ACCREDITATION CANADA

Driving Quality Health Services

Accreditation Report

Grand River Hospital

Kitchener, ON

On-site survey dates: October 18, 2015 - October 23, 2015

Report issued: November 6, 2015

ACCREDITATION CANADA
AGRÉMENT CANADA

Driving Quality Health Services
Force motrice de la qualité des services de santé

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About the Accreditation Report

Grand River Hospital (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. As part of this ongoing process of quality improvement, an on-site survey was conducted in October 2015. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

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

Confidentiality

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

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

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

A Message from Accreditation Canada's President and CEO

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 Accreditation Specialist 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,

Wendy Nicklin
President and Chief Executive Officer

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Section 1 Executive Summary

Grand River 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.

1.1 Accreditation Decision

Grand River Hospital's accreditation decision is:

Accredited with Commendation (Report)

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

1.2 About the On-site Survey

- **On-site survey dates: October 18, 2015 to October 23, 2015**

- **Locations**

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

  1 Freeport Health Centre
  2 K-W Health Centre

- **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 Leadership
  2 Governance
  3 Medication Management Standards
  4 Infection Prevention and Control Standards

  Service Excellence Standards

  5 Cancer Care and Oncology Services - Service Excellence Standards
  6 Reprocessing and Sterilization of Reusable Medical Devices - Service Excellence Standards
  7 Organ and Tissue Donation Standards for Deceased Donors - Service Excellence Standards
  8 Critical Care - Service Excellence Standards
  9 Point-of-Care Testing - Service Excellence Standards
  10 Ambulatory Care Services - Service Excellence Standards
  11 Diagnostic Imaging Services - Service Excellence Standards
  12 Medicine Services - Service Excellence Standards
  13 Rehabilitation Services - Service Excellence Standards
  14 Ambulatory Systemic Cancer Therapy Services - Service Excellence Standards
  15 Obstetrics Services - Service Excellence Standards
  16 Mental Health Services - Service Excellence Standards
  17 Transfusion Services - Service Excellence Standards
  18 Biomedical Laboratory Services - Service Excellence Standards

19 Perioperative Services and Invasive Procedures Standards - Service Excellence Standards

20 Emergency Department - Service Excellence Standards

- **Instruments**

  The organization administered:

  1 Governance Functioning Tool

  2 Canadian Patient Safety Culture Survey Tool

  3 Worklife Pulse

  4 Client Experience Tool

1.3 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)	75	1	0	76
 Accessibility (Give me timely and equitable services)	106	0	0	106
 Safety (Keep me safe)	691	5	26	722
 Worklife (Take care of those who take care of me)	163	1	4	168
 Client-centred Services (Partner with me and my family in our care)	241	1	7	249
 Continuity of Services (Coordinate my care across the continuum)	79	0	3	82
 Appropriateness (Do the right thing to achieve the best results)	1061	21	12	1094
 Efficiency (Make the best use of resources)	80	0	2	82
Total	**2496**	**29**	**54**	**2579**

1.4 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	42 (100.0%)	0 (0.0%)	0	32 (100.0%)	0 (0.0%)	0	74 (100.0%)	0 (0.0%)	0
Leadership	46 (100.0%)	0 (0.0%)	0	85 (100.0%)	0 (0.0%)	0	131 (100.0%)	0 (0.0%)	0
Infection Prevention and Control Standards	40 (97.6%)	1 (2.4%)	0	27 (87.1%)	4 (12.9%)	0	67 (93.1%)	5 (6.9%)	0
Medication Management Standards	74 (94.9%)	4 (5.1%)	0	62 (96.9%)	2 (3.1%)	0	136 (95.8%)	6 (4.2%)	0
Ambulatory Care Services	38 (100.0%)	0 (0.0%)	4	74 (98.7%)	1 (1.3%)	2	112 (99.1%)	1 (0.9%)	6
Ambulatory Systemic Cancer Therapy Services	50 (100.0%)	0 (0.0%)	0	99 (100.0%)	0 (0.0%)	0	149 (100.0%)	0 (0.0%)	0
Biomedical Laboratory Services **	71 (100.0%)	0 (0.0%)	0	103 (100.0%)	0 (0.0%)	0	174 (100.0%)	0 (0.0%)	0
Cancer Care and Oncology Services	33 (100.0%)	0 (0.0%)	0	75 (98.7%)	1 (1.3%)	0	108 (99.1%)	1 (0.9%)	0
Critical Care	34 (100.0%)	0 (0.0%)	0	92 (100.0%)	0 (0.0%)	3	126 (100.0%)	0 (0.0%)	3

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Diagnostic Imaging Services	65 (98.5%)	1 (1.5%)	1	68 (100.0%)	0 (0.0%)	0	133 (99.3%)	1 (0.7%)	1
Emergency Department	47 (100.0%)	0 (0.0%)	0	80 (100.0%)	0 (0.0%)	0	127 (100.0%)	0 (0.0%)	0
Medicine Services	31 (100.0%)	0 (0.0%)	0	70 (98.6%)	1 (1.4%)	0	101 (99.0%)	1 (1.0%)	0
Mental Health Services	36 (100.0%)	0 (0.0%)	0	88 (100.0%)	0 (0.0%)	0	124 (100.0%)	0 (0.0%)	0
Obstetrics Services	63 (100.0%)	0 (0.0%)	1	80 (100.0%)	0 (0.0%)	0	143 (100.0%)	0 (0.0%)	1
Organ and Tissue Donation Standards for Deceased Donors	19 (100.0%)	0 (0.0%)	20	63 (100.0%)	0 (0.0%)	17	82 (100.0%)	0 (0.0%)	37
Perioperative Services and Invasive Procedures Standards	99 (99.0%)	1 (1.0%)	0	86 (97.7%)	2 (2.3%)	0	185 (98.4%)	3 (1.6%)	0
Point-of-Care Testing **	38 (100.0%)	0 (0.0%)	0	48 (100.0%)	0 (0.0%)	0	86 (100.0%)	0 (0.0%)	0
Rehabilitation Services	31 (100.0%)	0 (0.0%)	0	69 (98.6%)	1 (1.4%)	0	100 (99.0%)	1 (1.0%)	0
Reprocessing and Sterilization of Reusable Medical Devices	49 (92.5%)	4 (7.5%)	0	58 (92.1%)	5 (7.9%)	0	107 (92.2%)	9 (7.8%)	0
Transfusion Services **	70 (100.0%)	0 (0.0%)	5	66 (100.0%)	0 (0.0%)	1	136 (100.0%)	0 (0.0%)	6
Total	**976 (98.9%)**	11 (1.1%)	31	1425 (98.8%)	17 (1.2%)	23	2401 (98.8%)	28 (1.2%)	54

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

1.5 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
Adverse Events Disclosure (Leadership)	Met	3 of 3	0 of 0
Adverse Events Reporting (Leadership)	Met	1 of 1	1 of 1
Client Safety Quarterly Reports (Leadership)	Met	1 of 1	2 of 2
Client Safety Related Prospective Analysis (Leadership)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Communication			
Client And Family Role In Safety (Ambulatory Care Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Ambulatory Systemic Cancer Therapy Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Cancer Care and Oncology Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Critical Care)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Diagnostic Imaging Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Medicine Services)	Met	2 of 2	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client And Family Role In Safety (Mental Health Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Obstetrics Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Perioperative Services and Invasive Procedures Standards)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Rehabilitation Services)	Met	2 of 2	0 of 0
Dangerous Abbreviations (Medication Management Standards)	Met	4 of 4	3 of 3
Information Transfer (Ambulatory Care Services)	Met	2 of 2	0 of 0
Information Transfer (Ambulatory Systemic Cancer Therapy Services)	Met	2 of 2	0 of 0
Information Transfer (Cancer Care and Oncology Services)	Met	2 of 2	0 of 0
Information Transfer (Critical Care)	Met	2 of 2	0 of 0
Information Transfer (Emergency Department)	Met	2 of 2	0 of 0
Information Transfer (Medicine Services)	Met	2 of 2	0 of 0
Information Transfer (Mental Health Services)	Met	2 of 2	0 of 0
Information Transfer (Obstetrics Services)	Met	2 of 2	0 of 0
Information Transfer (Perioperative Services and Invasive Procedures Standards)	Met	2 of 2	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information Transfer (Rehabilitation Services)	Met	2 of 2	0 of 0
Medication reconciliation as a strategic priority (Leadership)	Met	4 of 4	2 of 2
Medication reconciliation at care transitions (Ambulatory Care Services)	Met	7 of 7	0 of 0
Medication reconciliation at care transitions (Ambulatory Systemic Cancer Therapy Services)	Met	7 of 7	0 of 0
Medication reconciliation at care transitions (Cancer Care and Oncology Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Critical Care)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Emergency Department)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Medicine Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Mental Health Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Met	5 of 5	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures Standards)	Unmet	4 of 5	0 of 0
Medication reconciliation at care transitions (Rehabilitation Services)	Met	5 of 5	0 of 0
Safe Surgery Checklist (Obstetrics Services)	Met	3 of 3	2 of 2
Safe Surgery Checklist (Perioperative Services and Invasive Procedures Standards)	Met	3 of 3	2 of 2
Two Client Identifiers (Ambulatory Care Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Ambulatory Systemic Cancer Therapy Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Biomedical Laboratory Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Cancer Care and Oncology Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Critical Care)	Met	1 of 1	0 of 0
Two Client Identifiers (Diagnostic Imaging Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Emergency Department)	Met	1 of 1	0 of 0
Two Client Identifiers (Medicine Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Mental Health Services)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Two Client Identifiers (Obstetrics Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Perioperative Services and Invasive Procedures Standards)	Met	1 of 1	0 of 0
Two Client Identifiers (Point-of-Care Testing)	Met	1 of 1	0 of 0
Two Client Identifiers (Rehabilitation Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Transfusion Services)	Met	1 of 1	0 of 0
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management Standards)	Met	4 of 4	1 of 1
Concentrated Electrolytes (Medication Management Standards)	Met	3 of 3	0 of 0
Heparin Safety (Medication Management Standards)	Met	4 of 4	0 of 0
High-Alert Medications (Medication Management Standards)	Met	5 of 5	3 of 3
Infusion Pumps Training (Ambulatory Care Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Ambulatory Systemic Cancer Therapy Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Cancer Care and Oncology Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Critical Care)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Infusion Pumps Training (Emergency Department)	Met	1 of 1	0 of 0
Infusion Pumps Training (Medicine Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Mental Health Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Obstetrics Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Perioperative Services and Invasive Procedures Standards)	Met	1 of 1	0 of 0
Infusion Pumps Training (Rehabilitation Services)	Met	1 of 1	0 of 0
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
Client Safety Plan (Leadership)	Met	2 of 2	2 of 2
Client Safety: Education And Training (Leadership)	Met	1 of 1	0 of 0
Preventive Maintenance Program (Leadership)	Met	3 of 3	1 of 1
Workplace Violence Prevention (Leadership)	Met	5 of 5	3 of 3
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Compliance (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Infection Control			
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 (Ambulatory Care Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Ambulatory Systemic Cancer Therapy Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Cancer Care and Oncology Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Diagnostic Imaging Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Emergency Department)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Medicine Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Mental Health Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Obstetrics Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Perioperative Services and Invasive Procedures Standards)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Rehabilitation Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Cancer Care and Oncology Services)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Pressure Ulcer Prevention (Critical Care)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Medicine Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Perioperative Services and Invasive Procedures Standards)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Rehabilitation Services)	Met	3 of 3	2 of 2
Suicide Prevention (Mental Health Services)	Met	5 of 5	0 of 0
Venous Thromboembolism Prophylaxis (Cancer Care and Oncology Services)	Met	2 of 2	2 of 2
Venous Thromboembolism Prophylaxis (Critical Care)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Medicine Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Perioperative Services and Invasive Procedures Standards)	Met	3 of 3	2 of 2

1.6 Summary of Surveyor Team Observations

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

The organization, Grand River Hospital is commended on preparing for a participating in the Qmentum survey program. The Board of Directors is commended for the dedication, passion, commitment and genuine interest and pride in their role as governors of the Grand River Hospital. This is a diverse board with complimentary skill sets, and board members take their fiduciary responsibilities seriously. There are good working relationship between the board and senior leadership. Board members are diligent in pursuing continuing education opportunities. The board may wish to consider further cultural and gender diversity in future recruitments. The board is encouraged to continue to pursue strategic governance relationships with community partnerships to build on the success already achieved in this area, and which is in line with the provincial agenda on health care.

The leadership of the organization, including the chief executive officer and senior team are commended for their vision, leadership and collaborative actions in the design and delivery of health services. Together, they are a talented group and bring a lot of experience to their portfolios. There is commitment to quality care and patient safety and this commitment is yielding a culture of quality and safety across the organization. The leadership team is urged to continue the tactical approach so that quality and safety is an integral part of practice in all programs and services at all levels of the organization.

The strategic plan is carefully crafted to reflect the current needs of the catchment population. The plan was informed by several sources including community focus groups, staff focus groups, demographic information, the Local Health Integrated Network and several other sources. Recognition is given for the insight shown in deciding to complete a plan for only two years. This was due to the desire to coincide the timing of future strategic planning with those of neighbouring hospitals. The organization is challenged with responding to fiscal restraints. This will require creative planning and action at the governance and senior leadership levels as the pressure to address the health of the population continues.

The leadership team has fostered a positive culture in the organization which is reflected in the strong team spirit and sense of pride that was demonstrated on many of the units visited during the on-site survey.

