Accreditation Report

Carleton Place & District Memorial Hospital

Carleton Place, ON

On-site survey dates: May 30, 2019 - May 31, 2019

Report issued: June 14, 2019

About the Accreditation Report

Carleton Place & District Memorial 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 May 2019. 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.

© Accreditation Canada, 2019

A Message from Accreditation Canada

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

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

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

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

We look forward to our continued partnership.

Sincerely,

Leslee Thompson
Chief Executive Officer

Table of Contents

Executive Summary 1

Accreditation Decision 1

About the On-site Survey 2

Overview by Quality Dimensions 3

Overview by Standards 4

Overview by Required Organizational Practices 6

Summary of Surveyor Team Observations 10

Detailed On-site Survey Results 13

Priority Process Results for System-wide Standards 14

Priority Process: Governance 14

Priority Process: Planning and Service Design 16

Priority Process: Resource Management 18

Priority Process: Human Capital 19

Priority Process: Integrated Quality Management 20

Priority Process: Principle-based Care and Decision Making 22

Priority Process: Communication 23

Priority Process: Physical Environment 24

Priority Process: Emergency Preparedness 25

Priority Process: People-Centred Care 26

Priority Process: Patient Flow 27

Priority Process: Medical Devices and Equipment 28

Service Excellence Standards Results 30

Standards Set: Diagnostic Imaging Services - Direct Service Provision 31

Standards Set: Emergency Department - Direct Service Provision 33

Standards Set: Infection Prevention and Control Standards - Direct Service Provision 36

Standards Set: Inpatient Services - Direct Service Provision 38

Standards Set: Medication Management Standards - Direct Service Provision 41

Standards Set: Perioperative Services and Invasive Procedures - Direct Service Provision 43

Instrument Results 46

Governance Functioning Tool (2016) 46

Canadian Patient Safety Culture Survey Tool 49

Worklife Pulse 51
Client Experience Tool 52
Appendix A - Qmentum 53
Appendix B - Priority Processes 54

Executive Summary

Carleton Place & District Memorial 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

Carleton Place & District Memorial 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: May 30, 2019 to May 31, 2019**

- **Location**

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

  1. Carleton Place and District Memorial 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. Diagnostic Imaging Services - Service Excellence Standards
  6. Emergency Department - Service Excellence Standards
  7. Inpatient Services - Service Excellence Standards
  8. Perioperative Services and Invasive Procedures - Service Excellence Standards
  9. Reprocessing of Reusable Medical Devices - Service Excellence Standards

- **Instruments**

  The organization administered:

  1. Worklife Pulse
  2. Canadian Patient Safety Culture Survey Tool
  3. Governance Functioning Tool (2016)
  4. Physician Worklife Pulse Tool
  5. 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)	32	0	0	32
Accessibility (Give me timely and equitable services)	44	0	0	44
Safety (Keep me safe)	384	1	9	394
Worklife (Take care of those who take care of me)	90	0	1	91
Client-centred Services (Partner with me and my family in our care)	154	0	0	154
Continuity (Coordinate my care across the continuum)	29	0	0	29
Appropriateness (Do the right thing to achieve the best results)	503	4	4	511
Efficiency (Make the best use of resources)	42	1	0	43
Total	**1278**	**6**	**14**	**1298**

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	50 (100.0%)	0 (0.0%)	0	36 (100.0%)	0 (0.0%)	0	86 (100.0%)	0 (0.0%)	0
Leadership	50 (100.0%)	0 (0.0%)	0	95 (99.0%)	1 (1.0%)	0	145 (99.3%)	1 (0.7%)	0
Infection Prevention and Control Standards	40 (100.0%)	0 (0.0%)	0	31 (100.0%)	0 (0.0%)	0	71 (100.0%)	0 (0.0%)	0
Medication Management Standards	67 (97.1%)	2 (2.9%)	9	63 (100.0%)	0 (0.0%)	1	130 (98.5%)	2 (1.5%)	10
Diagnostic Imaging Services	68 (100.0%)	0 (0.0%)	0	68 (100.0%)	0 (0.0%)	1	136 (100.0%)	0 (0.0%)	1
Emergency Department	72 (100.0%)	0 (0.0%)	0	106 (99.1%)	1 (0.9%)	0	178 (99.4%)	1 (0.6%)	0
Inpatient Services	60 (100.0%)	0 (0.0%)	0	85 (100.0%)	0 (0.0%)	0	145 (100.0%)	0 (0.0%)	0
Perioperative Services and Invasive Procedures	115 (100.0%)	0 (0.0%)	0	109 (100.0%)	0 (0.0%)	0	224 (100.0%)	0 (0.0%)	0

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Reprocessing of Reusable Medical Devices	84 (98.8%)	1 (1.2%)	3	39 (97.5%)	1 (2.5%)	0	123 (98.4%)	2 (1.6%)	3
Total	**606 (99.5%)**	3 (0.5%)	12	632 (99.5%)	3 (0.5%)	2	1238 (99.5%)	6 (0.5%)	14

* Does not includes ROP (Required Organizational Practices)

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 (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
Client Identification (Perioperative Services and Invasive Procedures)	Met	1 of 1	0 of 0
Information transfer at care transitions (Emergency Department)	Met	4 of 4	1 of 1

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

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

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

In 2016, Almonte General Hospital (AGH) and Carleton Place & District Memorial Hospital (CPDMH) created the Mississippi River Health Alliance to provide their communities with the best possible care closer to home. The two organizations have a strong history of partnership and collaboration and together they are working to identify opportunities to achieve their goal of exceptional care.

The Mississippi River Health Alliance maintains two separate boards of directors; however, a joint committee called the Alliance Committee has several specific purposes identified in its terms of reference. The two hospitals have shared a president and chief executive officer since the fall of 2016. All of the vice presidents and several other leadership positions have similar integrated responsibilities.

Each board provides strategic direction and oversight for its local hospital. The Champlain Local Health Integration Network has supported this partnership from its inception. Prior to the formation of the official Alliance, there were several examples of collaborative planning and programming such as developing a joint pharmacy system with shared pharmacy staff and several support functions such as human resources. The two hospitals are commended for their innovative approach to delivering community-based care in a collaborative fashion.

The hospital is fully aware of the role it plays in the health care system and has a focus on providing inpatient and outpatient care that is closer to home. There are partnerships to meet the needs of patients and families when they require specialized services. The emergency department (ED) has a good reputation in the community and beyond for very good wait times.

CPDMH should be very proud of the health care outcomes it has achieved for its community. Firstly, the hospital prepared well for its accreditation on-site survey, although it routinely focuses on quality and safety improvement regardless of the timing of the survey. Board members are dedicated to ensuring the hospital provides the best possible care to the community. Care closer to home is the mandate and they recognize that strong governance processes are essential for a hospital to deliver outstanding patient care. The board of directors is commended for its vision and courage in enabling the Mississippi River Health Alliance to come to fruition.

