient feedback the obstetrical beds are now located closer to the birthing area.

Priority Process: Decision Support

Most policies and procedures have been updated, with a few that still require renewal. An OBS Committee that includes a patient has been formed to obtain patient input into policies and procedures.

Priority Process: Impact on Outcomes

The team is at the beginning stages of developing a robust quality improvement program that includes patient and family input. BORN Ontario indicators are reviewed.

The team is encouraged to focus on a few indicators and develop action plans to achieve them, and to continue to involve patients and families.

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

The surgical program provides mainly outpatient services. It is heavily committed to providing laparoscopic services as required.

The ORs operate daily. Services provided are general surgery, gynaecological surgery, and ophthalmology. C-sections are also performed in the main operating room.

Services are provided 24/7 and staff are on call once the day's elective procedures are completed. On occasion staff stay beyond this time to complete urgent procedures.

Priority Process: Competency

All staff working in the OR are expected to have OR certification. Currently, all the staff are registered nurses. Because of difficulty in recruiting registered nursing staff, leadership is looking at hiring registered

practical nursing staff.

The Perioperative Committee meets monthly. Any concerns that have arisen in the interim are discussed.

Staff are encouraged to participate in ongoing education and training. They are expected to attend the annual skills fair and those who are unable to attend are required to complete a computer-based education program. Staff meet monthly to review new procedures or equipment.

Priority Process: Episode of Care

The booking system operates with each surgeon receiving block time to do their cases. Requests are submitted to the OR booking clerk who then manually enters the patient's name and creates an OR list. This is a very time-consuming and inefficient system for booking and use of OR time. It is strongly suggested that leadership consider obtaining a computerized OR booking system such as Novari. This allows the surgeon's secretary to book cases and create an OR list. Changes to the list can usually be made up to 72 hours before the list is generated, improving efficiency and allowing the surgeon to modify the list and insert urgent cases as needed. Time given back can then be readily identified and picked up by individuals who require more time. The program also generates the average time for a given procedure based on the average time of the last 10 procedures performed by the surgeon.

Patients are provided with information as to what to expect postoperatively and how to manage it when they present for surgery.

The area where surgical procedures are performed is very small and cramped. There is equipment in the hallways that may impede transport if an acute emergency arises. The facility is heavily committed to performing laparoscopic procedures and it is suggested that leadership consider possibly making three larger rooms instead of having four. Also, with the renovation of the obstetrical area, it is suggested that consideration be given to designating a space for a new obstetrical OR where C-sections could be performed.

A housekeeper is present during the day to turn over and clean the rooms. During the night and in off hours, this activity is performed by the nursing staff. Instrumentation is cleaned and washed by the OR staff. The OR is waiting for a new washer to be installed and as a result some challenges have been created in cleaning instruments, especially in off hours.

Quality improvement programs have been initiated and are aligned with information to improve care and flow of patients coming through the surgical program. The staff are looking at when the first case starts. There have been some challenges to starting on time and these are slowly being addressed.

Anaesthetic masts, tubing, and laryngeal masks are reprocessed in medical device reprocessing. It is suggested, in view of unknown respiratory disorders, that only disposable products be used.

Priority Process: Decision Support

Most documentation is done electronically. Consent is available in hard copy.

All patients presenting for surgery are initially seen in the pre-op clinic. An algorithm is used to determine required testing and investigations are performed so they are available on the day of surgery. Required consultations or assessments are also done. When the patient arrives in the outpatient clinic on the day of surgery, it appears that all the information obtained during the pre-op assessment is repeated, thus duplicating the assessment. To improve efficiency, it is suggested that the nurse rapidly review the pre-op assessment and ask the patient if anything new has occurred since they were last seen. Vital signs could be obtained at that time and the patient prepared for surgery. The patient who was spoken with felt that the duplication was unnecessary and cumbersome.

Information is electronically documented and available for all to review.