The organization has partnerships with several key groups and organizations. There are partnerships with the University of Waterloo Research Program, St. Mary’s Hospital, Conestoga School of Health and Life Sciences and Community Services, Grand River Hospital Foundation, the Local Health Integration Network, Region of Waterloo Emergency Medical Services, Cambridge Memorial Hospital, Canadian Mental Health Association, Waterloo Regional Police Service, Cancer Care Ontario and the Waterloo Wellington Community Care Access Centres. At the Community Partners' focus group all representatives reflected a positive relationship with the Grand River Hospital. There was recognition of the forward thinking at the leadership level and great respect for the work being done to continually improve health service delivery for the catchment population. The relationship between the three hospitals was noted as a positive move forward in planning. Grand River Hospital is encouraged to continue its work in addressing population health issues including a focus on vulnerable populations.

Strong partnerships exist at many levels across the organization. This is especially so with regards to the flow team and the Waterloo Wellington Community Care Access Centre. This relationship has influenced many positive outcomes related to appropriate discharge times, as well as a decrease in Alternate Level of Care patients. Another example of this is in the area of mental health where the Grand River Hospital and its community partners have created a seamless system of service delivery across the transitions of care.

Insofar as delivery of care and service, compassionate care is evident throughout, and staff members are noted for their knowledge, commitment and ability to ensure a patient-focused approach is embedded in their day-to-day work. Clinical care units and service areas are well-organized and have established processes that are standardized. Team work was demonstrated across the organization.

The provision of quality and safe care is supported at all levels and this shows in the people that provide that care. It is also demonstrated in the implementation of several safety initiatives that are implemented across the organization. For example, a concentrated effort has been made to ensure that Medication Reconciliation has been implemented. Also, the transfer of accountability from unit to unit and transfer of information at the bedside using standardized processes such as Situation, Background, Assessment and Recommendation have been implemented in a consistent way across the organization. Delivery of care is characterized by many elements that are associated with safety and high quality. For example, there is standardization across sites and assessment and planning is well done. The interdisciplinary approach to care is well-established and evident in many areas. It is underpinned with good collaborative behaviour and a strong patient/client focus. All units are passionate about the work and staff members are patient focused and knowledgeable in their area of expertise, and focused on quality and risk management.

The Enterprise Risk Management program serves the organization well in the assessment, identification, and mitigation of risks. This serves the organization well at all levels, from front-line staff members to the board. There is an opportunity to look at future-oriented risks such as cyber theft, infectious diseases and business continuity.

Physician engagement is enhanced by the establishment of a medical and administrative lead for each of the programs offered by the organization. Physicians are encouraged to continue to ensure that safety requirements are ingrained into practice. For example, the elimination of verbal orders for medication, consistent use of venous thrombo embolism documentation and avoiding dangerous abbreviations need to be addressed.

Aging infrastructure creates challenges, not only in day-to-day maintenance, but in a few areas where there can potentially be safety risks. For instance, space is required for decontamination and reprocessing for the medical devices and reprocessing and diagnostic imaging areas. In the surgery unit, both the peri-operative and in-patient surgical areas have space limitations which lead to patient flow problems and threaten to impact on the quality of patient care.

The organization is encouraged to continue to introduce safe practices such as placing a follow-up a telephone call to patients following their discharge to determine effectiveness of service and to place increased emphasis on identifying and addressing emerging risks.

There are established processes for procuring supplies and equipment. Life cycle management is integrated by way of a capital equipment renewal process. The implementation of this preventive maintenance program for biomedical equipment has been a major achievement since the organization's previous Accreditation Canada survey.

As the organization pursues the purchase of the new health information system, it will be important to migrate to a fully electronic chart. It will also be necessary to ensure that the charting module is capable of supporting multidisciplinary processes for the delivery of care.

Leadership recognizes staff members for the work that they do in several ways, including the annual service awards and special recognition for staff members that exhibit the organization's values in their day-to-day work. There is also support for staff education.
Some programs use an analytic approach for workload planning and scheduling whereby staff members are fully

involved in the planning process. For example, in ambulatory oncology and systemic chemotherapy the nursing and pharmacy staff members were involved in developing a workload measurement tool. A similar approach has been used for rehabilitation to look at workload allocation for nursing, physiotherapists and occupational therapists.

Significant efforts are made across the organization to address human resources issues. There is an Human Resources plan has to address three strategic goals which capture the human resources direction. The goals and action steps address several areas including disability management, attendance support, recruitment and retention and several other areas. Significant work has been done to implement a Respectful Workplace policy.

Patients that were met during the on-site survey were satisfied with the care they received and were quite complimentary and appreciative of the care approach during their hospital stay. Direct feedback to the surveyor team was positive. There were compliments directed at the staff members and an observation made on how well the organization is managed. These comments align with the strategic goals of providing exceptional care. Several examples were cited where department questionnaires resulted in the implementation of corrective action to address the problems raised. One such example concerns Mammography and the need that was identified in that area, with the end result beings the purchase of new chairs.

Currently, the organization uses the Nation Research Corporation Canada survey to measure client satisfaction, and results from this method are used to make changes. There were also examples of where programs are introducing their own patient satisfaction questionnaires to measure patient/family satisfaction. For instance, on Pediatrics there was a recommendation to change the tool. The Family Advisory Council was engaged in changing the questions being asked. There are other examples of patient engagement including in Mental Health.

An opportunity exists for the organization to explore ways to further engage patients and families in strategic ways. The organization is encouraged to consider developing a corporate-wide strategy to address this area.

Section 2 Detailed Required Organizational Practices Results

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

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

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Communication	
Medication reconciliation at care transitions With the involvement of the client, family, or caregiver (as appropriate), the team generates a Best Possible Medication History (BPMH) and uses it to reconcile client medications at transitions of care.	· Perioperative Services and Invasive Procedures Standards 8.4

Section 3 Detailed On-site Survey Results

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

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

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

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

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

See Appendix B for a list of priority processes.

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

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

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

3.1 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.

3.1.1 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)

The board members are commended for the dedication, passion, commitment and genuine interest and pride in their role as governors of the Grand River Hospital. The board bylaw and policies clearly articulate roles, responsibilities and accountabilities and these documents are regularly reviewed. The skill mix for the board is regularly reviewed and forms part of the board succession planning process. Policies on succession planning of board members are written and approved. A skills inventory is maintained and this guides the board recruitment process. The succession planning process for the board addresses experience and gaps. The board may wish to consider further cultural and gender diversity in future recruitments.

There is an established succession plan for the chief executive officer and senior leaders of the organization. Strategic and operating plans are well established. The board monitors achievement of these plans by way of regular reporting from senior leadership. There are external factors that are integral to the operations of the organization including the Health Service Accountability Agreement and the Multi-Sector Service Accountability Agreement. There is also regular discussion with the Ministry of Health and the Waterloo Wellington Local Health Integrated Network regarding expectations and performance. It is clear that the mission and vision and values were carefully derived from multiple consultations and also, deliberate efforts were made to ensure that these statements reflected the thoughts of many.
Board members receive a robust orientation program when they are first appointed. This includes a session with the Ontario Hospital Association and an orientation to the board process as well as to the Grand River Hospital. There is also ongoing continuing education for the board. The board has the information it needs to make informed decisions. Information on multiple issues is received via the established committees. For instance, there are presentations on matters developed and recommended by the leadership team, and reports from clinical areas across the continuum, and identification of key achievements and challenges, and tours of the hospital facilities.

There are well-established collaborative relationships with neighbouring hospitals including St. Mary's General Hospital and Cambridge Hospital where they gain an understanding of one another's needs and consider some aspects of future planning. For example, at the governance level, there is a formal joint committee, and medical staff are shared between St. Mary's General Hospital and Grand River and there is currently planning to consider acquiring a common hospital information system. There are regular discussions between the vice chairs and chairs. All three hospitals recently participated in a process with the HAY group to create a common understanding of issues that will influence long range planning for health service delivery in the future.

This board has also changed its strategic planning cycle to two years to be in line with other hospitals in the area. These forms of collaborative planning are commendable and have the potential to advance health care planning so that all three hospitals are looking at the common long-term needs of this geographic area. This helps also to facilitate further planning as to the design and delivery of health care services in the future that best suit the population of the catchment area.

There is a position description with annual objectives for the chief executive officer. The chief executive officer is evaluated using a 360 process, and measuring performance against objectives. There is a succession plan for the chief executive officer and senior management team members. The board has instituted a succession planning process for the board which addresses experience and gaps. The board performs its fiduciary role via its resources committee. There is an annual audit by an external auditor and there is an internal auditor that reports directly to the board via the resources committee.

Patient safety forms a significant part of the board's agenda in order that board members can be assured that the organization provides quality safe care. There is quarterly reporting to the board using a scorecard approach which identifies risk issues. Senior leaders are held accountable for indicators and outcomes. The board reviews key system indicators and uses this information to make decisions. The board also begins each meeting with a patient story.
Risk management issues are considered by the board, and these are informed by the Enterprise Risk Management Assessment plan. There is a mix of issues highlighted in the risk management plan, many of which are quite operational. The board is encouraged to consider those risk management issues that are broader in nature, and which indicate potential harm to the entire organization should they become a reality. Examples include, major disease outbreak and business continuity planning.

The organization has partnerships with several key groups and organizations. This includes: the University of Waterloo Research Program; St. Mary's Hospital; Conestoga School of Health and Life Sciences and Community Services; Grand River Hospital Foundation; the Local Health Integration Network; Region of Waterloo Emergency Medical Services; Cambridge Memorial Hospital; Canadian Mental Health Association; Waterloo Regional Police Service; Cancer Care Ontario and Waterloo Wellington Community Care Access Centres. All representatives at the community partners' focus group spoke of a positive relationship with the organization. There was recognition of the forward thinking at the leadership level and great respect for the work being done to continually improve health service delivery for the catchment population. The relationship between the three hospitals was noted as a positive move forward in planning. Grand River Hospital is encouraged to continue its work in addressing population health issues, including a focus on vulnerable populations.

3.1.2 Priority Process: Planning and Service Design

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization's leaders model the values across the organization. The: “Values in Action” award is a great example that allows the organization to recognize employees for demonstrating the values of the organization.

There is an established process for the development and revision of the mission, vision, values and strategic direction of the organization. The community is engaged in formal and informal ways including town hall meetings. There is also a robust internal consultation amongst physicians and staff. The Grand River Hospital also participates in the strategic planning process of local hospitals and the Waterloo Wellington Local Health Integration Network.

There is a robust annual operating plan that is directly linked to the strategic plan. This plan is also incorporated into the annual budgeting cycle. There is regular reporting to the board by way of the operating plan update which is presented to the board on a quarterly basis. Included in this report are the prioritized risk themes as identified by the Enterprise Risk Management plan.

There is also good communication in the organization regarding the strategic plan, as well as the mission, vision and values.

3.1.3 Priority Process: Resource Management

Monitoring, administration, and integration of activities involved with the appropriate allocation and use of resources.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The Grand Rover Hospital has a well-established process for financial planning that spans the organization from the Board of Directors to the front line staff members and vice versa. This includes the annual budgeting process which starts at the unit level and works its way through the process to the senior leadership and the board. The annual operating budget is also integrated successfully with the strategic and operating plans of the organization. There is consultation with external and internal partners regarding the process.

Capital budgeting is completed in a similar manner whereby the identification, assessment, planning and prioritization of infrastructure and capital needs is planned well beyond the one-year cycle.

There is regular reporting on financial performance. These reports start with variance analysis at the unit or service level and formulate the basis for reporting to senior leadership and the board.

There is an external audit conducted by an external auditor. There is also an internal auditor that answers directly to the board via the resources committee. This serves the organization well in the management of financial risks to the organization.

3.1.4 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)

This human resources team is focused on and committed to the various roles performed by the human resources department. There is significant focus at the organization level on ensuring that employees have a healthy and safe workplace. The team is much encouraged by the recent Healthy Workplace Gold award which was presented to the team by the Region of Waterloo for its efforts to create a healthy workplace. There are several current initiatives which focus on creating and maintain a healthy workplace. Leaders are provided with education so that these efforts are organization wide.

There is significant focus on continuing education for all staff. This was clearly evident in interviews with staff members on many of the units visited during the survey.

The team is now engaged in the implementation of the annual immunization campaign. Last year the compliance rate was about 34% which was less than the previous year.

The team pays close attention to the effect of fatigue and stress in the workplace since these factors pose safety risks. There are several initiatives in place to address this matter, including the Employee and Family Assistance Program. There has been a notable increase in the uptake of this program in the past few years.

There is a well-established Respectful Workplace program in place. This program consists of a policy which clearly articulates the various roles, risk assessment, process for addressing concerns and other significant elements. The team conducts surveys of staff members on a regular basis to monitor the quality of worklife culture. The team also conducts a survey of employees to measures the effectiveness of the human resources services.

Span of control is an issue in some areas where the number of employees to one manager is high.

The human resources plan covers the period 2015–2018. The plan is aligned with the organization's strategic themes and operational plan. The plan has three major strategies and a total of nine goals. Each of the goals has measurable action steps and indicators have been developed to measure the success of the actions. Information collected from a number of sources has been used to create the plan. It addresses a number of relevant needs for the organization including continued work on the development of a comprehensive recruitment strategy, investment in education and a significant approach to employee attendance via a comprehensive disability management program and a progressive attendance support program.