The staff, leaders, physicians, and volunteers should be proud of their achievements since the last on-site survey. The teams have invested in making best practices in quality, risk, and safe patient care a priority. The hospital provides emergency care, inpatient medical-surgical care, and same day surgical care. It also supports palliative care in concert with community volunteers who are experts in palliative and end-of-life care as appropriate.

Patient care is an interprofessional team responsibility and staff and physicians place the needs of patients

and families at the centre of what they do. They are values-driven and collaborate with health care partners and other stakeholders to ensure care is provided as close to home as possible. The dedicated medical staff provide a suite of patient care services. The family physicians provide inpatient care and inpatient rounding, second assist surgical support to the perioperative team, management of orphan patients, and ED coverage.

The family physicians are supported by a variety of clinical specialists. Surgeons offer same day surgery and emergency surgery as required. Leadership is always working hard to identify the specialties needed to support the care team. Telehealth services through the Ontario Telemedicine Network reduce travel time for patients and families and make specialist care available closer to home. Mental health resources are identified as a specialty need, although it is recognized that this is a global issue for most health systems. However, the hospital is working to leverage partnerships and community resources to meet these ever-increasing care needs.

The hospital is developing a shared clinical services plan to support its strategic plan. The process was very robust and included collaboration with health care partners, leaders, and stakeholders including patients and families through the Patient and Family Advisory Committee (PFAC). While the plan is in its development phase, the hospital is acknowledged for engaging in this visionary and important work.

It is suggested that the hospital consider placing the purchase of smart infusion pumps on its capital list as a priority.

The hospital works hard to support the PFAC and has learned valuable lessons from the experience of other hospitals that have this type of committee. Education is provided to new PFAC members. In addition, staff, physicians, and volunteers have received training that highlights the important way that PFAC members contribute to quality patient care planning and processes.

The PFAC has had a significant influence on the delivery of patient- and family-centred care at the hospital, in particular during the last two years. Committee members are committed to making a difference to the community by providing important feedback and input into hospital processes and care delivery opportunities. They report that their influence at the hospital is real. They do not feel as though they are simply a “token voice” of patients and families but rather that they have a meaningful role that is making a difference.

PFAC members shared many examples of the work in which they are engaged. A key focus is recruitment of new members. Several ideas were discussed such as meeting with PFAC members from other hospitals and recruiting students who have an interest in a health care profession career coupled with experience with the hospital as a patient or family member.

Patient satisfaction is high. Patients report that patient care is outstanding and the vision for the future is compelling. Staff and physicians include patients and families in assessments and care planning activities. Education is a priority for the interprofessional team. Staff ensure that patients are well prepared to manage their care outside of the hospital and communication with health care partners, while not perfect, is good.

Community partners report that hospital staff live the mission, vision, and values, and are outstanding colleagues and partners for the community. They are responsive to suggestions to consider new approaches or services. Communication is excellent. Staff create a welcoming environment for colleagues and stakeholders. One partner stated that the ED staff are "simply outstanding" and sees them as professional, knowledgeable, compassionate, and dedicated. There is good collaboration and trust with front-line staff and leaders. The CEO is always available and is transparent, genuine, and welcoming to the hospital partners and stakeholders.

Partners note that there is a palpable focus on engaging in a true partnership with patients and families. One reported being asked to provide a paragraph about her organization's services that could be included in the patient and family handbook, while another stated that patients or community residents who require medical care are rarely left without the appropriate supports—they are not allowed to get lost in the system. While there might not be a perfect solution, the staff problem solve to find the most appropriate solution. The family physicians know their patients and the partners believe that this helps keep patients from falling through the cracks. Opportunities for improvement were discussed and their advice is to "keep on keeping on!" Partners encourage the hospital to continue with its collaborative, open, and transparent approach to working with health care system partners; to seek opportunities to develop partnerships in the new Ontario health team strategy; and to advance its electronic documentation system so that all departments and professionals can use electronic documentation. If at all possible, the partners suggest that one electronic system for the two hospitals would be ideal.

Staff satisfaction was assessed during the on-site survey. The leaders have been trained in the Studer leadership model that includes some standardized approaches to rounding with staff, addressing goals that are aligned with the hospital strategic plan to create a cascade effect from the strategic plan to the CEO goals and then to front-line staff. Leaders round regularly with staff and engage in discussions related to several safety and quality topics. The leaders hold staff accountable for these discussions and outcomes. A stoplight methodology provides a visual notification of the safety topics that are identified as issues. Leaders are expected to address these issues and as this happens the stoplights become green. If they cannot address them, an explanation is provided on a red stoplight posters. The leaders report that rounding has had an extremely positive impact on staff engagement. Well done!

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
	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.

The organization has met all criteria for this priority process.
Surveyor comments on the priority process(es)

In 2016, Almonte General Hospital (AGH) and Carleton Place & District Memorial Hospital (CPDMH) created the Mississippi River Health Alliance to provide their communities with the best possible care closer to home. The two organizations have a strong history of partnership and collaboration and together they are working to identify opportunities to achieve their goal of exceptional care.

The board of directors is proud of its accomplishments. Members are fully apprised of their fiduciary responsibilities and hold one another accountable for maintaining oversight of hospital functions without moving into operational activities. They work well with the senior leaders and there is an obvious respect for the roles that each play in providing high-quality care to the communities served.

Each board provides strategic direction and oversight for its local hospital. The Champlain Local Health Integration Network has supported this partnership from its inception. Prior to the formation of the official Alliance, there were several examples of collaborative planning and programming such as developing a joint pharmacy system with shared pharmacy staff and several support functions such as human resources. The two hospitals are commended for their innovative approach to delivering community-based care in a collaborative fashion.

The board of directors is commended for its foresight in developing one consolidated strategic plan for both organizations. The strategic planning process began approximately 18 months ago and involved comprehensive community engagement; health care partner consultation; and opportunities for staff, physician, volunteer, patient, and family feedback. The PFAC also provided important commentary into the strategic planning outcomes to ensure the voices of patients and families were appropriately incorporated into the plan's priorities.

The mission, vision, and values of each hospital were found to still be relevant and were maintained. The key strategic directions for the hospitals include providing outstanding care closer to home; working with health system partners to strengthen communication and collaboration to make accessing care and

support as easy as possible for patients, residents, and families; aligning and activating their people to bring the vision and priorities to life; and maximizing the potential of the Alliance.

Each key strategic direction has goals and strategies to facilitate achievement. Strategic enablers that support achievement of the main strategic directions have been identified. The strategic directions and enablers are translated into indicators and outcomes and leaders' performance is assessed according to the achievement of these measurable results. These indicators continue to be shared with front-line staff to continue the cascade of accountability throughout the entire organization.

Board members use scorecards and quality improvement plans to determine and monitor quality outcomes, and they understand how these relate to the strategic plan. The board provided specific examples of when it has formally used the ethics framework. There are reminders on the agendas to reinforce the importance of making ethical decisions. The board has invited the ethicist to its meetings to discuss case scenarios and to identify potential clinical and non-clinical ethical decisions.

Board policies and procedures are regularly reviewed and updated every two years as are the governance by-laws.