When patients present to the OR, antibiotics are started if appropriate and they are again reviewed by one of the OR nurses.

Priority Process: Impact on Outcomes

Standardized order sets are available for the postoperative care of patients. Information pamphlets are also available for patients to review, for the specific procedure that they have undergone.

Safety is a top priority in the surgical program to protect staff and patients. All staff have undergone training as to how to manage and de-escalate situations to provide a safe working environment.

Priority Process: Medication Management

Medication provided to the anaesthesiologist is dispensed by the charge nurse. The physician then documents the medication that was used and for which patient. Medication in the post-anaesthesia care unit is also obtained from a locked cupboard.

As in other areas of the hospital, a medication select unit is not yet available. It is strongly suggested that leadership install such a unit in the OR area. This would allow pharmacy to know who is accessing the medications and who is administering them. This would also improve safety and storage.

All areas where anaesthesia is administered have standardized medication carts. Medications used are replaced by the nurses at the end of the day. It is suggested that trays be obtained and restocked by pharmacy on a daily basis. The refreshed trays could be then changed by the nursing staff.

Nurses are involved in transfer and movement of patients from the OR table to the stretchers. To avoid potential injury to nursing staff, leadership could consider creating a dual role where an individual would be involved in cleaning the room after a procedure and also help to move patients in the OR to the stretcher.

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 lead for point-of-care testing is very skilled and focused on patient safety. There are excellent policies, processes, and procedures in place. Excellent automated monitoring and quality control processes have been implemented. Audit results are excellent.

Nurses on the units follow protocols appropriately.

Standards Set: Transfusion Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Transfusion Services	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)
Priority Process: Episode of Care
Priority Process: Transfusion Services
Transfusion medicine is well organized. The team indicates that the new automated equipment has improved processes and patient safety. The team is knowledgeable. Standard operating procedures are up to date and followed.

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: September 2, 2019 to September 25, 2019**
- **Number of responses: 7**

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	93
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	0	0	100	97
3. Subcommittees need better defined roles and responsibilities.	86	0	14	66
4. As a governing body, we do not become directly involved in management issues.	0	0	100	85
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	93

	% 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	98
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	0	100	95
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.	57	0	43	60
10. The composition of our governing body contributes to strong governance and leadership performance.	0	0	100	93
11. Individual members ask for and listen to one another's ideas and input.	0	0	100	96
12. Our ongoing education and professional development is encouraged.	0	0	100	91
13. Working relationships among individual members are positive.	0	0	100	95
14. We have a process to set bylaws and corporate policies.	0	0	100	92
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	98
16. We benchmark our performance against other similar organizations and/or national standards.	0	0	100	78
17. Contributions of individual members are reviewed regularly.	0	29	71	64
18. As a team, we regularly review how we function together and how our governance processes could be improved.	0	0	100	79
19. There is a process for improving individual effectiveness when non-performance is an issue.	0	14	86	61
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	0	0	100	84

	% 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.	29	29	43	34
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	0	0	100	81
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	14	86	80
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	0	29	71	92
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	0	0	100	86
27. We lack explicit criteria to recruit and select new members.	100	0	0	76
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	0	0	100	90
29. The composition of our governing body allows us to meet stakeholder and community needs.	14	0	86	93
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	94
31. We review our own structure, including size and subcommittee structure.	0	0	100	89
32. We have a process to elect or appoint our chair.	0	0	100	91

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2019 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	29	71	82

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	14	86	84

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2019 and agreed with the instrument items.