There is a good process and template for the completion of performance appraisals. It is noted however, that the policy on completing appraisals every two years is not always followed. There were pockets of compliance but in other areas, an employee's last performance appraisal was more than two years ago. The team is encouraged to increase compliance to policy.

3.1.5 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)

Integrated Quality Management is identified as a strategic priority in the organization. Several examples of implementing standardized process were provided. Best practices introduced by Cancer Care Ontario and the provincial renal program were highlighted. Eighteen clinical practice guidelines have been implemented across the organization.

The organization leaders promote learning from quality improvement results by using data intelligently. An in-depth analysis of the data is conducted so that causal factors are clearly identified and changes made for improvement are implemented.

The organization has well-established programs for patient safety and risk. Quarterly reports are prepared and submitted to the board. There is also a reporting system for adverse events, sentinel events and near misses.

There is a detailed policy entitled: "Disclosure of Harm to Patients/Visitors". The team members were able to cite several examples of where the policy had been implemented. These examples demonstrate a clear understanding of the process of disclosure, and the ability to reach clients and families at the appropriate time following the event as well as regular follow-up.

The team has conducted several prospective analyses during the past few years. One of the most current was the implementation of a Failure Modes Effects Analysis on medication safety.

The implementation of the falls program demonstrates the organization's ability to use the quality improvement process to initiate change. Noting that the incidence of falls was high across the organization the leadership team initiated several studies to establish what the issues were, where the falls were occurring and why. Once the extent of the problem was clearly identified, a concentrated effort took place to reduce falls, with a focus on those falls causing harm. Multidisciplinary teams were formed, Risk-pro data were organized to provide the best possible information, policies were revamped and implemented in clinical areas, and falls were reported every day. Implementation of change management strategies resulted in the 'ownership' of the analysis and problem-solving at the unit level. The falls program is well established and integrated into daily routines at the unit level. There is a concentrated effort made to sustain the gains. This is partially achieved by a continued daily focus on this issue by senior management.

Several teams demonstrated in-depth knowledge of the planning cycle for quality improvement activities. The team is encouraged to continue to embed the planning cycle for quality improvement activities across the organization so that it becomes ingrained in all services and programs as a routine practice in the management and delivery of services at the unit level.

The organization has successfully engaged patients in several aspects of the operation. Encouragement is offered to continue this thoughtful process in how to integrate patients in more aspects of 'doing the business' of the organization. A concentrated effort to develop a plan for patient engagement needs to be considered.

The Patient Safety Culture Tool was conducted in 2014. A careful analysis of the results was also conducted, with an action plan developed and implemented. Staff members have raised concerns/observations about the actual wording of some of the questions, and the team is encouraged to pass these observations on to Accreditation Canada complete with suggestions for change.

3.1.6 Priority Process: Principle-based Care and Decision Making

Identifying and decision making regarding ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The Grand River Hospital has a long established practice of addressing ethics issues. This is evidenced by the focus on education for staff members and physicians as well as the ethics review process. The ethics resources in the organization are well known and respected for their approach in addressing ethical concerns.

Several tools are available to assist in ethical decision-making in the organization. These include: Ethical Decision Making Worksheet; Guide to Solving Difficult Issues, and the Ethical Framework Checklist. There is intranet access to these tools. The organization is commended for its efforts to continually improve the ethics committee process and structure, as well as build capacity across the organization. Encouragement is offered to continue with this valuable work.

There is a concentrated focus on building the organization's capacity to use the ethics framework. This includes work with the Hamilton Health Sciences Ethics program. This relationship is aimed at strengthening the well-established ethics process at Grand River Hospital. Some of the current work with the Hamilton Health Sciences Ethics program includes a review of the current ethics process at Grand River Hospital which resulted in several actions being recommended including a revamping of the current committee and terms of reference. The team now has access to an ethicist.

There are well-established processes for reviewing the ethical implications of research activities. The organization is commended for the continued growth in this area, and for streamlining the process for approval of research activities via the appropriate bodies structured for this role.

During the time of the previous survey two recommendations were made. One recommendation was to implement a formal process for the implementation of departmental impact of research activities. This is now routinely conducted in a structured way to ensure that resource implications of research proposals are clearly documented and considered in the approval process. The second recommendation was to monitor progress in developing capacity in both clinical and organizational ethics by tracking and formal reporting on the number and types of consultation requests received and their origin. Data are currently being collected which are used to identify trends. The team is encouraged to continue this process to be able to measure over time. This way the data analysis can be used to influence the way the ethics service and process are established and organized.

3.1.7 Priority Process: Communication

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization has good relationships with external partners and the community. The organization has a range of strategies to communicate with external stakeholders and this includes YouTube videos, Twitter and the ePulse newsletter. Focus groups were held with the community to provide input to the new strategic plan. The organization recently engaged the community in a research and innovation science fair.

It is noted that Grand River Hospital has good government relations with local municipal leaders, the Ministry of Health and Long Term Care and the Waterloo Wellington Local Health Integrated Network.

Internal communications are delivered in multiple ways via email, the intranet, town halls, the GRH now newsletter and the chief executive's "Tim's Line" conversations.

It is suggested that the Strategic Communications plan be refreshed jointly with the Hospital Foundation to re brand and identify key opportunities that align with the new strategic plan.

Grand River Hospital has identified an urgent need to begin planning for procurement of a Hospital Information System due to the fact that the current McKesson Horizon product will be 'sunset' in March 2018. Under the current provincial context, the organization must obtain consent from the provincial e-Health Investment and Sustainment Board upon a recommendation by the Ministry of Health and Long Term Care Hospital Information System Renewal Advisory Panel. The Grand River Hospital has developed an aggressive four-phase timeline to select, procure and implement the new system by March 2018.

The Grand River Hospital is a Registered Nurses Association of Ontario Best Practice Spotlight Organization, with 18 of that organization's best practices implemented.

"Risk Pro" is the electronic incident reporting, data analysis and trending software used across both sites. Lotus Link is user friendly and well utilized for policy management.

3.1.8 Priority Process: Physical Environment

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization's physical environment is generally well maintained. The issue noted at the time of the previous survey about no separation of clean and dirty areas has been corrected in all areas. There were no noted issues with cleanliness, although clutter continues to be a significant problem, particularly on the surgery in-patient unit. Restricted space is an issue in the operating room area.

During the recent major redesign of the atrium and the five-stage pharmacy redevelopment there was careful coordination with the Joint Occupational Health and Safety committee to ensure health and safety were top priority.

The organization plans a testing of the main and back-up power supplies in the near future. Extensive planning has gone into ensuring appropriate system availability.

The organization has received awards for compliance with green initiatives at the Kitchener-Waterloo site and the Freeport site.

3.1.9 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)

Code policies and procedures are standardized across the two sites, and are available on the intranet. They are regularly reviewed and updated. Code red drills are held monthly with debriefing and follow-up as required. There was a recent table-top exercise for code grey and a mock fan-out was tested. The incident management system structure was recently tested with the flood at St Mary's General Hospital. The learning management system has code courses for all staff.

Staff members that work in high-risk areas attend a two-day training program for code white, plus one half-day of de-escalation training.

There is a business continuity plan for Information Services. There is a data centre at the Freeport site, with downtime procedures that are regularly tested. There is a virtual server platform with 60% migrated. The intranet is hosted at St. Mary's General Hospital.

The chemical, biological, radioactive nuclear equipment is stored in a locked cage in the garage of the emergency department at the Kitchener Waterloo campus. There is a decontamination area in that department with a holding tank for appropriate removal of dangerous waste.

Infection prevention and control policies and procedures are available on the intranet to respond to outbreaks and for planning for pandemics. The team plans for all-hazard disasters and emergency response with its regional partners to address community-wide emergencies.

The organization has responded effectively to the Ebola crisis with the development of policies as per Ministry of Health and Long Term Care directives and a YouTube training video for donning and doffing of personal protective equipment.

Facilities have good back-up power for loss of essential services, with two sources of water and hydro, gas and diesel, three generators and emergency power.

3.1.10 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)

The organization has made significant improvements in access and flow since the previous accreditation survey. The position of Manager of Access and Flow was established to work proactively with internal and external stakeholders and oversee the daily flow management activities across the organization. Detailed protocols and responsibilities to facilitate timely access to care are set out in the Grand River Hospital's over capacity and surge protocol documents.

There is clear evidence of a whole system approach for access to care. The emergency department, pre-operative services and clinical areas work collaboratively on a daily basis to ensure timely access to care. This is facilitated by excellent daily bed meetings and the use of the Medworxx bed board. Escalation protocols are well-defined to ensure prompt and timely 24/7 response to defined capacity trigger levels. The tool: "The Grand" is a tool that allows for easy access to real time bed availability on staff Blackberries to expedite resolution of over capacity and surges. There is 24/7 support provided by the Access and Flow office staff.

There are well-established processes to monitor and manage flow in the emergency department and peri-operative services. The Emergency Department Operations committee meets regularly with representatives from the programs and services. This committee meets monthly. Performance is measured using a comprehensive list of indicators trended over the previous twelve months. Although significant improvements have been realized, the trended data show notable monthly variations.

Discharge planning commences at the point of admission. Community Care Access Centre care coordinators carry out daily discharge planning with a major focus on Alternate Level of Care clients. A multi-stakeholder Community Care Access Centre committee has been established in the region and it reports directly to the vice president and CNE committee.

Surgical wait times are reviewed regularly by peri-operative services. The establishment of an acute surgical operating room on the day shift has resulted in more timely access to pediatric appendectomies and improved capacity overall.

Each of the programs has customized flow performance indicators which are trended and reviewed at the respective program councils. The over all and program-specific flow performance metrics are reported at the Senior Quality and Board Quality committee meetings two times per year.

There is an overall opportunity to support the next phase of this excellent work, which is to consider how best to leverage the well-established data repository to predict barriers in a more comprehensive and substantive way and thereby, enable development of more effective system-wide strategies.

3.1.11 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: Diagnostic Imaging Services		
8.7	All diagnostic imaging reprocessing areas are equipped with separate clean and decontamination work areas as well as separate clean storage, dedicated plumbing and drains, and proper air ventilation and humidity levels.	!
Standards Set: Reprocessing and Sterilization of Reusable Medical Devices		
13.5	The team identifies measurable objectives for its quality improvement initiatives and specifies the timeframe in which they will be reached.	!
13.6	The team identifies the indicator(s) that will be used to monitor progress for each quality improvement objective.	
13.9	The team designs and tests quality improvement activities to meet its objectives.	!
13.10	The team collects new or uses existing data to establish a baseline for each indicator.	
13.11	The team follows a process to regularly collect indicator data to track its progress.	
13.12	The team regularly analyzes and evaluates its indicator data to determine the effectiveness of its quality improvement activities.	!
13.13	The team implements effective quality improvement activities broadly.	!
13.14	The team shares information about its quality improvement activities, results, and learnings with clients, families, staff, service providers, organization leaders, and other organizations, as appropriate.	
13.15	The team regularly reviews and evaluates its quality improvement initiatives for feasibility, relevance and usefulness.	

Surveyor comments on the priority process(es)

The Corporate Equipment Replacement committee, Product Evaluation committee and Capital Steering committee regularly review equipment purchase and replacement requirements. Both a business case and five-year plan is required for all equipment purchases.

The manager of the Medical Devices Reprocessing department has designated responsibility for reprocessing and sterilization under the direction of the director of pre-operative services. The organization has an external contract with Sterilmed via the Mohawk purchasing group for reprocessing and sterilization of designated previously used single use devices. The purchasing manager reviews the contract annually. The quality of the service is regularly monitored.

The Canadian Standards Association Medical Devices Reprocessing Certification Course is a requirement upon hire for all Grand River Hospital staff members that are responsible for cleaning and reprocessing medical devices. All staff members that perform reprocessing have completed the certification. Annual competency testing is done. Staff certification records are archived in the department.

The reprocessing function has been centralized except for endoscopy and diagnostic imaging at both sites. Otherwise, re-usable equipment is sent to the Medical Devices and Reprocessing department. The cleaning and decontamination area in that department is well-organized and maintained. The space in the cleaning and decontamination section of the department is small given the amount of activity, especially at peak times. The pass-through, clean preparation and sterile supply storage rooms are spacious and well maintained. Staff members are knowledgeable. Personal protective equipment is readily available and worn. There is a well-developed and managed quality control program that meets standards for all stages of reprocessing and sterilization. Preventive maintenance is in place for all equipment. Sterile case carts are transported in closed stainless steel cabinets in a supply elevator, which goes directly to the operating room. Used carts are returned in the same manner. The stainless steel cabinets pass through the cart wash after each use. Handwashing sinks and eyewash stations are readily available. Temperature, humidity and air flow are monitored continuously and meet current standards.

Cleaning and reprocessing of ultrasound probes in diagnostic imaging are carried out in the same room. This area is small and has a poor physical layout. The work flow presents significant potential for cross-contamination and does not meet current standards. This situation needs to be addressed.

The organization has established a comprehensive preventive maintenance program for biomedical devices, medical equipment and air handling systems since the previous survey. Complete preventive maintenance checks are managed and tracked in a database in the biomedical and maintenance departments. Status reports are readily available.

The quality improvement plans for reprocessing and sterilization of re-usable medical devices needs to be developed further and then formalized to build on the excellent work, which is being done.

3.2 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:

Episode of Care - Ambulatory Systemic Cancer Therapy

- Healthcare services provided for a health problem from the first encounter with a health care provider through the completion of the last encounter related to that problem.