Board members have learned a great deal about how to incorporate feedback from patients and families through several initiatives. The PFAC has had a significant influence and provides feedback into a variety of patient care processes and decision-making opportunities. The board hears about positive and negative stories and experiences at its monthly meetings and these provide valuable learnings. The PFAC chair sits on the Quality Committee of the board.

Each board committee has an annual workplan to ensure outcomes are achieved. Board member education occurs at most meetings. Orientation of new members is comprehensive.

The board chair and CEO are evaluated annually. Each board member completes a self-evaluation. Board functioning is assessed at the end of each meeting and improvements are implemented when they are identified. The boards of each hospital have met together on several occasions.

Board policies and by-laws are posted on the hospital website for the public to review. An annual report of hospital outcomes and achievements is also available to the public.

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		
6.5	Formal strategies or processes are used to manage change.	

Surveyor comments on the priority process(es)

The consolidated strategic plan for AGH/Fairview Manor and CPDMH was developed approximately two years ago based on very comprehensive engagement with communities, partners, staff and physicians, volunteers, and patients and families. Key strategic directions and enablers were identified as a result of this very engaging approach. The mission, vision, and values were reviewed and validated as still appropriate and meaningful to the community. The strategic plan guides the organization's workplan with goals and objectives cascading down to individual units. The leaders are encouraged to continue to work with front-line staff to reinforce how the staff's work contributes to the strategic plan's strategic directions and to ensure alignment throughout the organization.

The clinical service plan that is being developed will identify clinical priorities and further strengthen the quality and level of care provided to the communities of Almonte and Carleton Place. The hospitals are commended for their commitment to this important work, particularly in light of the uncertainty in the provincial health care environment. Working together with partners on the clinical service plan illustrates the vision and innovation of the board and senior leaders to bring quality care closer to home for their communities. Good luck with this important work.

The PFAC provides valuable input into decisions that are made at the hospital. Several examples were provided that illustrate the important role the voice of patients and families has in planning, educational activities and documents, and policies and procedures. The involvement of patients and families as partners at the delivery point of care (i.e., at the bedside) could be strengthened. This will take time as the patient- and family-centred approach to care matures. Ongoing education for care providers about how to strengthen patients and families as partners will facilitate this evolution.

Given the size of the hospitals, formal change management processes have not been used to manage change. In anticipation of changes that may be forthcoming, given the changes in the health system landscape, it would be prudent to identify a formal change management strategy.

Most of the significant policies and procedures are regularly reviewed and best practices are incorporated into this process.

An enterprise risk management approach (HIROC risk assessment) is used to identify corporate risks. The top risks have been identified and plans have been developed to address them. The plan is in its early stages and ongoing assessment and review are necessary to ensure the risks are mitigated, eliminated, or reduced. Cybersecurity issues were highlighted with both the board and the planning and service design teams during the on-site survey. They are encouraged to continue to review ongoing risk as these issues can change with time, and to engage physicians to ensure medical issues are incorporated into risk assessment processes.

Priority Process: Resource Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The integrated vice president of finance has had a significant impact on fiscal oversight at both organizations. The finance team and the leaders are commended for their management of resources to provide high-quality patient care. It is not easy to manage the resources of small hospitals given the nature of the provincial funding models.

The hospital is commended for balancing its budget. As an example, staff received education about the cost of supplies and front-line staff were part of identifying strategies to reduce supply costs. Attendance management strategies will be rolled out this June to reduce costs associated with sick time.

Operational budget processes are well defined and occur in alignment with Local Health Integration Network timelines, with approvals occurring at the board level. The capital planning process involves a multi-year approach to identifying equipment needs. Managers are required to identify their units' needs and provide a ranking based on the severity of the need for the equipment. The hospital foundations and auxiliaries provide an amount of funding that they can support for capital purchases. The community is very generous and is commended for supporting the hospital to purchase much-needed equipment so it can continue to provide high-quality care.

The ethical allocation of resources is at the forefront of decisions made at the hospital. There are reminders on the board agendas to reinforce the importance of making ethical decisions. Leaders assess the outcomes of their resource allocations during reviews of their financial variance reports. The organizations are encouraged to continue to evaluate ways to share resources and leverage purchasing opportunities between the two hospitals.

Internal controls and auditing processes are well defined and strong oversight is provided by the board auditing and finance committees. External independent auditing occurs annually. There is segregation of authority to ensure inappropriate sign-off cannot occur.

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)

Since the last on-site survey, the organization has significantly invested in the development and implementation of strategies and tools to improve staff recruitment and retention, leadership/management competencies, and the quality of the work environment. In addition, the completion of performance evaluations has dramatically improved and is complemented with one-to-one rounding with each staff. The stoplight methodology provides a visual management tool for teams to identify and resolve emerging issues. Managers and staff report feeling empowered by this proactive and collaborative problem-solving approach.

There is strategic communication with unions prior to making significant changes in management practices or staffing. The quality of the organization's worklife culture is a priority. Staff report feeling heard, supported, and empowered. Notes of appreciation and recognition are routine and have had a positive impact on morale.

The organizations are commended for their work to harmonize human resource practices between both hospitals, such as developing and implementing an integrated and more streamlined onboarding process. The pillars of patient- and family-centred care are presented at staff orientation. The organization is encouraged to involve a patient and/or family member in the presentation about the pillars.

Workplace violence is assessed and addressed. Aggression among patients is mitigated with training and individualized responses (e.g., Gentle Persuasive Approach) and plans of care. The organization may want to consider introducing a hospital-wide universal precautions approach to strengthen its prevention and mitigation policies and activities.

Analysis of the span of control of managers is used to inform team and staffing realignments. Managers are provided with support to gain and strengthen skills to address performance and attendance issues and engage in difficult conversations. A proactive approach to analyzing vacancies and recruitment strategies is now in place.

Human resources records that were reviewed were comprehensive, up to date, and securely stored. Position descriptions are up to date and were also recently updated to reflect people-centred language.

Priority Process: Integrated Quality Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

There is a formal organizational structure for oversight of quality, safety, and risk at the hospital. The board Quality Committee reviews quality reports and identifies relevant indicators and carefully assesses targets for these indicators. The Patient Care Committee meets regularly and provides operational oversight for quality, safety, and risk. The committee also reviews indicators. There is PFAC representation on the board Quality Committee. Workplans are in place for both the hospital and the board Quality Committees.

An excellent safety plan has been developed. One of the goals of the plan is to improve the just culture throughout the hospital. A "near miss of the month" was recently implemented in response to the results of the patient safety culture survey results. An information handbook was reviewed and updated with input from PFAC and is available on the hospital website and hard copy. A patient safety pamphlet also highlights the patient and family role in safety, and this was updated with PFAC input.

Leaders are held accountable to the strategic plan using a Studer model concept of cascading goals that begin with the strategic plan and are then assigned to the CEO and then down through the leadership teams. These leader evaluation manager (LEM) goals are written as SMART goals and targets are developed annually. These goals form the basis for the hospital's operating plan that is monitored when leaders meet with their supervisors. Ninety-day plans are also reviewed regularly and a leader's "leader" will help identify any barriers that need to be addressed or resources that might be needed to achieve the targets. This is an impressive and commendable approach to making the strategic plan come alive and to align activities with quality improvement activities.