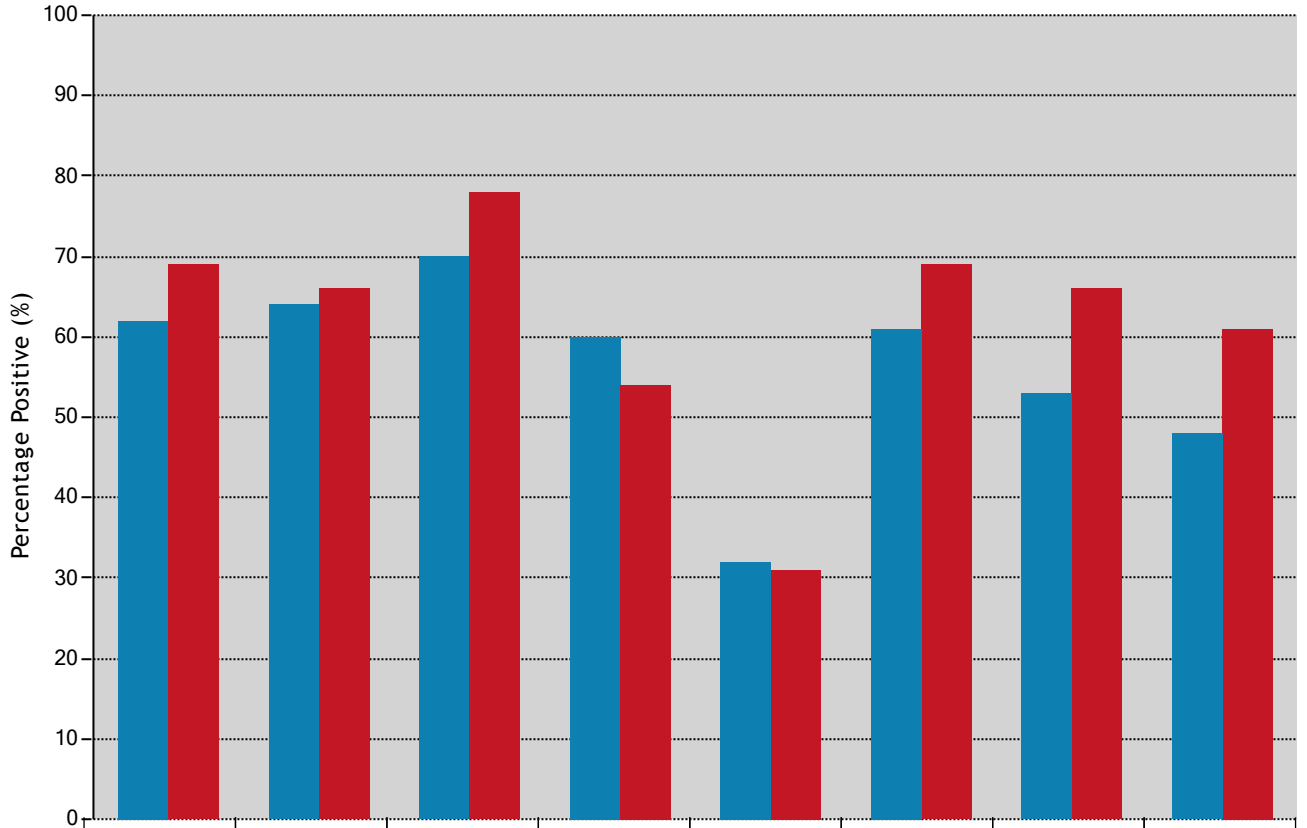
Canadian Patient Safety Culture Survey Tool

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: September 2, 2019 to October 16, 2019**
- **Minimum responses rate (based on the number of eligible employees): 198**
- **Number of responses: 220**

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%	64%	70%	60%	32%	61%	53%	48%
	69%	66%	78%	54%	31%	69%	66%	61%

Legend

Norfolk General Hospital

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2019 and agreed with the instrument items.

Worklife Pulse

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

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

The organization used an approved substitute tool for measuring the quality of worklife.

Client Experience Tool

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

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

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

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

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

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

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

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

Appendix A - Qmentum

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

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

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

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

Action Planning

Following the on-site survey, the organization uses the information in its Accreditation Report and Quality Performance Roadmap to develop action plans to address areas identified as needing improvement.

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