Point-of-care Testing Services

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

Clinical Leadership

- Providing leadership and overall goals and direction to the team of people providing services.

Competency

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

Episode of Care

- Providing clients with coordinated services from their first encounter with a health care provider through their last contact related to their health issue

Decision Support

- Using information, research, data, and technology to support management and clinical decision making

Impact on Outcomes

- Identifying and monitoring process and outcome measures to evaluate and improve service quality and client outcomes

Medication Management

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

Organ and Tissue Donation

- Providing organ donation services for deceased donors and their families, including identifying potential donors, approaching families, and recovering organs

Infection Prevention and Control

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

Surgical Procedures

- Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge

Diagnostic Services: Imaging

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

Diagnostic Services: Laboratory

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

Transfusion Services

- Transfusion Services

3.2.1 Standards Set: Ambulatory Care Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
12.6 Following transition or end of service, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)
Priority Process: Clinical Leadership
The majority of ambulatory care services involve the renal dialysis program, although out-patient rehabilitation services provided at the Freeport site. The Freeport services are good, with excellent facilities that are in the process of being updated and refreshed. The renal dialysis services at both sites are excellent, with cheerful and enthusiastic staff members that are deeply appreciated by the patients. They make exceptional use of limited physical space, the demand for which is increasing steadily. They also provide services for two other satellite units, as well as home hemo dialysis and peritoneal dialysis.
Priority Process: Competency
Ambulatory care staff members are highly trained, competent and work diligently to maintain high standards.
Priority Process: Episode of Care
The ambulatory care team integrates care well with both internal and external partners.
Priority Process: Decision Support
Very good client care records are maintained, and detailed service provision statistics are generated.
Priority Process: Impact on Outcomes
There is an excellent falls prevention program in place, as well as detailed processes to reduce risks and improve safety.

3.2.2 Standards Set: Ambulatory Systemic Cancer Therapy Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Episode of Care - Ambulatory Systemic Cancer Therapy	
The organization has met all criteria for this priority process.	
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: 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: Episode of Care - Ambulatory Systemic Cancer Therapy	

Clients are assessed and prepared for systemic cancer therapy in the ambulatory clinic. Consent for therapy is obtained by the oncologist. Cancer Care Ontario access indicators are followed for time to be seen from referral time, and for time from first clinic visit to the first treatment.

Clients and their families receive a comprehensive orientation to the service including contact information for team members responsible for their care. After-hours services are provided in the emergency department.

Client education is well done, and supported by a broad array of written materials specific to chemotherapy, home therapy and self-care, safety, rights and complaints process. All clients are scheduled for pharmacy teaching before commencing therapy.

The record is currently a hybrid electronic and paper form. The electronic record includes the Horizon electronic documentation system which is used by nursing and, connected to the clinical portal which is used by oncology physicians, nurse practitioners and general practitioners for dictation purposes. The laboratory and diagnostic imaging record is in a separate electronic system.

Interdisciplinary assessment and care planning is well done. Symptom assessment is done at the beginning of every visit and the care plan is adjusted and/or appropriate referrals are arranged accordingly. The height and weight of the client and other clinical parameters are documented at every visit. The treatment goals are re-evaluated by the interdisciplinary team at each ambulatory clinic visit prior to commencement of each chemotherapy treatment cycle.

Medication reconciliation is well done and clearly documented on admission, transfer and discharge from service. Transfer of information tools are used for transfers to the emergency department and for all inter-departmental transfers.

Priority Process: Clinical Leadership

The Grand River Hospital Cancer Centre is one of fourteen regional programs in the province. The program offers a comprehensive range of in-patient and ambulatory services. The service includes out-patient clinics and an out-patient chemotherapy clinic. A formal review of the program services is conducted annually. Service volumes, referral patterns in the region and access to services inform decisions about the configuration of services and identify potential new referral sources.

Cancer care program goals and objectives are driven by Cancer Care Ontario's priorities and targets which are aligned with Grand River Hospital's priorities and set out in the corporate operating plans. The Ambulatory Oncology Program Quality Council oversees the development and implementation of the program priorities including time lines, action plans, outcomes, responsibilities and communications. The Project Tracking tool is used to monitor progress on monthly basis. Access to care and person-centred care are major Cancer Care Ontario priorities this year. A scan is underway to identify opportunities to improve access to care. The Patient and Family Advisory Council for Oncology is overseeing the approaches to improved person-centred care. A recent initiative is the introduction of 'Patient Storytelling' to front-line staff members which has been well received.

The team welcomes a full complement of students in medicine, nursing, radiation, dietetics, and social work. There are more than 100 volunteers that support the program. The student roles are clearly defined in the rotation goals and objectives, and volunteers receive orientation to the service in addition to the general orientation.

Support services for interpretation are readily available.

A nursing workload tool has been developed and tested and is currently used to ensure fair and equitable workload assignments. A pharmacy component has recently be added, and is shared externally. A quantitative data repository is now in place and used to predict and pre schedule assignments.

The team has good resources currently, but it is anticipated that upcoming change in funding for non-malignant hematology will present challenges in the coming year.

Priority Process: Competency

The service is supported by a full interdisciplinary team that includes registered nurses, nurse practitioner, social work, dietician, pharmacists, radiation oncologists (5.5), hematologists (5), medical oncologists (8), palliative care physicians (2), and urologists (2). A newly created general practitioner with oncology specialist training will join the in-patient oncology service in January 2016.

Nursing services has partnered with the De Sousa Institute and all oncology nurses complete the certification and continuing competency course yearly. Detailed guidelines direct nursing roles and practice standards for all aspects of oncology clinic nursing. Radiation therapists are required to complete 20 hours of continuing education annually.

There is a detailed service-specific orientation program in place.

Priority Process: Decision Support

The client record is up-to-date. Evidence-based guidelines come primarily from Cancer Care Ontario. They are reviewed for adoption by the disease site teams. The Registered Nurses Association of Ontario's Best Practice Guidelines are reviewed for adoption by the unit council. The service is currently implementing best practice guidelines for: "Care Transitions" and "Therapeutic Relationship".

Research foci include exploring novel technical approaches (non-clinical) in partnership with the University of Waterloo, and participation in clinical trails in partnership with McMaster University, and University of Guelph. The Tri-City Research Ethics Board oversees the approval for and monitoring of all research studies.

Priority Process: Impact on Outcomes

The commitment to safety and quality of care is clearly evident. The organization's processes are followed for the reporting and follow-up of sentinel events and adverse events. Staff members are knowledgeable about the disclosure policy and there is evidence it is being followed.

Improvement work flows from Cancer Care Ontario priorities and targets and organizational priorities and feedback received via the National Research Corporation Picker out-patient surveys which are conducted two times per year.

Improvement initiatives and targets are aligned with the four corporate quadrants of quality. Examples of current initiatives include more appropriate referrals to a dietician, timelier access to laboratory services, pain and symptom management education, and best possible medication history. Quality improvement metrics are tracked and posted on the quality boards in each of the ambulatory areas. The service has a quality consultant that is readily available and works with the team.

Staff members are engaged in quality work via the unit councils, based on skills sets, aptitude and interest in the specific projects. There is a need to continue to build team capacity to carry out improvement work by way of education on the science of improvement and the use of quality tools and methods to assist this team maximize the benefit from the excellent improvement work underway.

Indicators are tracked using the ambulatory clinics' operational dashboard. Performance reporting is done for oncology via Cancer Care Ontario. Bi-annual internal reporting is done at the senior quality team meeting. A formal process to evaluate the effectiveness of the quality improvement plan has yet to be developed.

Priority Process: Medication Management

All chemotherapy orders are entered by the oncologist using computerized order entry. Chemotherapy preparations are done by a team of pharmacy technicians certified in chemotherapy preparation. Chemotherapy preparation is carried out in a negative pressure room under externally exhausted bio hazard hoods. The room is also used to store chemotherapy preparation supplies and staffs' personal protective equipment which is put on and removed inside the room. There is no dedicated hand washing sink. The room is cramped and there is a risk of staff distractions. Plans are underway to create an adjacent supply room, and ante room for staff to put on and take off personal protective equipment, as well as a pass through window for dispensing chemotherapy preparations.

3.2.3 Standards Set: Biomedical Laboratory Services - Direct Service Provision

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

Surveyor comments on the priority process(es)
Priority Process: Diagnostic Services: Laboratory
Laboratory services at the Grand River Hospital provide all the laboratory services for both Grand River Hospital sites and also St. Mary's General Hospital. The total annual test volume is more than 2.8 million. Not is made of the recently implemented total lab-automation, which has improved capacity and productivity. The laboratory makes excellent use of limited geographic space. The staff members are proud and enthusiastic about their work.

3.2.4 Standards Set: Cancer Care and Oncology 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	
11.5 Following transition or end of service, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The in-patient unit is a twenty bed unit which includes three negative pressure isolation rooms. Service planning and goal setting for in-patient services follows the cancer care program planning process. A formal review of the program services is conducted annually as part of the overall cancer care program review.

Service goals and objectives are driven by Cancer Care Ontario's priorities and targets which are aligned with Grand River Hospital priorities and set out in the corporate operating plans. Access to care and person-centred care are major Cancer Care Ontario priorities this year. A scan is underway to identify opportunities to improve access to care. The Patient and Family Advisory Council for oncology is overseeing the approaches to improved person-centred care. A recent initiative is the introduction of 'Patient Storytelling' to front-line staff members which has been well received.

The Inpatient Oncology Program Quality Council oversees the development and implementation of the program priorities including timelines, action plans, outcomes, responsibilities and communications. The Project Tracking tool is used to monitor progress on a monthly basis.

The team welcomes a full complement of students in medicine, nursing, radiation, dietetics and social work. There are more than 100 volunteers that support the program. The student roles are clearly defined in the

rotation goals and objectives, and volunteers receive orientation to the service in addition to the general orientation.

Support services for interpretation are readily available.

Priority Process: Competency

The service is supported by a full interdisciplinary team including, registered nurses, a nurse practitioner, social work, dietician, pharmacists, radiation oncologists, hematologists, medical oncologists, and palliative care physicians. A newly created general practitioner with oncology specialist training will join the in-patient oncology service in January 2016.

The positive interdisciplinary team spirit of this excellent team is palpable. The commitment to excellence in compassionate care and a strong team with common goals was verbalized repeatedly during discussions with the interdisciplinary members, and validated in discussion with clients. The team was #3 in the most recent employee engagement survey. The nursing team on the unit won the Team award during nurses' week, and Nurse Mentorship was awarded to one of the nursing team members.

Nursing services has partnered with the de Sousa Institute and all oncology nurses complete the certification and continuing competency course yearly. There is a detailed service-specific orientation program for the in-patient unit.

The physical space is organized and free of clutter. Safe practices for handling and disposal of chemotherapeutic agents are followed.

The dedicated handwashing sinks located adjacent to in-patient rooms and at staff workstations are extremely small and are hand controlled and do not meet current Provincial Infectious Diseases Advisory Committee specification. This should be assessed.

Priority Process: Episode of Care

Approximately 30% of admissions are pre-booked and admitted directly from home and the remainder are either direct admissions from the ambulatory clinics or via the emergency service. The service covers a wide spectrum of malignancies. Management of complicated treatment regimens, complications of treatment, and complications of progressive cancer are the major reasons for admission to the in-patient unit.

The palliative care team works closely with the interdisciplinary team and Community Care Access Centre staff to arrange the most appropriate placement for end-of-life care.

Clients and families receive a comprehensive orientation to the service, which includes contact information for team members responsible for their care. Client education is well done, supported by a broad array of written materials specific to chemotherapy, self care, safety, rights, privacy and the complaints process.

The health record is a hybrid electronic and paper form. The electronic record includes the Horizon electronic documentation system which is used by nursing and it is connected to the clinical portal which is used by oncology physicians, nurse practitioners and general practitioners for dictation purposes. Laboratory and diagnostic imaging documentation is in a separate electronic system. Medical progress notes and orders are recorded in the paper client record.

Interdisciplinary assessment and care planning are well done. Symptom assessment is done using the

Interdisciplinary assessment and care planning are well done. Symptom assessment is done using the Edmonton Symptom Assessment Scale. All patients are assessed for falls risk, pressure ulcers and eligibility for venous thrombo embolism prophylaxis. Treatment goals are re-evaluated and discharge plans are discussed at daily interdisciplinary team rounds.

Medication reconciliation is well done and clearly documented on admission, transfer and discharge from service. Pharmacy is an integral part of the team and the medication management process.

Transfer of Information tools are used for transfers from the emergency department all inter-departmental transfers. Transfer of information is done at the bedside, with participation of the client at change of shift. Clients report that they appreciate being involved in discussions about daily care and that they felt fully informed about their care and progress.

A music therapist, funded by a donor, visits the unit regularly and attends rounds to identify clients that would benefit from musical therapy.

The radiation therapy unit is the sole provider of radiation therapy in the Waterloo Wellington area. There are four treatment rooms and one simulator and one planning room in the suite. The service is fully compliant with Canadian Nuclear Safety Commission. Computerized tomography is fully compliant with Healing Arts Radiation Protection. Radiation therapy oncology group protocols are followed. There is a comprehensive safety and quality control program in place. The service works closely with occupational health and safety. The radiation safety committee meets all guidelines and legal requirements.

Quality improvement work is aligned with the cancer program areas of priority. Performance indicators are tracked on the quality board. Access to service had been a major challenge, and a quality improvement project was successfully carried out and currently, 97% of clients are having the appropriate treatment according to designated priority levels.