There is an emphasis on best practices. Order sets and evidence-based guidelines have been adopted and the teams are commended for this important work to ensure a standardized approach to patient care.

Leaders perform regular rounding with their teams and staff and leaders acknowledge that this activity is making a significant difference in addressing quality, safety, and risk issues. Staff and leaders have discussions about opportunities for quality improvement projects and several process improvements have been identified by staff during rounding. This is a commendable strategy that engages staff and leaders in quality activities. The PFAC has been involved in quality improvement work and members identified several of these projects.

Medication reconciliation improvements have been implemented following an evaluation of audits. A training module was developed to improve compliance with the best possible medication history,

admission, and transfer aspects of medication reconciliation. Audits are now being conducted to focus on the quality of medication reconciliation rather than simply on whether reconciliation was completed.

A patient safety promotion campaign was organized during patient safety week. All staff and visitors were encouraged to participate. Paid staff manned the various patient safety booths and this reflects the organization's allocation of resources for patient safety. A skills day was organized by the clinical educator to review and recertify staff on skills and competencies to keep patients safe.

Post-discharge phone calls include three questions related to patient safety.

Patient safety incidents are reported using a paper-based system. There is a manual methodology to review and analyze these incidents. The hospital is encouraged to adopt an electronic incident management system. Leaders are required to sign off on these incidents for closure. Leaders report that they follow up with their teams after a root cause analysis to close the loop on the outcome of the incident. Auditing and reports are easily performed using this automated system.

Risk management assessments have been completed using the HIROC assessment tool. The top risks have been identified using this enterprise risk strategy and associated plans have been implemented to reduce, eliminate, or mitigate these risks.

The hospital is acknowledged for the various strategies used to recognize staff for outstanding work. Thank you letters are sent home to staff so family members can share the limelight. The board also offers letters of praise and recognition for quality work and positive achievements by staff.

External contracts are managed efficiently and leaders evaluate accountabilities.

Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The Joint Ethics Committee has been in existence for approximately five months. This committee replaces the two Ethics Committees that were in existence at AGH/Fairview Manor and CPDMH. These were in varying degrees of use and had varying degrees of expertise prior to the creation of the joint committee.

The committee meets bi-monthly and meeting minutes are widely distributed to various interest groups such as senior management, medical advisory committees, and patient care committees at both hospitals.

The Joint Ethics Committee has representation from all sites and most clinical and organizational services and departments, including board, clergy, PFAC, front-line staff, physicians, managers, and leaders. Of particular note, the committee has access to a regional ethicist from a partnership with the Champlain Centre for Health Care Ethics.

Other benefits of the Champlain Centre for Health Care Ethics partnership include availability for consultations on challenging clinical and organizational issues as well as education through regional ethics rounds, online ethics education programs, and formal in-services on specific ethical issues.

The organization uses two different but similar types of decision-making documents. The IDEA decision-making framework guides deliberations about clinical ethical issues; and the Accountability for Reasonableness framework is used at the organizational or governance level to support ethical decision making. While front-line staff are inconsistent in their ability to give examples as to when they have used the IDEA decision-making framework to help them work through an ethical issue, they know the Ethics Committee exists and how to access the service. The organization is encouraged to continue to build capacity with regard to resources for staff who may be dealing with an ethical issue.

Even though the newly formed Ethics Committee has only been in existence for five months, the members have already generated and accomplished a great deal of ethics-related activity, such as the creation of a workplan and action plan for the coming year; training for board members on the use of the ethics framework; lunch and learn activities; and information flyers on ethics and the IDEA decision-making framework, to name a few. In addition, the committee was consulted on an ethics-related matter.

The hospital is not actively involved with research at this time. If research is conducted it is usually done by one of the universities and its process for the review of the ethical implications of research serves this purpose for the hospital. It is suggested that the Ethics Committee develop and implement a process to supplement this review to ensure that the interests of the hospital and its patients are reflected in the ethics review process for research conducted at the hospital.

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)

Effective internal and external communication strategies have been implemented to highlight essential information for staff, physicians, volunteers, patients, and families. The hospital website offers a wide range of information that represents its values of transparency, honesty, and patient/family partnerships. The website was designed with significant input from the PFAC, facilitated by a well-developed integrated communication plan. Publicly reported indicators, board of director policies and by-laws, clinical programs and services, details about leadership positions, and ways to provide the hospital with feedback are examples of content found on the website.

Strategies have been put in place to increase the profile of the hospital in addition to the Mississippi River Health Alliance. News releases have replaced the organization's column in the local newspaper. The hospital also produces an internal newsletter. The first edition of the Alliance newsletter was being distributed at the time of the on-site survey; the main objective was to highlight the benefits and goals of the Alliance. Official branding of the Alliance is being developed.

Internally, several new communication tools have been implemented to increase the frequency and quality of communication. These include monthly communication notes, leader rounding with staff, and the use of AIDET which is a best practice communication tool to improve interactions and anticipate and meet the expectations of patients, co-workers, and visitors.

A policy on the use of personal portable electronic devices has been developed and implemented.

The hospital uses the Meditech electronic documentation system. Meditech PCS optimization is taking place in the near future and this will enhance patient safety features. The hospital is encouraged to continue with the rollout of the electronic documentation system to reduce the risk associated with a hybrid documentation system.

There are effective linkages for ongoing communication and collaboration with the foundations and volunteer partners.

Priority Process: Physical Environment

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The facility is clean and it is obvious that staff take great pride in the historical value of the hospital building. Given that the aging infrastructure and space limitations of the building, the team works in an innovative and creative way to ensure that the safest patient care processes are in place.

The team has submitted plans to the Ministry of Health and Long-Term Care to redevelop the ED and are awaiting approval for stage 2 of the process. The ED space is very cramped and does not effectively support quality care. Confidentiality, privacy, and infection control practices are limited due to the nature of this old space. Additional planning will be needed to manage future space requirements of the hospital given the expected population growth of the community. The OR, recovery/day surgery, and reprocessing areas are all within the ED patient care space. This requires the teams to work safely and to be aware of risks given the busy activity of these areas.

The hospital has received ministry funding to replace and upgrade life safety systems. Heat exchangers, pressure regulators, a generator, roofs and windows, and boilers and mechanical systems are some of the systems that have been replaced. Lighting has been made more efficient which has helped improve staff safety by addressing previously poorly lit areas of the hospital grounds.

The facilities management team manages all required legislative requirements and building facility inspections. Backup generators and contingency systems are in place in the event of a failure in a major system. The water supply for the hospital is from the town supply.

There have been humidity issues in the OR and the infection control practitioner works with the facilities team to monitor and address occasions when the humidity levels exceed safe values. Surgical cases have not needed to be cancelled; however, some sterile trays have required reprocessing. Additionally, the acceptable number of air exchanges needs to be corrected and the team is working to address this situation.