Clients spoken to during the survey were highly complimentary about the service. Overall, the organization was complimented for the highly efficient service on the unit/program, and for knowledgeable, compassionate highly dedicated nursing staff members that respond to all client needs, dedicated interdisciplinary teams and support staff. Particular mention was made about the cleaning staff members that do daily cleaning and regular garbage pick up 24/7. Clients also stated that the staff members and overall ambience were calming and felt like home. Note was made of the plan to add a family doctor with oncology training to the unit team. This is noted to be an improvement in order to provide easy client access to a physician to answer questions.

The only negative pressure rooms in Grand River Hospital are on the in-patient unit and this presents a challenge when occupancy is high.

Priority Process: Decision Support

The client record is up-to-date. Evidence-based guidelines come primarily from Cancer Care Ontario. They are reviewed for adoption by the disease site teams. The Registered Nurses Association of Ontario's Best Practice Guidelines are reviewed for adoption by the unit council. The service is currently implementing best practice guidelines for: "Care Transitions" and "Therapeutic Relationship". BPGs.

The Tri-City Research Ethics Board oversees the approval for and monitoring of all research studies.

Priority Process: Impact on Outcomes

There is a strong commitment to safety and excellence in the quality of care. The organization's processes are followed for the reporting and follow up on sentinel events and adverse events. The disclosure policy is followed for all adverse events.

Improvement work on the in-patient unit flows from Cancer Care Ontario priorities and targets and organizational priorities. The improvement initiatives and targets are aligned with the four corporate quadrants of quality. Current improvement initiatives include: transfer of information; discharge follow-up, and falls prevention. The quality consultant works with the service. Staff members are engaged in quality work via the unit councils and based on skills sets, aptitude and interest in the specific projects. There is a need to continue to build team capacity to carry out improvement work. This can be done by education on the science of improvement and the use of quality tools and methods to assist the team maximize benefits from the excellent improvement work underway.

Indicators are tracked using the in-patient dashboard. Performance reporting is done for oncology via Cancer Care Ontario. Bi-annual internal reporting is done at the senior quality team meeting. A formal process to evaluate the effectiveness of the quality improvement plan has yet to be developed.

3.2.5 Standards Set: Critical Care - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Both the adult and neonatal intensive care units were surveyed. The adult service A is a 20-bed closed unit with 16 level 3 beds and 4 level 4 beds, and intensivist led 24/7. The adult service B is an eight-bed level 2 step down unit. During the day, there is an intensivist covering this unit, plus the Critical Care Response Team and emergency department. Overnight, there is one intensivist on site. The team collects information about the population it serves from the Waterloo Wellington Local Health Integrated Network and various other databases such as the Critical Care Information System. The team sets goals and objectives for the unit measured against targets. Transitioning out of the critical care unit is a particular focus for this team with an aim to enhance the support patients are afforded before and after transitioning to the next level of care. The intensive care leadership team also measures a number of indicators using a critical care scorecard, including the Safer Healthcare Now central line and ventilator associated pneumonia, occupancy, ventilator days and more received from the critical care information system.

The neonatal intensive care unit is a level 2B unit, with more than 750 admissions per year, caring for neonates that can be vented for up to 48 hours. The teams' major sources of referrals and repatriations are received from McMaster Health Sciences, Mount Sinai Hospital, London Health Sciences, Sunnybrook Hospital

and the Hospital for Sick Children. The team uses the Better Outcomes Registry Network database to review the services it delivers. The unit's goals and objectives are focused on five core measures for developmental care. The quality council meets monthly. Any quality improvement activities identified by the team are discussed at the council. There is a clinical teaching unit group of four pediatricians that teach clinical clerks, and first and second year residents. There are 12 pediatricians in total that take call and admit to the unit. This is a highly collaborative multidisciplinary team that would like to assume a greater regional role in the future should the opportunity arise.

Priority Process: Competency

The neonatal intensive care unit staff members have extensive training opportunities to develop and maintain skills and competencies to work at full scope of practice. There are quarterly skills days, neonatal resuscitation program and pediatric advanced life support, breastfeeding conferences, webinars, and the Leadership Academy, to name a few. The educator recently attended an educational event to learn best practices in neuro developmental protection for babies in neonatal intensive care, and the manager and educator are passionate to implement this learning in the unit.

There is documented evidence of intravenous pump training at more than 90% completion in both units.

The intensive care units have an educator that supports comprehensive orientation and education of new staff. Most receive between 150-300 hours depending on past experience. Nurses will also spend some time to learn the roles of the Allied team. This is an excellent strategy that enhances the collaborative interdisciplinary team model on the units. There is a critical manual, the Moseby's Skills resource is online as well as specific requirements on the learning management system.

Grand River Hospital's intensive care units serve as a large academic teaching centre that supports many learners, clinical clerks and residents. The medical director is keen to grow the academic teaching program.

Priority Process: Episode of Care

Care in the neonatal intensive care unit is patient and family centred. There is no restriction on visiting hours for parents. Families are encouraged to participate and/or direct the care. The unit is implementing an evidence-based model of neuro developmental risk and protection for pre-term infants, which will reduce physiologic and environmental stressors in the unit for example, sound, light, feeding cycles, and skin to skin. There are sound-activated noise meters throughout the unit to measure sound levels.

There is a Retinopathy of Prematurity or ROP nurse that does eye testing on babies at the Grand River Hospital, and the physician participates via Telemedicine. This practice prevents babies from a transfer out for this procedure. The neonatal physiotherapists assess and treat babies, working under medical directives according to specific criteria.

There are no visiting hour restrictions. Care is patient and family centred. Patients are engaged in their care with regards to decisions and preferences. End-of-life decisions are documented for all charts in the intensive care units. Medication reconciliation is completed on admission and transfer. There are also specific transfer orders for transitioning out of the unit. Daily rounds are carried out with the inter-professional teams, and patients are engaged wherever possible. Teams are respectful of one another's roles and expertise.

Priority Process: Decision Support

The neonatal intensive care unit uses the Better Outcomes Registry Network database to collect data on specific procedures, in addition to Gran River Hospital decision support and patient satisfaction data received from families. It is noted the car seat tests for safe discharge is performed in the unit, and this data is recorded on the cardiac monitors.

Both intensive care units have up-to-date client records, and the record is a hybrid of electronic and paper. Evidence-based order sets are used for specific protocols. The teams receive education on the information systems and technology in these units including for the cardiac monitors, dialysis machines, and Alaris intravenous pumps.

Priority Process: Impact on Outcomes

The neonatal intensive care unit uses two identification bands on every infant and one on the mother. The mother and father's armbands are checked upon entry to the unit as a security procedure. Two nurses double-check the identification of the breast milk with baby's identification before it is given to mom to administer. The clinical manager in the unit is leading quality improvement work at the front line, and has implemented the "Quality Improvement Ticket" to engage front-line staff.

Patient arm bands are taped to the foot of the bed in most cases where patients are critically ill. The teams check client identifiers with the medical record number, most responsible nurse and birth date. Many medications and drips have independent double checks. Purple bands are used for patients at risk for falls. Work stations are outside each patient room, with cardiac monitors and all client documentation.

There is an intensive care unit charter stating: "I Will..." which is posted on the wall in the unit, and which staff members have signed, and this is nice touch. Encouragement is offered to continue to build capacity for improvement work at the front line.

All units have quality improvement boards, with data that are visible to patients and families and staff.

Priority Process: Organ and Tissue Donation

Staff members are trained in the Trillium Gift of Life processes. The regional coordinator for Trillium Gift of Life has an office on the unit and is a great resource for staff.

3.2.6 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

The Diagnostic Imaging team provide services using six modalities namely: general x-ray; bone mineral density; ultrasound; magnetic resonance imaging; computerized tomography; interventional radiology and mammography. Each of these services are well organized and delivered by staff members that are patient focused not only in their individual approaches to patients but in the design, structure and delivery of each of the six modalities. During the survey there was an energy and enthusiasm amongst the several staff members interviewed during the tracer. They demonstrated pride in the work they do.

The team partners with outside agencies with the aim to improve services to patients. For example, there is a strong relationship with the Osteoporosis Canada - Fracture Clinic Screening Program. The result of this relationship is their ability to effectively address high-risk patients.

The team collects and monitors multiple indicators for the purpose of making changes to continually improve the program. For example, there is an annual patient satisfaction survey where the team compiles the responses, analyzes the data and makes changes based on the analysis of the results.

Staff members have credentials for the provision of specialized services. Nurses from other departments provide sedation to patients that come to Diagnostic Imaging for services. When a patient requires a sedative, a nurse accompanies the patient to radiology, administers the sedative and remains until the procedure is completed.

The physical space for each of the six modalities is adequate. However, the need for additional space is indicated in some areas such as reprocessing. The team has implemented effective signage so that way finding is made easy.

There is a comprehensive preventive maintenance program. The team reviews the log for maintenance and downtime in order to identify and address trends in maintenance issues.

There are well-established policies and processes for requesting diagnostic imaging services both on a regular basis and in stat situations. There are good processes for the provision of information to patients and families on diagnostic imaging examinations as well as post-procedure instructions. This is articulated in several brochures that are available for each of the modalities.

The team closely monitors time frames for interpreting diagnostic imaging results. There is a process for informing the referring physician following unusual, unexpected or urgent findings.

Safety is a highlighted in several ways in each of the modalities. The team is encouraged to review the process for screening patients for falls to ensure that the current procedure is adequate and meets the intent of the organization-wide program.

The policy and procedure manual for the department is comprehensive and up to date. Team members depend on the manual and it is readily available in each of the modalities. There are well-established quality control procedures for each of the modalities and these are strictly followed.

Quality improvement objectives are aligned with the organization's strategic and operational plans. Data are collected and analyzed for the purpose of improving services. Dashboards are used in each of the modalities. Other examples of monitoring indicators include radiologists turnaround times and patient satisfaction. Information is shared with the whole team and across the organization as appropriate. Quality improvement activities are regularly reviewed for feasibility, relevance and usefulness.

3.2.7 Standards Set: Emergency Department - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The emergency leadership team collects information about the community it serves and uses it to set priorities and define scope of services. There are regional services for stroke, trauma, psychiatry, renal and cancer. The physical plant is well-equipped to serve these populations. The emergency department operations council meets every two weeks with various clinical program leaders and senior leadership to review metrics that will drive performance. Patient satisfaction data are shared with the team and used to make quality improvements.

The electronic tracking board is used to manage flow of the department and admitted patients. It is readily accessible via computers and workstations throughout the department. There is a concurrent coder in the department that reviews charts to ensure timely and complete documentation.

Quarterly meetings with Emergency Medical Services and St Mary's General Hospital take place to review off-load data. It is recommended that a regional response to emergency disasters be considered for coordinated planning purposes.

There is a strong interdisciplinary team focus on care of the elderly in the emergency department. This team which includes a geriatric emergency management nurse, social worker, physiotherapist and Waterloo Wellington Community Care Access Centre work collaboratively to determine the most appropriate disposition. To support a safe discharge and prevent readmissions there is follow-up by telephone within 24-48 hours, along with a letter to the family physician.

Priority Process: Competency

There is a comprehensive orientation program for new hires and which has been designed by the emergency department educator. There is educational support for triage, trauma nursing critical care, pediatric advanced life support, neonatal resuscitation program and advanced cardiac life support.

Staff members receive ongoing training for intravenous pumps and any new equipment. Training specific to the emergency department also includes education to prevent workplace violence, code white training and de-escalation techniques. There is a 24/7 crisis nurse, respiratory therapy support, security 24/7, and an administrative coordinator on site in the off hours.

There is peer recognition program and it aligns with the values of the organization.

Priority Process: Episode of Care

The emergency department team demonstrates excellent interdisciplinary teamwork to collaboratively provide a high level of quality care. Concern for patient safety is evidenced in the many practices that are in place such as falls prevention, monitoring of safety information and patient satisfaction scores. The team is commended for implementing the communication technique known as: acknowledge, introduce, duration, explanation and thank you. These well-known behaviours are important to reduce anxiety and increase satisfaction. In fact, the team noticed an increase in their patient satisfaction scores shortly after implementation. Triage would be an area that would benefit from this communication technique. This will be an important practice to sustain.

Transfer of accountability is completed using a situation, background, assessment, recommendation paper documentation tool, along with a verbal telephone report, or by being accompanied by a nurse to critical care or pediatrics. This tool is standardized across the organization and consistently used for transfer of accountability. The emergency department team is urged to monitor and audit the process of telephone report to ensure there are no delays in transfer to in-patient beds, which could not only impact quality and safety, but emergency department metrics.

The team works well with Emergency Medical Services to monitor off-load times. The nurse practitioner is highly valued working both independently and collaboratively with the emergency physicians and consultants to support her scope of practice. There are good consultant coverage and response times. The team has improved the wait times for admits and time to in-patient bed.

Priority Process: Decision Support

Evidence-based guidelines and order sets are used for various patient populations. Medical directives are also used to support parallel processing and scopes of practice for various professionals.

Priority Process: Impact on Outcomes

The team collects patient satisfaction data and shares it on the quality board for patients and staff. Client satisfaction data are shared with staff members and used to make continuous improvements. The team shares information about quality improvement activities such as the IDEAS program and priorities to further quality improvement activities.

During the survey, client identifiers were checked before providing care, and handwashing was consistently carried out. Falls prevention strategies are in place.

The Waterloo Wellington Local Health Integrated Network provides benchmarking data for certain indicators. The team leaders use a business intelligence dashboard to monitor metrics that drive performance.

Priority Process: Organ and Tissue Donation

The team is familiar with the process for organ donation. A resource binder is kept in the resuscitation room.

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

Unmet Criteria		High Priority Criteria
Priority Process: Infection Prevention and Control		
14.1	The organization has a quality improvement plan for the IPC program.	!
14.2	The organization monitors IPC performance measures.	
14.3	The organization seeks input from staff, services providers, volunteers, and clients and families on components of the IPC program.	
14.4	The organization uses the information it collects about the IPC program to identify successes and opportunities for improvement, and makes improvements in a timely way.	
14.5	The organization shares evaluation results with staff, service providers, volunteers, clients, and families.	

Surveyor comments on the priority process(es)

Priority Process: Infection Prevention and Control

The infection prevention and control program at Grand River Hospital is led by an enthusiastic, dedicated knowledgeable team of manager, four full-time infection control professionals and a medical director. All infection control practitioner have certification in infection control. The medical director holds specializations in both infectious diseases and microbiology and is director of the clinical microbiology laboratory. After hours, infection control practitioners and medical coverage are available via the on-call administrator. On call medical coverage is shared co-jointly with another infectious diseases physician. The staffing complement meets current recommendations of one infection control practitioner for every 125 acute care beds and one infection control practitioner for every 250 beds in complex care. Overall, the resources meet needs, but can be challenging when crisis situations arise. Management and staff members reported during the survey that the team is readily available as required.

Program oversight is provided by the joint Grand River Hospital and St. Mary's General Hospital Infection Control committee. Annual program goals and objective are approved and monitored by the committee.

There are well-established partnerships with building services, occupational health, environmental services, and food services, all of whom are members of the Joint Infection Control committee. The program provides consultation on all new construction and renovations.

Infection control works closely with occupational health and sits as an ad hoc member on the Joint Occupational Health and Safety committee. All infection prevention and control policies are reviewed by the Joint Occupational Health and Safety committee annually in compliance with the Occupational Health and Safety Act. Occupational health and safety policies and procedures to reduce the risk of infection transmission meet Ontario Hospital Association and Ontario Medical Association guidelines. There is an opportunity to review the occupational health and safety policies with infection control implications at the

infection control committee, as this does not occur at this time. There is an infection control representative on the Sharps committee which oversees the sharps safety program.

The hand-hygiene program has been adopted for a number of years. There is a well-established audit process that infection control practitioners perform. Hand-hygiene compliance results are reported back to the units on a regular basis. The current focus is on finding innovative ways of leveraging, sustaining and improving the foundational work. Recently, the infection prevention and control service partnered with Cambridge Memorial Hospital to conduct cross-over hand-hygiene audits in their respective hospitals. Results indicated the compliance was lower when the staff members did not recognize the auditor. This finding is in keeping with current research in this area. The dedicated hand-hygiene sinks in the clinical units are small free standing sinks with hand controls, which do not meet current Provincial Infectious Diseases Advisory Committee specifications. This needs to be assessed and considered as future renovations are done. Hand-hygiene audits are used to give constructive feedback to staff members and reinforce best practices.

Infection control policies and procedures are reviewed annually and as the new evidence emerges. There is a well-developed environmental services program with evidence of full input from infection prevention and control. Cleaning schedules align with Provincial Infectious Diseases Advisory Committee risk levels. The Microbial simulation is a quality-monitoring program that is used to audit/evaluate the cleaning performance and identify environmental areas that are difficult to clean.

Comprehensive surveillance is carried out. Surveillance includes central line primary blood stream infections, ventilator associated pneumonia, surgical site infections for clean surgeries in orthopedics, general surgery and cesarean sections, methicillin resistant staphylococcus aureus and vancomycin resistant enterococcus. Infection rates are reported back to the clinical areas. Surgical site rates are reported to the surgeons and surgical service on a quarterly basis. Overall infection rates have shown a downward trend apart from methicillin resistant staphylococcus aureus which has higher rates at the Freeport campus.

There is good laboratory support from microbiology. Increased access to molecular testing has resulted in shorter turn around time for results and also decreased unnecessary isolation bed days.

The physical space for cleaning and reprocessing of endocavity probes in diagnostic imaging is cramped and does not allow for adequate separation of the clean and dirty, in keeping with current recommendations. This process requires review.

There is a low threshold for declaring outbreaks and an overall decreased number of declared outbreaks. The outbreak policy and process are well defined. Results of outbreak investigations are analyzed and implementation of recommendations is tracked. The organization has an established Ebola response plan as part of the emergency preparedness plan. There are policies for the management of viral hemorrhagic fevers.

Although there are initiatives to evaluate specific aspects of the infection control program the service has yet to develop a formal quality improvement plan for the infection prevention and control program. Overall, the program is well developed and managed. The team is proud of the work it does. The new information management platform will significantly enable the team to carry out surveillance which is currently time consuming and labour intensive.

3.2.9 Standards Set: Medication Management Standards - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Medication Management		
7.2	The organization has a policy for when and how to override CPOE alerts.	!
7.4	The organization regularly tests the CPOE to make sure that the alerts built into the system are working.	!
7.5	The organization manages alert fatigue by regularly evaluating the type of alerts required by the CPOE based on best practice information and input from staff and service providers.	
7.6	The organization integrates the CPOE with other information systems used by the organization for medication management.	!
8.2	The organization has a policy for when and how to override alerts by the pharmacy computer system.	!
14.5	The organization helps provide minimal distractions, interruptions and noise for prescribing, writing and verifying medication orders either manually or electronically.	
Surveyor comments on the priority process(es)		
Priority Process: Medication Management		

This team continues to make improvements in medication management practices. There is a medication safety plan that was developed and supported by senior leadership and the board and significant improvements have been made since the previous survey.

The Medication Safety newsletter is a valuable resource used to update, inform and educate staff members on incident reporting data, corporate trends in safety incidents and medication safety practices. This will assist in continuing to develop a patient safety culture.
There is good committee structure and processes that include a Medication Safety committee chaired by the Vice President Cancer, Renal and Diagnositc Services, Grand River Hospital/Regional Vice President, Cancer Services, Waterloo Wellington Regional Cancer Program, a Medication Management committee with nursing representatives, pharmacy and risk management and a Medication and Therapeutics committee that reports in to the Medical Advisory committee.

There is a five-phased multi-year pharmacy renovation plan underway, and the organization is currently in phase four. The many significant improvements to the physical space include appropriate lighting, ventilation, a quiet area where orders are transcribed and entered into computers, and an improved medication preparation and dispensing area. These renovations will assist with improved compliance to these medication management practices.

A vast amount of work has been undertaken to move from a centralized to a decentralized medication distribution model across both the Kitchen Waterloo and Freeport campuses. The pharmacy quality improvement coordinator used a number of quality improvement tools and techniques to support the decision-making process. Tools included process mapping, failure modes effect analysis, gap analysis, and spaghetti mapping as well as others. The team has successfully implemented the AcuDose decentralized distribution system across the two sites. This process change has significantly improved compliance with medication management. Both nursing and pharmacy are duly commended.

New intravenous smart pumps have been implemented across the organization. There is a policy that outlines infusion pump usage and procedures. There is also a continuous quality improvement pump committee in place to monitor pump data for safe administration of intravenous and epidural medications. The organization is commended for the high compliance to using the guard rail technology.

The practice for medication reconciliation is excellent. There is a comprehensive policy, process and other tools such a prospective process maps to support staff learning. Pharmacy has implemented an innovative strategy to improve accuracy and completion of all best possible medication histories across Grand River Hospital. This is currently being carried out by dedicating resources in the form of University of Waterloo Pharmacy Co-Op students being assigned to areas where there are gaps in the medication reconciliation process.

To date, chemotherapy is the only area with computerized physician order entry. There is an important drug access facilitator role in place to assist with accessing drugs for compassionate and other reasons. The intravenous 1 negative pressure room for sterile chemotherapy drug preparation is a small area in which for four staff work, and it does not have an ante room. Consideration needs to be given to expediting the renovations to this area for staff safety, and to prevent contamination and maintain sterility.

The organization monitors compliance to required organizational practices via annual audits. While there has been improvement with non-emergency telephone and verbal orders, these are still in evidence. There has been a minimal decrease in the percentage of orders written using dangerous abbreviations in the last three years. Policies exist but are not consistently being followed. The organization is strongly encouraged to continue to audit compliance to these safety practices and implement an accountability framework as well.

3.2.10 Standards Set: Medicine Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
11.6 Following transition or end of service, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Medicine program leadership has undergone changes, both administrative and medical. Best practice model of care and service delivery changes have been implemented on all units to serve a broad range of medical conditions. The program comprises a clinical teaching unit, regional stroke, acute care of the elderly and general internal medicine, and a newly designed general internal medicine rapid assessment clinic.

The medicine team collects demographic and community information to determine the scope of service delivery. The teams use this data to design and implement new programs and services such as the aforementioned clinical teaching unit, acute care of the elderly and the general internal medicine rapid assessment clinic. Each of the in-patient units has specific goals and objectives and measures these goals using scorecard metrics. All units have quality boards to display metrics, and the boards are visible to clients and families.

The pediatrics unit is a 12-bed closed unit with capacity to open two additional beds if necessary, and an out-patient pediatric clinic. The service admits clients with a broad range of conditions and ages up to 18 years. Major reasons for admission includes urinary tract infections, sepsis, hyperbilirubinemia, new onset diabetes, cystic fibrosis, pediatric oncology, cycle cell anemia, eating disorders, anemia and day surgery tonsillectomies. There are seasonal variances in occupancy, with increased demand in the winter season. As more patients are effectively managed in the out-patient setting, the overall acuity in the in-patient unit has increased.

The pediatric out-patient clinics comprise a diabetes clinic, cystic fibrosis clinic, chemotherapy clinic, respiratory syncital virus clinic, which runs from November to April, and a circumcision clinic.

Annual goals and objectives are developed in the department of pediatrics planning cycle and brought forward for corporate approval by the administrative director and chief of pediatrics.

Priority Process: Competency

The Medicine program team is an engaged and skilled interdisciplinary team. The Adult Medicine team members have position profiles for each role in the team. The front-line staff members are appreciative of the educational opportunities available to them. Education is provided both internally and externally, and is specific to the various specialties such as stroke, palliative, peritoneal dialysis, and the model of care for adult care of the elderly. Intravenous pump training is provided on a regular basis and documented. The teams spoke about the various ways they are recognized for their contributions. Performance reviews are well done.

The interdisciplinary team for the pediatric unit in medicine includes registered nurses, social work, pharmacist, and child life specialist, dietician, and 12 pediatricians, four of whom cross-cover after hours. Team members are knowledgeable, enthusiastic and display a strong sense of pride in the unit, the team and work they do. All nursing staff have pediatric advanced life support certification. The clinic nurses administering chemotherapy have completed the De Sousa certification. There is a well-developed unit orientation program. Required hospital education is completed via the learning management system. All staff members have completed infusion pump training. A number of the nurses have completed breastfeeding certification. An intense central venous line training program have recently been done in order to maintain skills.

Regular team debriefings are done post code, and following unit bereavement or a traumatic event. There are numerous activities to recognize staff. These include the: “High Five” board which displays client and family words of appreciation, and where positive comments from client satisfaction are posted. Several staff members have completed the: “crucial conversations” course, which is offered in-house to learn how to communicate better.

Priority Process: Episode of Care

The approach to care on the adult medicine unit is patient and family centred. The teams are passionate about their work and bring a quality and safety focus to the delivery of care. There is a real sense of pride in their work. The clinical teaching unit is a relatively new and unique model of care, staffed by five core general medicine internists, with a strong academic teaching focus and attracting many diverse learners. The Acute Care for the Elderly is also a relatively new model of care. This is a locked and secure unit with specialized geriatric services. The Hospital Elder Life program, under the leadership of a recreational therapist is a best practice and serves the patients well.

Each of the units has a discharge lounge, staffed by a registered practical nurse that assists with patient flow to free-up patient rooms for new admissions. This is proving to be a very successful initiative. The Geriatric Internal Medicine Rapid Assessment Clinic is a new out-patient clinic that provides a service to assist with earlier discharge, prevent admissions from the emergency department, and provide a resource to family physicians to improve access to consultant referrals

The overall approach to care on the pediatric medicine unit is patient and family centred. The in-patient rooms are spacious with accommodations for family. There is a family lounge and nutrition centre. The white boards in the client rooms are used for timely communications between the care team and parents. The Family Advisory Council meets regularly to discuss the patient experience and make recommendations. The Children's' Program's patient experience survey was recently changed to a short form. The form now includes the questions most pertinent to family, and this form is the result of a recommendation from the council.

A child life specialist works with clients on the in-patient unit and out-patient clinics. Admission assessments are comprehensive and care planning is well done. The Children's' Program In-patient Unit Parent Guidebook is used to orientate parents to the service. Parents sign a: "Safety Pledge" to acknowledge that they have reviewed their role in the safety of their child. Fall risk assessment and skin assessment is customized for the pediatric populations.

Priority Process: Decision Support

The teams receive the data they need to evaluate their services. Outcome indicators are tracked. Each of the units has a quality board and units track various safety initiatives using safety crosses. The Hospital Elder Life program is a comprehensive best practice that ensures optimal care for older adults and helps to reduce delirium. This is a leading practice and is available throughout medicine and surgery.