Priority Process: Emergency Preparedness

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Emergency preparedness is well organized and highly functional. The hospital complies with all applicable municipal, county, provincial, and national requirements. All-hazard emergency response plans are regularly tested and debriefing is extensive.

It is particularly reassuring that, when a disaster plan is implemented, in addition to asking identified volunteers, the public is also asked how they may be of help.

CPDMH participated in Operation Tornado in November 2018. This was a test of the emergency management plan and the response for the town of Carleton Place.

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.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The PFAC is small but mighty. It has had a significant influence on the delivery of patient- and family-centred care at the hospital, in particular during the last two years. Committee members are committed to making a difference to the community by providing important feedback and input into hospital processes and care delivery opportunities. They report that their influence at the hospital is real. They do not feel as though they are simply a “token voice” of patients and families but rather that they have a meaningful role that is making a difference.

PFAC members shared many examples of the impressive work in which they are engaged. Leaders, staff, and physicians recognize the influence of PFAC’s work. An annual report is circulated that reports on the activities and accomplishments of the PFAC. The committee knows there is more work to be done. Members are looking for innovative ways to recruit new members to the committee and they would like to work more closely with the Almonte PFAC. This would be an excellent opportunity to strengthen the influence of both committees and further instil the voice of the patient and family into the work of the hospitals. In January 2019 the chair of the hospital’s PFAC made a presentation to the leadership teams of AGH and CPDMH as part of a Leadership Development Institute event, to raise awareness of the PFAC and its accomplishments.

Patients and families are treated with respect and dignity. Post-discharge phone calls identify that there is still work to be done to ensure discharge plans and education are clear, comprehensive, and reinforced by the care teams. Patient satisfaction is high but the teams are committed to doing what they can to further enhance satisfaction levels. There are several opportunities for patients and families to provide meaningful feedback. The leaders are becoming even more responsive to this feedback about ways to improve care planning processes and outcomes.

PFAC identifies the strengths of the organization as “small and efficient, community-oriented, innovative and approachable, personable, proud, good reputation as evident in the generous community donations, engaged leaders, and goal-oriented.” Given these strengths, the hospital is well positioned to continue to develop expertise in incorporating the voice of the patient and family into its daily work.

The committee has developed a workplan to ensure they do not just rubber stamp processes, policies, or other decision-making activities. The members emphasize that they want to make sure they are making a difference and that patients and families are perceived and treated as valuable members and partners of the care team. This goal will continue to evolve, and it will take time to achieve all of their goals. They cannot achieve everything they want to do overnight.

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)

Patient flow is referenced and monitored in a highly effective manner. The realities and challenges related to flow that the paramedic service, the ED, and the hospital face are mutually respected and collaboration is evident. This collaboration involves police services when necessary, particularly as it relates to concerns about patients with mental health and violence issues.

There are several areas in the service that create bottlenecks, some of which are quite typical, such as needing to have patients move from the ED to an inpatient bed or needing to see patients in the ED when primary care services appointments are over subscribed.

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		
12.5	SOPs are followed for handling, distributing, and transporting sterile medical devices and equipment.	!
12.6	Sterile medical devices are distributed and transported using clean, enclosed, or covered carts and bins, or plastic bags.	

Surveyor comments on the priority process(es)

The area designated for sterilization and reprocessing of medical devices is situated next door to the OR suite. The allocated space is small and cramped but practical strategies have been put in place to separate clean and dirty activity. Reprocessing flows in one direction only.

Space conditions for the storage of sterile devices are not ideal as they are stored in the same area where sterilized items are being wrapped. This situation needs to be constantly monitored and managed, and needs to be factored into any future space planning.

Medical devices are cleaned and sterilized according to prescribed standards. There is one full time staff member, with a casual replacement, who appears to be knowledgeable, well trained, and efficient. She has an unrelenting focus on trying to meet and exceed standards.

The way in which sterile devices and equipment are transported to and/or stored in the appropriate clinical area could be improved. It is suggested that the practice of physically carrying the towel-covered sterile packages in repeated trips be replaced by using clean and enclosed carts or bins for timely delivery to and storage in the appropriate clinical areas.

Preventive maintenance programs are in place for reprocessing surgical instruments and diagnostic imaging, which has few reusable devices. The logs demonstrate that these are sterilized based on the manufacturer's standards and protocols.

For other medical devices and equipment in the organization, a comprehensive preventive maintenance program is provided by the biomedical engineering services of Children's Hospital of Eastern Ontario. This service was established by the Champlain Health Supply Services and involves another 12 hospitals in the catchment area. Clinical equipment is listed by area and location; make, model, and serial number; and preventive maintenance frequency checks and due dates. Corrective maintenance service requests are emailed to CHEO and reports are provided to the organization. CHEO also provides safety alert management issued by manufacturers and long-range clinical capital equipment planning. Pending service

calls are tracked monthly. The agreement is up for renewal and the Champlain Health Supply Services will review and evaluate the service before updating the contract.

Service agreement contracts are in place with suppliers for other equipment such as lifts and radiology equipment. Overall, the organization is commended for its diligent preventive maintenance programs.

Ongoing training and support about quality improvement would benefit the medical device reprocessing department team, helping to sustain improvement activities, ensure alignment with strategic directions, and create opportunities to track indicators that impact overall and team-based metrics.

Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Clinical Leadership

- Providing leadership and direction to teams providing services.

Competency

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

Episode of Care

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

Decision Support

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

Impact on Outcomes

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

Medication Management

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

Organ and Tissue Donation

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

Infection Prevention and Control

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

Diagnostic Services: Imaging

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

Standards Set: Diagnostic Imaging Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Diagnostic Services: Imaging

Improvements since the last on-site survey include improving the workflow for reprocessing ultrasound probes, addressing privacy issues when patients present to the diagnostic imaging department, and making space available for spiritual care needs. The latter is managed depending on the requests and needs of patients and families.

With regard to the improvement to the workflow for reprocessing ultrasound probes, the staff and leader question whether the “fix” might create more of an infection prevention and control (IPAC) issue. The team is encouraged to consult an expert in this regard. The reprocessing of the probe is done right by the door on the soiled side of the reprocessing area and the clean probe is placed in a covered bin that is then transported through the passthrough window to the clean side. This could create more of a workflow issue. The team is commended for trying to address this issue given the limited space available.

The team is small but is very passionate and committed to providing safe and quality patient care. Services include radiology, ultrasound, cardiac stress testing, pacemaker clinic, ECG monitoring, and holter monitoring. Portable x-rays are offered as needed. The chief of radiology at Queensway Carleton Hospital provides chief coverage for diagnostic imaging at the hospital. There are no on-site radiologists as images are interpreted remotely. It would be beneficial to send out images for peer review and to have external education sessions with radiologists to enhance their learning and expertise. This would also contribute to further job satisfaction.

Hours of operation are 7:30-19:30 for x-ray and standby for after hours. Ultrasound is available during the week with no after-hours support. Some ED physicians perform their own ultrasound procedures.

Patient satisfaction is high and they are very happy with wait times. Patients and families have access to education materials appropriate for the type of services offered.

The hospital is fortunate to have a new digital X-ray machine. There are relatively no waits for service in the department. Reporting on images is almost instantaneous. There is a system to identify images interpreted by the ED physicians and the results interpreted by the remote radiologist (A B C). Should there be a discrepancy between the interpretations, there is a process to notify the team.

Goals and objectives are posted for the department and reviewed at staff meetings and during individual rounding by the manager.

Several examples of quality improvements were discussed, and the team is very responsive to change. Ongoing training and support about quality improvement would be beneficial for diagnostic imaging services, to help sustain improvement activities. This will help ensure they are aligned with the strategic directions and create opportunities to track indicators that impact overall and service-based metrics.

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		
11.2	There is a policy on neurological determination of death (NDD).	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The ED is ably and reliably staffed with family physicians who have an interest and additional training in emergency medicine.

Since the last on-site survey, there has been Ministry of Health and Long-Term Care approval for the creation of a new ED, although the completion of this project is estimated to take several more years. As such, the ED will continue to be challenged for space on many fronts, including storage, medication room, examination rooms, and nursing station, among others.

In addition, the location of the ED is less than ideal as perioperative services is located behind it. Despite volunteers directing families to where they should go, people often knock on the ED window to inquire about a family member who is a surgical service patient. These are needless distractions in an already busy ED.

Despite the limitations of the physical plant, staff provide good care to the patients.

Priority Process: Competency

Credentials, qualifications, and competencies are well defined and monitored. They span clinical services and information systems.

Staff and physicians working in the ED are well trained and have additional knowledge, skills, and experience to function effectively and provide safe care. There is a commitment to maintaining and increasing competency.

There is a collaborative team approach and staff support each other. There is also a focus on workplace health and safety. The ED nurses have worked with the internal Occupational Health and Safety Committee to identify and address safety risks. Staff see a need for non-violent crisis intervention training.

There is an established protocol to lock down the ED. This includes the potential situation of an active shooter in the ED.

An area for potential improvement is to consider a more formal process for patients and families to provide input about ED services and to ensure their perspective is included.

Priority Process: Episode of Care

The Canadian Triage and Acuity Scale (CTAS) used reliably. The atmosphere is collegial and open and when needed the functionality and purpose of CTAS is reinforced. Orientation and monitoring of flow contribute to this highly efficient system.

Student placements are encouraged and staff and student feedback is excellent. The volunteers are very helpful in the department and feel appreciated. There is excellent orientation for new volunteers.

Priority Process: Decision Support

The emergency record documentation is paper. There are plans for a change to Meditech in the fall of 2019.

Processes to ensure adequate information transfer are used.

Staff have access to current reference material and evidence-informed guidelines and are well schooled in how to access information, policies, and procedures.

Priority Process: Impact on Outcomes

The paper-based system requires additional effort and resources to collect indicator data to use for monitoring, evaluation, and quality improvement activities.

The ED would benefit from a more formal process to share initiatives that improve quality and safety.

There is excellent collegiality among the ED staff, the ED physicians, and emergency medical services, who commented that the emergency team is helpful and has no concerns with their offload times or interactions with the staff.

Documentation and review of significant patient safety and quality events is rigorously followed and staff meet accepted standards and processes. The environment is one of healthy respect for learning from all adverse events, close calls, and good catches.

Obtaining input from patients and families varies. The team is encouraged to consider a more formal processes to obtain their input.

Priority Process: Organ and Tissue Donation

There is a policy and procedure for eye donation and retrieval as per the Trillium Gift of Life Network Act.

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 hospital has invested in resources to support effective infection prevention and control (IPAC) practices. The interprofessional members of the Infection Control Committee are commended for their commitment and passion. Their enthusiasm has helped to reinforce the importance of infection control practices and they proudly report that all staff work together to prevent and/or reduce the spread of infections and outbreaks. They have a can-do attitude toward keeping patients and residents free of infections. The committee reports to the board Quality Committee and to the perioperative team for surgical site infection indicators. Reports are also provided to the Patient Care Committee. Physician representatives on the various committees are expected to share the information about IPAC activities and outcomes with their colleagues.

Policies and procedures are reviewed frequently and content is based on best practices from the Provincial Infectious Diseases Advisory Committee. The infection control practitioner is certified which is a tremendous accomplishment and she is commended for this. She brings information and best practices from the IPAC Ottawa region meetings.

The hospital reports low infection rates. Should any staff member or physician or surgeon have concerns about trends in surgical site infections, the infection control practitioner evaluates these situations.

To recognize and celebrate infection control week, the hospital provides educational opportunities based on the identified needs for that particular year. New staff receive a comprehensive orientation about hand hygiene and other IPAC-related topics.

During the on-site survey, staff were observed to perform hand hygiene regularly. Audits are regularly conducted and improvements are made when necessary. Staff report that hand hygiene and other infection control activities are everyone's responsibility. Mobile equipment is cleaned using wipes between patient use.

An effective flu campaign was undertaken to encourage more staff to receive the influenza vaccine and there was an increase in the number of staff who were vaccinated.

When there is an outbreak, the team quickly comes together and develops an action plan. Following the outbreak, staff and physicians engage in a debrief and this is communicated to appropriate stakeholders. Current institutional outbreak status reports are regularly distributed. The IPAC team knows that patients present to the hospital from outside of the normal catchment area so a wide range of community outbreak reports are included in this process.

A checklist is used to audit the effectiveness of room cleaning processes and the hospital plans to implement visual inspections of the effectiveness of the cleaning processes.

The IPAC team provided the clinical background and best practice information for a business case that supports the need for a negative pressure room in the new ED plans.

The hospital would benefit from a review of isolation carts as they are bulky and not ideally suited for their purposes.

The infection control practitioner is involved in any type of construction activity to determine the risk for patients in the vicinity of construction zone.

Housekeeping and laundry staff are well aware of the necessary policies and procedures to keep patients and families safe. They are well trained. Laundry services, except for mop heads, etc., have been transferred to AGH.

The reprocessing department would benefit from having ergonomic tables and shallow sinks.

Staff are knowledgeable about which cleaning products to use for which items, as a result of a quality improvement project. They had identified that they weren’t sure which products to use because there were so many. The hospital worked diligently with the cleaning supply company to reduce the number of products available, recognizing that standardization is a good thing. Dilution rates are tested.

An in-hospital quality assurance hygiene program in being put in place. The hospital is in the training phase of this program.

Dietary staff must complete a safe food handling program to be eligible to work in the kitchen. Frequent temperature monitoring is conducted in the kitchen and when food is delivered to patient care areas.

Standards Set: Inpatient Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Goals and objectives are aligned with the organization's strategic directions. There is strong evidence of work to ensure services reflect the needs of patients and families. Post-discharge follow-up phone calls are completed to further inform service design and delivery. Patient family committees are consulted for additional input when new practices are introduced.

Team members appreciate working in a supportive environment where issues can be addressed and resolved.

Staff report that there is an emphasis on developing and maintaining partnerships with a wide variety of community agencies to better meet the patient needs.

Families and patients are supported during transitions. Discharge plans are developed and connections are made to other services.

Priority Process: Competency

The inpatient unit is space challenged on my fronts, especially with regard to storage. As a result, equipment is placed in corridors, and in some areas, on both sides, throughout the unit. Despite the

limitations of the aging physical plant the staff provide good care to the patients.

The team is interdisciplinary and demonstrates cohesiveness and a commitment to teamwork. Rounding has improved the regular evaluation of team functioning and the identification of improvement opportunities.

Other improvements since the last on-site survey include monitoring staff education, identifying training needs, and performance evaluations.

Team members report feeling supported to raise and work through conflict and ethical dilemmas. Professional practice training focuses on ensuring staff are working to their full scope of practice.

Priority Process: Episode of Care

Communication before and at admission is supported by dialogue between referring and receiving physicians and nurses. Ongoing communication with patients and families includes care conferences and family meetings as needed. Communication about changes in patients' health status with the most responsible physician is effective.

The team actively engages with community partners to ensure seamless transfers and discharges. Staff work in partnership with patients and families when sharing information about their care and how to respond to changes in their medical and/or rehabilitation process.

Medication reconciliation is thorough and consistently completed at care transitions. Discrepancies are followed up and reviewed. The clinical educator works in close collaboration with the manager and team lead to ensure training and competency on infusion pumps.

Care plans are individualized and goals for medical and surgical patients are driven by patients. Whiteboards in patient rooms reinforce goals and timeframes and also serve as an additional communication tool between staff. Care transitions are carefully planned. The depart program was referenced as an effective discharge tool that is signed by the patient and copied into the clinical record.

Priority Process: Decision Support

The implementation of the electronic health record has facilitated the completion of standardized assessments and notification to other interdisciplinary team members about individual patient risk factors. This will be further enhanced with the upgrade to the Meditech system.

Documentation is informed by the patient, family, and/or substitute decision maker.

Standardized order sets are based on best practice guidelines. Additional sets are being explored.

Information about best practices is available to team members through online resources, the clinical

educator, and, when required, community-based agencies that may be able to provide additional support, education, and resources about age-related conditions, chronic diseases, and end-of-life and palliative care.

Priority Process: Impact on Outcomes

The electronic health record includes a standardized and comprehensive assessment tool that is customized to flag important individual patient medical and other risk factors.

Good, solid work is being done by the medical team.

It is suggested that the team more clearly identify the metrics it is monitoring that are aligned to the corporate scorecard but are relevant to the program/service level for the inpatient area.

It is also suggested that the team might benefit from being more proactive in its benchmarking activities and in comparing itself with peer groups around its performance on metrics that are relevant to the medical population.

Standards Set: Medication Management Standards - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Medication Management		
8.2	A policy on when and how to override alerts by the pharmacy computer system is developed and implemented.	!
18.2	Medications are dispensed in unit dose packaging.	!
Surveyor comments on the priority process(es)		
Priority Process: Medication Management		

The medication management team is a strong interdisciplinary team that addresses accreditation standards as well as interdepartmental collaboration. There is also a standing Patient Care Committee that meets regularly to update the formulary; address best practice updates as required; review medication management issues, medication errors, or reported near misses; evaluate medication use; implement medication risk reduction strategies; and communicate information to stakeholders as appropriate.

The pharmacy department is well organized. The storage area is clearly labelled for look-alike and sound-alike mediations and is also separated by clinical groupings.

The medication management team is a cohesive team with open communication and a strong commitment to improving the medication management system and services to the patients.

The Patient Care Committee includes physicians, the manager of pharmacy services, the vice president patient resident services/CNE, and nursing and laboratory staff. It is responsible for reviewing and evaluating the antimicrobial stewardship program on an annual basis, and monitoring and supporting antimicrobial stewardship program activities as well as facilitating communication with the medical staff.

There is a plan to replace the infusion pumps with smart pumps within the next six months.

There is a process for when and how to override alerts but there is no policy. This high-risk criterion was unmet at the last on-site survey.

Even though the Do Not Use list is audited as required, pharmacy was continuing to fill orders that had unapproved abbreviations and/or symbols from the Do Not Use list. However, once this practice was discussed with leadership during the on-site survey, an immediate plan was put in place to remedy the situation. The organization is encouraged to adopt a policy, process, and procedure that indicates that prescribers will be notified when their orders contain items on the Do Not Use list and that these must be corrected before pharmacy will fill their orders.

Whole tablets are packaged in the unit dose packages even when the actual dose required is for half the tablet. Patient safety is enhanced when medications are dispensed in the most ready-to-administer form. The hospital is encouraged to review its processes to ensure medications are dispensed in the most ready-to-administer form.

Medication reconciliation is supported by the pharmacists. Initial development of the best possible medication history showed many errors, but these have decreased as the process has been further developed and fail-safe steps were added. There is also a plan for the pharmacist to provide one-to-one education to certify the nursing staff in obstetrics and emergency to properly fill out the best possible medication history.

Several medication management policies need to be updated. The manager reports that there is a new template for organizational policies and a plan to merge all polices into the template and update them as required.

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

Perioperative services and invasive procedures is located in an aging physical structure, behind the ED.

Perioperative services and invasive procedures are provided in a highly skilled and well-organized milieu. Surgical checklists and time-outs are conducted with rigour and enthusiasm. Participation in this process is done with passion and a "matter of factness" that respects the proven benefit to patient safety and quality of services. The entire process, from preop to anaesthetic assessment to the surgical checklist and pause to the return to the recovery room, follows the same high standards.

Family involvement and support was evident during a procedure. Each staff member knew their job and completed it in a very professional way. The patient's family felt very reassured and comforted by the whole procedure.

Staff have access to education and a solid orientation is provided for new team members.

Priority Process: Competency

Respect for the development and maintenance of competencies is evident.

Staff and physicians are well trained with additional knowledge, skills, and experience to function effectively and provide safe care. There a commitment to maintaining and increasing competency.

There is a collaborative team approach and staff support each other.

Patients are well informed about their surgery and what to expect post operatively. Comprehensive information and educational material is readily available for patients and families.

There is an easy flow of information and patients from the preop area to the OR to recovery and eventually home or to the inpatient area.

Documentation flows easily and patients have a clear sense of what is next and who will look after them.

Priority Process: Episode of Care

Respect for confidentiality and informed consent is reliably addressed with patients.

The surgical checklist is impressive and is used with each patient.

The clinical pharmacist supports the medication reconciliation process for same day admit surgical patients.

The anaesthetic handover in the recovery room is clearly verbalized by the anaesthetist to the post-anaesthetic care unit staff. The anaesthetist remains until the patient is safely breathing.

Staff members consistently comply with the two patient-specific identifier policy when doing medication administration, as well as for other activities where it is important to ensure that the procedure or treatment is patient specific.

Priority Process: Decision Support

Interprofessional teamwork and commitment are evident among physicians and staff.

Patient records are primarily in paper format. The organization has a plan in place to advance the implementation of electronic documentation.

Patient satisfaction with the care providers and the care processes is high across all areas in the perioperative areas.

Priority Process: Impact on Outcomes

Documentation and review of significant patient safety and quality events are rigorously followed and staff meet accepted standards and processes. The environment is one of healthy respect for learning from all adverse events, close calls, and good catches.

It is suggested that the team more clearly identify the metrics it is monitoring that are aligned to the corporate scorecard but are relevant to the program/service level for the inpatient area.

It is also suggested that the team might benefit from being more proactive in its benchmarking activities and in comparing itself with peer groups around its performance on metrics that are relevant to the medical population.

Priority Process: Medication Management

Medication management in the perioperative services areas is consistent with best practices.

Recent amendments to the narcotic sheet used by anaesthesia have improved wastage.

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: May 3, 2018 to December 14, 2018**
- **Number of responses: 13**

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	N/A
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	0	0	100	N/A
3. Subcommittees need better defined roles and responsibilities.	91	9	0	N/A
4. As a governing body, we do not become directly involved in management issues.	0	0	100	N/A
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	N/A

	% 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	8	92	N/A
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	0	100	N/A
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	0	0	100	N/A
9. Our governance processes need to better ensure that everyone participates in decision making.	69	15	15	N/A
10. The composition of our governing body contributes to strong governance and leadership performance.	0	0	100	N/A
11. Individual members ask for and listen to one another's ideas and input.	0	0	100	N/A
12. Our ongoing education and professional development is encouraged.	0	0	100	N/A
13. Working relationships among individual members are positive.	0	0	100	N/A
14. We have a process to set bylaws and corporate policies.	0	8	92	N/A
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	N/A
16. We benchmark our performance against other similar organizations and/or national standards.	0	0	100	N/A
17. Contributions of individual members are reviewed regularly.	8	17	75	N/A
18. As a team, we regularly review how we function together and how our governance processes could be improved.	8	15	77	N/A
19. There is a process for improving individual effectiveness when non-performance is an issue.	8	33	58	N/A
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	8	8	85	N/A

	% 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.	31	23	46	N/A
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	0	15	85	N/A
23. As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	N/A
24. As a governing body, we hear stories about clients who experienced harm during care.	8	31	62	N/A
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	8	0	92	N/A
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	0	8	92	N/A
27. We lack explicit criteria to recruit and select new members.	100	0	0	N/A
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	0	0	100	N/A
29. The composition of our governing body allows us to meet stakeholder and community needs.	0	0	100	N/A
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	N/A
31. We review our own structure, including size and subcommittee structure.	0	17	83	N/A
32. We have a process to elect or appoint our chair.	0	0	100	N/A

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	15	85	N/A
34. Quality of care	0	15	85	N/A

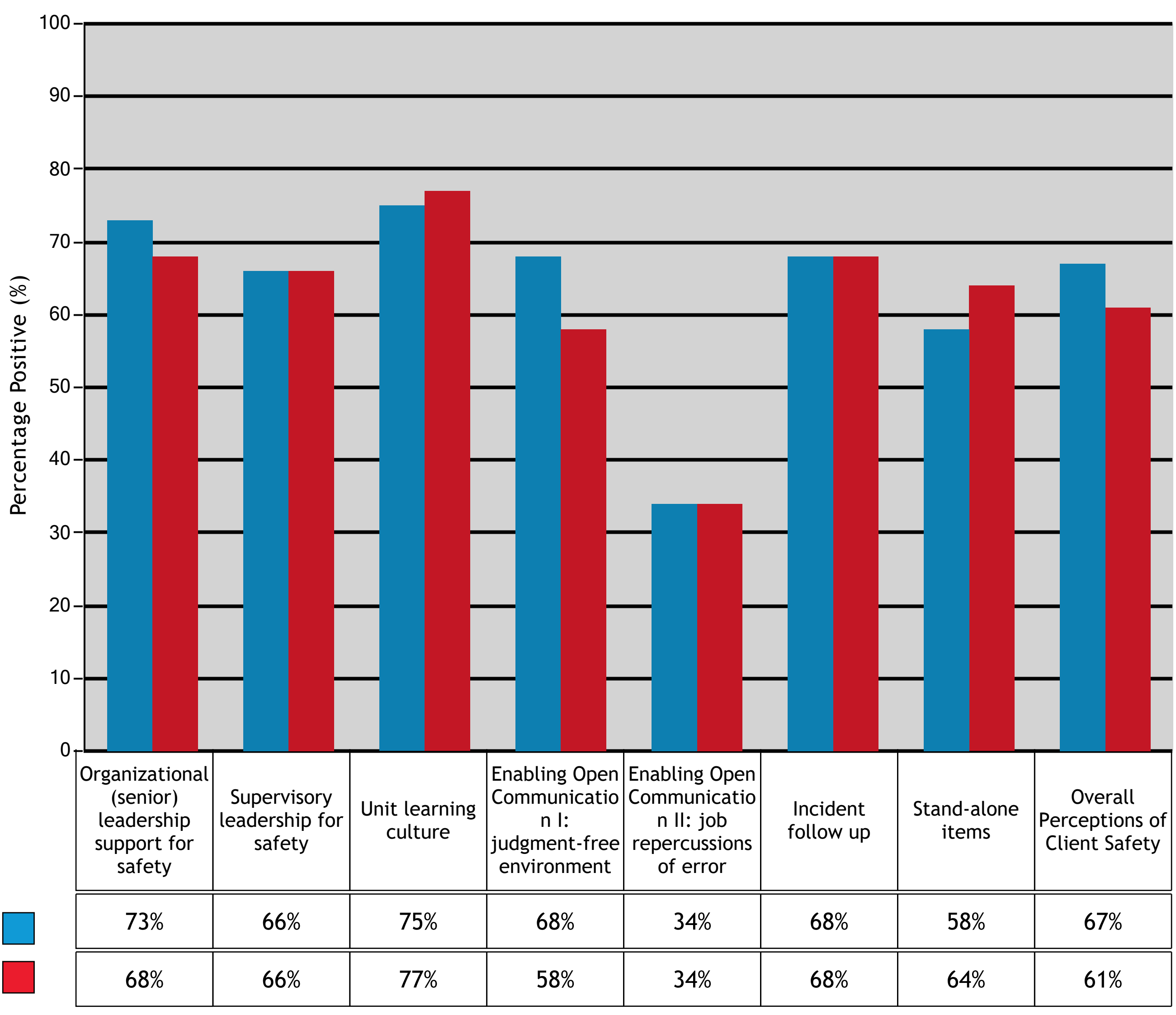
Canadian Patient Safety Culture Survey Tool

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: November 5, 2018 to January 16, 2019**
- **Minimum responses rate (based on the number of eligible employees): 65**
- **Number of responses: 65**

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
Carleton Place & District Memorial Hospital	73%	66%	75%	68%	34%	68%	58%	67%
* Canadian Average	68%	66%	77%	58%	34%	68%	64%	61%

Legend

Carleton Place & District Memorial Hospital

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2018 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 quality of Worklife. The organization has provided Accreditation Canada with results from its substitute tool and had the opportunity to identify strengths and address areas for improvement. During the on-site survey, surveyors reviewed actions the organization has taken.

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
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.