There is an up-to-date record for all clients and the record is a hybrid of electronic and hard copy.

Priority Process: Impact on Outcomes

Falls prevention is well-implemented on the adult medicine units, with identification of falls risk and bed alarms. The team identifies the populations at risk. The teams have begun implementing delirium training. Prevention of pressure ulcers is a focus as is use of specialized mattresses. Prevalence and incident audits have been done recently. It is recommended these audits continue for both prevalence and incident at regular intervals, including hospital acquired pressure ulcers. There is a growing expertise in regional stroke care, with quality-based procedures implementation.

The clinical unit manager in pediatric medicine is leading the work to introduce the model for improvement and build capacity to carry out improvement work at the front line. Note is made of the: "Pediatrics Quality Improvement Ticket" that has been adopted for staff members and families to bring forward any problems needing improvement along with a proposed solution.

The Children's Program Patient Experience surveys are entered into Survey Monkey. Monthly reports are posted on the unit quality board. Time to admission to an in-patient bed is another area of focus for the team.

3.2.11 Standards Set: Mental Health Services - Direct Service Provision

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

The clinical leadership teams of each of the five programs reviewed are commended for their focus on providing and maintaining a safe and comfortable environment for their respective populations. The teams show an enthusiasm, knowledge, passion and commitment in their delivery of care and services within a well-functioning interdisciplinary environment. The physical spaces are relatively well-appointed and designed to meet the needs of the populations.

The current program and service offerings of the mental health program reflect an understanding and analysis of the needs of the client population. For example, the current transition unit was established to facilitate the seamless transition of the client from being an in-patient in a hospital setting to being successfully integrated in the community.

The teams' goals and objectives for the program are focused on two particular areas. The: “Quality Plan for 2014 – 2015 - Instilling hope…fostering recovery” outlines the goals and objectives for the program covering the five program areas: access to care; appropriateness of care; patient safety; patient experience and quality of worklife. The Quality and Patient Safety committee for the Mental Health and Addictions program have developed three major goals. These goals are: to decrease the number of patients with mental health and addictions having frequent emergency department visits; to decrease overall events with harm for elopements and falls, and to improve access to serve more patients well. Each of these goals is monitored and reported on a regular basis using a standardized approach.

Each of the program areas has established a client assessment process for services that works well, and forms the basis for interdisciplinary care planning. A good example is the Seniors Specialized Mental Health program which uses the physical, intellectual, emotional, environment social self care plan.

Priority Process: Competency

Care is provided by an interdisciplinary team whose members are focused on addressing the unique needs of every client. As an interdisciplinary team the members communicate in multiple ways to ensure that there is commonality of focus for every client and their individualized care plan. One example is the “hot spots” conversation that occurs every morning. In this discussion, team members from all disciplines contribute information on changes to individual clients and provide information that is pertinent for the entire team. These discussions are short, approximately 15 minutes, and are effective in ensuring transfer of relevant client information.

All staff members are recruited based on their individual skills and training. A thorough orientation to the organization and the unit is provided to all new employees. The orientation includes such topics as: safe patient handling; palliative care pain management; inter-professional practice; smoking cessation; intervention infection control; clinical Medworxx; bed-board; central lines and intravenous access de-escalation. Other specific training for mental health staff includes: therapeutic relationships; recovery: Lived Experience; inter-professional care documentation; trauma; informed care dementia, delirium and depression; consent and capacity; community treatment order rights; mental health and the law; Mental Health Status Exam and extrapyramidal symptoms. Refresher programs are provided for all topics

The Mental Health and Addictions Program's child and adolescent program also has its own orientation which is built on the Canadian Nurses Association standards for psychiatric mental health nursing, and the: Substance Abuse and Mental Health Services Administration Components of Recovery. This manual contains information pertaining to both general clinical orientation, mental health and addictions unit-specific orientation, core competencies and learning activities. This orientation is aimed at assisting participants in understanding the competencies that are needed to meet the expectations of clinical practice.

Priority Process: Episode of Care

Five programs in Mental Health Services were reviewed. These are: The Adult Inpatient unit at Kitchener-Waterloo Campus and the Child and Adolescent Inpatient unit at Kitchener-Waterloo Campus; Specialized Mental Health–Adult Inpatient program includes adult transition and senior's care at the Freeport campus. There are established criteria for admission to each of these programs. There is a well-established assessment process for client admission to each of the programs.

The team uses a “recovery based” philosophy in the delivery of care. Needs and strengths of the client are identified and the client is involved in the development of care goals and their implementation with the interdisciplinary team. Care plans are developed with involvement of the client and family.

Programming is put in place to address client’s individual needs. Evidence-based practice is often used to influence program design and delivery for patients. For example, in the child and adolescent unit, the: “Let’s Get Moving” program was the result of research and use of best practice. This program is now an integral part of the delivery of services on that unit because of the proven benefit to adolescents being treated for a mental health issue.

Risk assessments are conducted on every client for falls. There is also a monitoring process for risk of suicide. Reassessments of these clients for these identified risks are repeated on a frequent basis.

The team offers much support for patients and their families as well as providing forums for persons that experience mental illness and their families. One example is the Families for Awareness, Change and Education, which is a family advisory council. This group acts as an advisory resource committee to Grand River Hospital's Mental Health and Addictions program. There is also a community advisory panel, and this group provides a forum for community partners, individuals with lived experience of a mental health and addiction issue, and family members to offer advice and feedback around program planning and service delivery. A key aspect of this panel is to ensure programs and services are aligned with recovery principles, the program vision, mission and values, and the program's annual goals.

The teams are commended for the seamless approach to client discharge and transfer. This is accomplished, in part, by the strong collaborative relationships that exist with community support groups and agencies. Continuity of services and supports continue so that the client's transition is seamless. One example of this is the Adult Transition team which is an interdisciplinary team that provides comprehensive out-patient services to individuals that have been discharged from Specialized Mental Health in-patient programs. The team works collaboratively with the client, the in-patient team, and family and community partners to enable clients to maintain and improve their mental health and to achieve their recovery goals while optimizing community integration.

Priority Process: Decision Support

There is excellent communications amongst the interdisciplinary services in each of the programs reviewed. This communication exists internally as well as externally with community supports so that the transition for patients from the in-patient areas to the community is seamless.

The interdisciplinary team currently functions well in its support of the goals of care. However, the charting does not reflect the interdisciplinary care model that is provided. The team has modified the current program, and it is somewhat disjointed from the perspective of supporting the interdisciplinary process. It is suggested that as the organization pursues a replacement for the current program, care will need to be taken so that the new automated charting process can complement the interdisciplinary care provided.

The team members were able to cite several examples of using evidence-based guidelines in the design and delivery of care in the Mental Health Services programs.

Priority Process: Impact on Outcomes

Significant emphasis is placed on ensuring safety in the units and it includes the identification of risks for team members. The Risk-Pro system is used for reporting and analyzing incidents. Team members receive training in being able to identify and reduce and manage risks for clients and staff.

Discussions occur with all patients and their families regarding risks. This conversation is supported by the literature on risk issues such as falls, which is provided to patients and their families.

Team members are familiar with the organization's policy on disclosure of adverse events to the affected clients and families. Examples of where team members have participated in disclosure were provided during the survey.

The team has established measurable goals and objectives for the service. Data are collected and analyzed, with corrective actions taken when indicated.

3.2.12 Standards Set: Obstetrics Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	
Surveyor comments on the priority process(es)	
Priority Process: Clinical Leadership	
The leadership of this unit establishes appropriate services and ensures quality services. The leadership is deeply committed to following best practices and closely monitors performance on a series of indicators.	
Priority Process: Competency	
This obstetrical unit manages 4300 deliveries per year, with good outcomes. Routine deliveries are all done in the Labour Delivery Recovery Postpartum rooms, and high priority is placed on skin to skin contact.	
Priority Process: Episode of Care	
Clinical management follows best practices. The team provides detailed written and verbal information on a wide variety of clinical issues. Patients and their families are generally pleased with their care.	
Priority Process: Decision Support	
Patient records are all paper based. Information on pregnant women is sent via facsimile from the offices of the obstetricians and midwives.	

Priority Process: Impact on Outcomes

The unit places a strong emphasis on safety and quality. Adverse events are all investigated and managed. A strategy to reduce infant falls has been developed and implemented.

3.2.13 Standards Set: Organ and Tissue Donation Standards for Deceased Donors - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	
Priority Process: Organ and Tissue Donation	
The organization has met all criteria for this priority process.	
Surveyor comments on the priority process(es)	
Priority Process: Clinical Leadership	
The organization's donation coordinator works closely with the Trillium Gift of Life Network, which handles most of the logistics.	
Priority Process: Competency	
The donation coordinator works closely with the Trillium Gift of Life Network which arranges all transplant services.	
Priority Process: Episode of Care	
Please refer to earlier comments about organ and tissue donation.	

Priority Process: Decision Support

The issues of organ and tissue donation are handled by Trillium Gift of Life Network.

Priority Process: Impact on Outcomes

Issues of organ and tissue donation are mostly handled by Trillium Gift of Life Network.

Priority Process: Organ and Tissue Donation

Issues of tissue and organ donation are managed in coordination with Trillium Gift of Life Network.

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

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

The organization has met all criteria for this priority process.

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

Grand River Hospital has a robust Point-of-Care Testing system. The vast majority of the testing is glucose, and aggressive ongoing quality control measures have dramatically reduced errors to less than four percent.

3.2.15 Standards Set: Rehabilitation 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	
11.5 Following transition or end of service, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning.	
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

This accreditation review included the rehabilitation unit, complex care and restorative care units at the Freeport campus of Grand River Hospital.

Services are reviewed annually as part of the corporate operating planning process. The focus this year is on stroke. A right-sizing exercise was done to determine the number of stroke rehabilitation beds across the region. Annual goals and objectives are reviewed at the bi-annual senior leadership meetings.

All patient referrals are via the Waterloo Wellington Community Care Access Centre. The team works closely with the centre and participates on the provincial Rehabilitative Care Alliance committees. Two major foci are patient-reported outcomes and establishment of a community database.

The team welcomes a full complement of students including nursing, physiotherapy, occupational therapy and medicine. Volunteers play a major role in care delivery for example, the Hospital Elder Life program is run by trained volunteers that come to work with clients three times per day. Stroke recovery volunteers visit stroke patient to provide peer support.

Priority Process: Competency

The service is supported by a full interdisciplinary team of registered nurses, registered practical nurses, social worker, pharmacist, nurse practitioner, dietician, pharmacists, and two general practitioners that visit the units three days per week. Medical consultation is provided by a physiatrist, psychiatrist, gerontologist and respirologist that make weekly visits. Pharmacy is available on-call after hours and weekends.

There is a well-developed education program tailored to the specific patient population. Education topics include lifts and transfers, safety, pain management, and other topics. Participation in online webinars and team educational rounds is encouraged. The education board includes information on upcoming topics and required education such as policy updates, use of new equipment, and so on. The organization offers a tuition assistance program. Occupational therapy and physiotherapy avail of the ministry funding for continued education. The stipend allowed for student mentorship is banked by the hospital for individual staff education. The physiatrist leads monthly rounds. Regular training is provided by the occupational health therapist.

Changes in funding this year for physiotherapy and occupational therapy have resulted in increased coverage by both disciplines and this has allowed the service to meet ministry length of stay targets for stroke in particular, and resulted in a significant improvement in the Functional Independence Measure scores from 1 to 1.5.

The change in the staffing model has also resulted in more collaborative working relationships and allowed nursing in particular to maximize its scope of practice. Staff members report that the new approach has resulted in a more mindful approach to the concept of "wasted days". The functional independence measure scores are used to calculate the predicted discharge dates for each of the patients and benchmarked within the provincial bands. The service is exceeding the provincial targets. External services have come to shadow and learn from this initiative.

Priority Process: Episode of Care

All client admissions come through the Waterloo Wellington Community Care Access Centre and are admitted to either the rehabilitation, complex continuing care or restorative care units.

Clients and families receive a comprehensive orientation to the service. Client education is well done, supported by written materials specific to the service. Safety is a major focus in client teaching, particularly fall prevention. Client rights and the process to address concerns is provided verbally and in writing. Advanced directives are validated with the client or substitute decision maker.

The electronic record includes the Horizon Electronic Documentation (HED) system which is used for interdisciplinary documentation. Laboratory and Diagnostic Imaging is in a separate electronic system. The Care Organizer section of the Horizon Electronic Documentation is used to develop and update the care plan on an ongoing basis.

Interdisciplinary assessment and care planning is comprehensive and well done. All patients are assessed for falls risk, pressure ulcers, and eligibility for Venous Thromboembolism prophylaxis. Treatment goals are revaluated daily and discharge plans are discussed daily.

The major thrust in complex continuing care and Restorative Care is maximizing the opportunities to assist the client "graduate" to the next level of care. The team is beginning to see some early successes in the number of complex care clients discharged to long term care and restorative transitions to complex care. The length of stay from restorative care clients has been reduced from forty four to thirty six days. A ventilator strategy for the long term ventilated patients on complex continuing care is in the final stages of development under the leadership of the unit manager.

Nursing can order a consult with the wound care team for clients score at risk on the Braden Scale. Social Work and Spiritual Care provide emotional support for clients dealing with grief associated with lifestyle changes.

Medication Reconciliation is well done and clearly documented upon admission, transfer and discharge from service. Pharmacy is an integral part of the team and the external organizations and medication management process.

Transfer of Information tools are used at all transition points including inter-facility, intra-facility and change of shift. Transfer of information is done at the bedside with the participation of the client at change of shift.

A range of recreational programs are offered in the restorative care unit including music therapy. Group therapy is offered in the complex continuing unit.

Laboratory services are provided on site. A number of staff are trained in venipuncture.

Clients spoken to were complimentary about the service. Clients noted they were involved in care and treated with respect and that the therapy and education was excellent. Cost of parking, bedside television and internet access was considered prohibitive for elderly

Priority Process: Decision Support

The client record is kept up-to-date for every visit. While the client record is a hybrid of Horizon electronic documentation and paper, the team has maximized the use of the electronic tool.

Priority Process: Impact on Outcomes

There is a strong commitment to quality improvement, with an emphasis on maximizing client outcomes. The teams are fully engaged in improvement work. There is evidence of significant improvement in a number of metrics.

Each of the units has a quality board aligning the key performance indicators for the service within the four quality dimensions. A recently introduced metrics board displays a range of key performance indicators. Quality storyboards are used to display team improvement work.

Indicators are tracked using the rehabilitation and complex continuing care scorecard. Performance reporting is done at the senior quality team meeting. A formal process to evaluate the effectiveness of the quality improvement plan has yet to be developed.

The organization's processes are followed for the reporting and follow-up of sentinel events and adverse events. Staff members are knowledgeable about the disclosure policy and can readily speak to the process used in their service.

3.2.16 Standards Set: Transfusion Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Transfusion Services	

The organization has met all criteria for this priority process.

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

The blood bank provides services for Grand River Hospital and St. Mary's General Hospital. There is a large and comprehensive inventory of blood products, and utilization stats are excellent. There is no home transfusion service in the region.

3.2.17 Priority Process: Surgical Procedures

Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge

Unmet Criteria		High Priority Criteria
Standards Set: Perioperative Services and Invasive Procedures Standards		
7.8	The team verifies that the client's informed consent has been obtained prior to going to the operating/procedure room.	!
8.4	With the involvement of the client, family, or caregiver (as appropriate), the team generates a Best Possible Medication History (BPMH) and uses it to reconcile client medications at transitions of care.	ROP
8.4.5	The team provides the client, community-based health care provider, and community pharmacy (as appropriate) with a complete list of medications the client should be taking following discharge.	**MAJOR**
10.1	The physical layout of the operating and/or procedure room(s) and equipment are designed to consider client flow, traffic patterns, the types of procedures performed, ergonomics, and equipment movement logistics.	
24.8	The team follows a process to follow up with discharged day surgery clients.	

Surveyor comments on the priority process(es)

The Grand River Hospital performs about 4800 in-patient procedures per year, the vast majority of which are general surgery and orthopedics, with a smaller number of gynecology cases. There is also about 13,000 day surgery cases annually.

The flow-through in the surgical unit is not optimal due to physical constraints. Patients are registered, and then must wait in a crowded waiting room until they are taken down to the operating room via a long corridor. Then they wait just outside the main operating room desk in a crowded area with no privacy to be taken to the operating room. The corridor along which they are taken is narrow and busy, with many staff members going back and forth. Along this same narrow corridor, patients are taken from the operating room to the post-anesthetic care unit.

Most of the operating rooms are small in size, with one door so clean and contaminated carts come and go via this same door. Pre-operative marking of the surgical site is often done in the corridor outside the operating room, which is not optimal. Elective surgical cases that are booked via the surgeons' offices do not document in writing that they have consented to the surgery. Hospital policy does not clearly state that patient signatures are required. It is suggested that policy be revisited.

There is good pre-operative and post-operative management of joint replacement cases, and a central booking process. There is also evidence of extensive patient teaching.

The in-patient surgical unit is small in size, with crowded corridors that are cluttered. During the survey the unit was undergoing renovations to install a new Accudose unit, so the area was extremely crowded. Discharge medication management is not consistent with best practices, but planned improvement to the process should resolve this issue.

Section 4 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.

4.1 Governance Functioning Tool

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: August 8, 2014 to October 10, 2014**
- **Number of responses: 7**

Governance Functioning Tool Results

		% Disagree	% Neutral	% Agree	%Agree * Canadian Average
		Organization	Organization	Organization	
1	We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations.	0	0	100	93
2	Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	0	0	100	95
3	We have sub-committees that have clearly-defined roles and responsibilities.	0	0	100	97
4	Our roles and responsibilities are clearly identified and distinguished from those delegated to the CEO and/or senior management. We do not become overly involved in management issues.	0	0	100	95
5	We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decisionmaking.	0	0	100	92

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
6 Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	95
7 Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	98
8 Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	0	0	100	96
9 Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	0	0	100	94
10 Our governance processes make sure that everyone participates in decision-making.	0	0	100	94
11 Individual members are actively involved in policy-making and strategic planning.	0	0	100	89
12 The composition of our governing body contributes to high governance and leadership performance.	0	0	100	93
13 Our governing body’s dynamics enable group dialogue and discussion. Individual members ask for and listen to one another’s ideas and input.	0	0	100	96
14 Our ongoing education and professional development is encouraged.	0	0	100	88
15 Working relationships among individual members and committees are positive.	0	0	100	97
16 We have a process to set bylaws and corporate policies.	0	0	100	95
17 Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	97
18 We formally evaluate our own performance on a regular basis.	0	0	100	82
19 We benchmark our performance against other similar organizations and/or national standards.	0	14	86	72
20 Contributions of individual members are reviewed regularly.	0	0	100	64

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
21 As a team, we regularly review how we function together and how our governance processes could be improved.	0	0	100	81
22 There is a process for improving individual effectiveness when non-performance is an issue.	0	0	100	64
23 We regularly identify areas for improvement and engage in our own quality improvement activities.	0	0	100	80
24 As a governing body, we annually release a formal statement of our achievements that is shared with the organization's staff as well as external partners and the community.	14	0	86	84
25 As individual members, we receive adequate feedback about our contribution to the governing body.	0	0	100	69
26 Our chair has clear roles and responsibilities and runs the governing body effectively.	0	0	100	96
27 We receive ongoing education on how to interpret information on quality and patient safety performance.	0	0	100	84
28 As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	95
29 As a governing body, we hear stories about clients that experienced harm during care.	0	0	100	85
30 The performance measures we track as a governing body give us a good understanding of organizational performance.	0	0	100	92
31 We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	0	0	100	87
32 We have explicit criteria to recruit and select new members.	0	0	100	84
33 Our renewal cycle is appropriately managed to ensure continuity on the governing body.	0	0	100	90

		% Disagree	% Neutral	% Agree	%Agree * Canadian Average
		Organization	Organization	Organization	
34	The composition of our governing body allows us to meet stakeholder and community needs.	0	0	100	94
35	Clear written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	94
36	We review our own structure, including size and subcommittee structure.	0	0	100	89
37	We have a process to elect or appoint our chair.	0	14	86	95

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2014 and agreed with the instrument items.

4.2 Canadian Patient Safety Culture Survey Tool

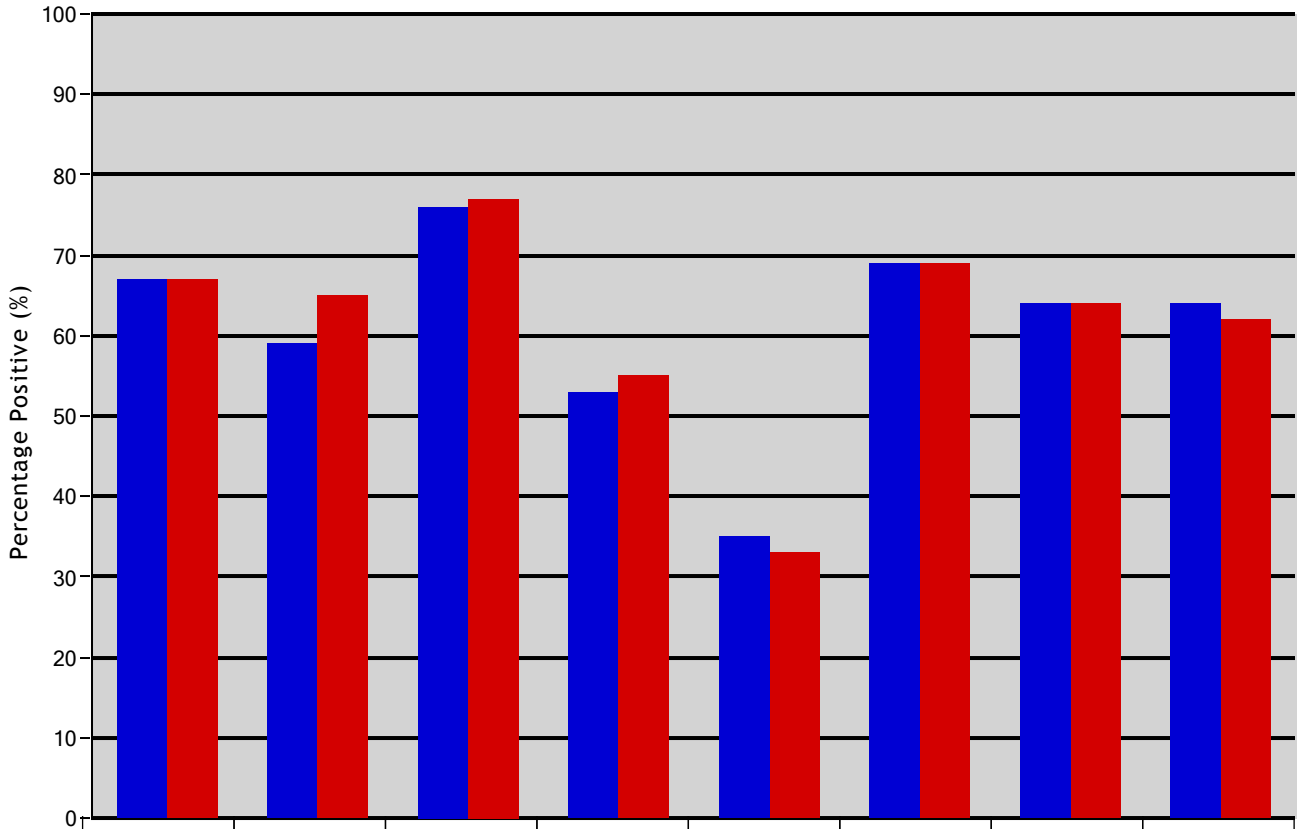
Organizational culture is widely recognized as a significant driver in changing behavior and expectations in order to increase safety within organizations. A key step in this process is the ability to measure the presence and degree of safety culture. This is why Accreditation Canada provides organizations 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: August 8, 2014 to October 10, 2014**
- **Minimum responses rate (based on the number of eligible employees): 332**
- **Number of responses: 1190**

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
	67%	59%	76%	53%	35%	69%	64%	64%
	67%	65%	77%	55%	33%	69%	64%	62%

Legend

Grand River Hospital

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2014 and agreed with the instrument items.

4.3 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.

4.4 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. The organization provides Accreditation Canada with evidence of the actions it has taken to address these required follow ups.

Evidence Review and Ongoing Improvement

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

Appendix B Priority Processes

Priority processes associated with system-wide standards

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

Priority processes associated with population-specific standards

Priority Process	Description
Chronic Disease Management	Integrating and coordinating services across the continuum of care for populations with chronic conditions
Population Health and Wellness	Promoting and protecting the health of the populations and communities served, through leadership, partnership, innovation, and action.

Priority processes associated with service excellence standards

Priority Process	Description
Blood Services	Handling blood and blood components safely, including donor selection, blood collection, and transfusions
Clinical Leadership	Providing leadership and overall goals and direction to the team of people providing services.
Competency	Developing a skilled, knowledgeable, interdisciplinary team that can manage and deliver effective programs and services
Decision Support	Using information, research, data, and technology to support management and clinical decision making
Diagnostic Services: Imaging	Ensuring the availability of diagnostic imaging services to assist medical professionals in diagnosing and monitoring health conditions
Diagnostic Services: Laboratory	Ensuring the availability of laboratory services to assist medical professionals in diagnosing and monitoring health conditions
Episode of Care	Providing clients with coordinated services from their first encounter with a health care provider through their last contact related to their health issue
Impact on Outcomes	Identifying and monitoring process and outcome measures to evaluate and improve service quality and client outcomes
Infection Prevention and Control	Implementing measures to prevent and reduce the acquisition and transmission of infection among staff, service providers, clients, and families
Medication Management	Using interdisciplinary teams to manage the provision of medication to clients
Organ and Tissue Donation	Providing organ donation services for deceased donors and their families, including identifying potential donors, approaching families, and recovering organs
Organ and Tissue Transplant	Providing organ transplant services, from initial assessment of transplant candidates to providing follow-up care to recipients
Organ Donation (Living)	Providing organ donation services for living donors, including supporting potential donors to make informed decisions, conducting donor suitability testing, and carrying out donation procedures
Point-of-care Testing Services	Using non-laboratory tests delivered at the point of care to determine the presence of health problems

Priority Process	Description
Primary Care Clinical Encounter	Providing primary care in the clinical setting, including making primary care services accessible, completing the encounter, and coordinating services
Public Health	Maintaining and improving the health of the population by supporting and implementing policies and practices to prevent disease, and assess, protect, and promote health.
Surgical Procedures	Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge