ACCREDITATION
AGRÉMENT
CANADA
Qmentum

Accreditation Report

Huron Perth Healthcare Alliance

Stratford, ON

On-site survey dates: October 20, 2019 - October 25, 2019

Report issued: November 13, 2019

About the Accreditation Report

Huron Perth Healthcare Alliance (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 2019. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

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

Confidentiality

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

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

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

A Message from Accreditation Canada

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

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

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

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

We look forward to our continued partnership.

Sincerely,

Leslee Thompson
Chief Executive Officer

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Executive Summary

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

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

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

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

Accreditation Decision

Huron Perth Healthcare Alliance's accreditation decision is:

Accredited with Commendation (Report)

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

About the On-site Survey

- **On-site survey dates: October 20, 2019 to October 25, 2019**

- **Locations**

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

  1. Alzheimer Society of Huron County
  2. Alzheimer Society of Perth County
  3. Clinton Family Health Team
  4. Clinton Public Hospital
  5. Knollcrest Lodge
  6. North Perth Family Health Team
  7. Ritz Lutheran Villa / Mitchell Nursing Home
  8. Seaforth Community Hospital
  9. St. Marys Memorial Hospital
  10. Stratford General Hospital

- **Standards**

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

  System-Wide Standards

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

  Service Excellence Standards

  5. Biomedical Laboratory Services - Service Excellence Standards
  6. Community Health Services - Service Excellence Standards
  7. Critical Care Services - Service Excellence Standards
  8. Diagnostic Imaging Services - Service Excellence Standards
  9. Emergency Department - Service Excellence Standards
  10. Inpatient Services - Service Excellence Standards

11. Long-Term Care Services - Service Excellence Standards
12. Mental Health Services - Service Excellence Standards
13. Obstetrics Services - Service Excellence Standards
14. Perioperative Services and Invasive Procedures - Service Excellence Standards
15. Point-of-Care Testing - Service Excellence Standards
16. Primary Care Services - Service Excellence Standards
17. Rehabilitation Services - Service Excellence Standards
18. Reprocessing of Reusable Medical Devices - Service Excellence Standards
19. Transfusion Services - Service Excellence Standards

- **Instruments**

  The organization administered:

  1. Worklife Pulse
  2. Canadian Patient Safety Culture Survey Tool: Community Based Version
  3. Governance Functioning Tool (2016)
  4. Physician Worklife Pulse Tool
  5. Client Experience Tool

Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
Population Focus (Work with my community to anticipate and meet our needs)	57	0	0	57
Accessibility (Give me timely and equitable services)	114	1	1	116
Safety (Keep me safe)	656	15	19	690
Worklife (Take care of those who take care of me)	144	5	1	150
Client-centred Services (Partner with me and my family in our care)	446	4	1	451
Continuity (Coordinate my care across the continuum)	95	0	2	97
Appropriateness (Do the right thing to achieve the best results)	1108	19	14	1141
Efficiency (Make the best use of resources)	58	2	1	61
Total	**2678**	**46**	**39**	**2763**

Overview by Standards

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

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

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

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

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	49 (98.0%)	1 (2.0%)	0	36 (100.0%)	0 (0.0%)	0	85 (98.8%)	1 (1.2%)	0
Leadership	46 (92.0%)	4 (8.0%)	0	92 (95.8%)	4 (4.2%)	0	138 (94.5%)	8 (5.5%)	0
Infection Prevention and Control Standards	37 (92.5%)	3 (7.5%)	0	26 (89.7%)	3 (10.3%)	2	63 (91.3%)	6 (8.7%)	2
Medication Management Standards	69 (94.5%)	4 (5.5%)	5	61 (100.0%)	0 (0.0%)	3	130 (97.0%)	4 (3.0%)	8
Biomedical Laboratory Services **	72 (100.0%)	0 (0.0%)	0	105 (100.0%)	0 (0.0%)	0	177 (100.0%)	0 (0.0%)	0
Community Health Services	43 (97.7%)	1 (2.3%)	0	79 (98.8%)	1 (1.3%)	0	122 (98.4%)	2 (1.6%)	0
Critical Care Services	60 (100.0%)	0 (0.0%)	0	104 (100.0%)	0 (0.0%)	1	164 (100.0%)	0 (0.0%)	1
Diagnostic Imaging Services	68 (100.0%)	0 (0.0%)	0	66 (97.1%)	2 (2.9%)	1	134 (98.5%)	2 (1.5%)	1

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Emergency Department	71 (98.6%)	1 (1.4%)	0	106 (100.0%)	0 (0.0%)	1	177 (99.4%)	1 (0.6%)	1
Inpatient Services	59 (100.0%)	0 (0.0%)	1	81 (100.0%)	0 (0.0%)	4	140 (100.0%)	0 (0.0%)	5
Long-Term Care Services	55 (100.0%)	0 (0.0%)	1	99 (100.0%)	0 (0.0%)	0	154 (100.0%)	0 (0.0%)	1
Mental Health Services	49 (98.0%)	1 (2.0%)	0	89 (96.7%)	3 (3.3%)	0	138 (97.2%)	4 (2.8%)	0
Obstetrics Services	71 (100.0%)	0 (0.0%)	2	86 (100.0%)	0 (0.0%)	2	157 (100.0%)	0 (0.0%)	4
Perioperative Services and Invasive Procedures	111 (98.2%)	2 (1.8%)	2	108 (99.1%)	1 (0.9%)	0	219 (98.6%)	3 (1.4%)	2
Point-of-Care Testing **	38 (100.0%)	0 (0.0%)	0	46 (100.0%)	0 (0.0%)	2	84 (100.0%)	0 (0.0%)	2
Primary Care Services	59 (100.0%)	0 (0.0%)	0	90 (98.9%)	1 (1.1%)	0	149 (99.3%)	1 (0.7%)	0
Rehabilitation Services	45 (100.0%)	0 (0.0%)	0	79 (98.8%)	1 (1.3%)	0	124 (99.2%)	1 (0.8%)	0
Reprocessing of Reusable Medical Devices	75 (90.4%)	8 (9.6%)	5	37 (92.5%)	3 (7.5%)	0	112 (91.1%)	11 (8.9%)	5
Transfusion Services **	71 (100.0%)	0 (0.0%)	5	68 (100.0%)	0 (0.0%)	1	139 (100.0%)	0 (0.0%)	6
Total	**1148 (97.9%)**	25 (2.1%)	21	1458 (98.7%)	19 (1.3%)	17	2606 (98.3%)	44 (1.7%)	38

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

Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client Identification (Long-Term Care Services)	Met	1 of 1	0 of 0
Client Identification (Mental Health Services)	Met	1 of 1	0 of 0
Client Identification (Obstetrics Services)	Met	1 of 1	0 of 0
Client Identification (Perioperative Services and Invasive Procedures)	Met	1 of 1	0 of 0
Client Identification (Point-of-Care Testing)	Met	1 of 1	0 of 0
Client Identification (Rehabilitation Services)	Met	1 of 1	0 of 0
Client Identification (Transfusion Services)	Met	1 of 1	0 of 0
Information transfer at care transitions (Critical Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Emergency Department)	Met	4 of 4	1 of 1
Information transfer at care transitions (Inpatient Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Long-Term Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Mental Health Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Obstetrics Services)	Met	4 of 4	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information transfer at care transitions (Perioperative Services and Invasive Procedures)	Met	4 of 4	1 of 1
Information transfer at care transitions (Rehabilitation Services)	Met	4 of 4	1 of 1
Medication reconciliation as a strategic priority (Leadership)	Met	3 of 3	2 of 2
Medication reconciliation at care transitions (Critical Care Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Emergency Department)	Met	1 of 1	0 of 0
Medication reconciliation at care transitions (Inpatient Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Long-Term Care Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Mental Health Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures)	Met	4 of 4	0 of 0

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

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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Infection Control			
Infection Rates (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Critical Care Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Inpatient Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Long-Term Care Services)	Met	5 of 5	1 of 1
Falls Prevention Strategy (Mental Health Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Obstetrics Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Perioperative Services and Invasive Procedures)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Rehabilitation Services)	Met	2 of 2	1 of 1
Pressure Ulcer Prevention (Critical Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Inpatient Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Long-Term Care Services)	Met	3 of 3	2 of 2

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

Summary of Surveyor Team Observations

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

The Huron Perth Healthcare Alliance (HPHA) is commended for undergoing the Qmentum accreditation process. This is an accreditation prototype where six organizations that have never gone through the accreditation process have voluntarily joined HPHA for the on-site survey. The partner organizations are the Alzheimer Society of Huron County, the Alzheimer Society of Perth County, the Clinton Family Health Team, the North Perth Family Health Team, Knollcrest Lodge, and the Ritz Lutheran Villa/Mitchell Nursing Home. The purpose is system improvement and standardization of service delivery. All of the organizations were highly engaged in the process.

The partners feel there is significant opportunity for collaboration with the changing model of health care in Ontario. This report focuses on progress made by HPHA since the last on-site survey in 2014 as well as the integration of the new teams into the accreditation process. HPHA has submitted a proposal to be one of the new Ontario Health Teams and has been shortlisted. Sixty-one partner organizations have signed on.

It is evident, through discussions with the many teams, that the organizations have a history of working together in the region to enhance the provision of health care. The focus has been on avoiding duplication, leveraging opportunities and partnerships, and promoting knowledge transfer. The philosophy is that together they are stronger and better able to respond to change more effectively and efficiently. Each team has a separate governance structure and board members are considering how they may need to strengthen their boards to successfully navigate system change. Leaders from all of the organizations have worked on harmonizing policies, such as effective governance evaluation, safety incidents, and workplace violence, and have adopted one ethics framework. HPHA supports some of the organizations in the areas of human resources (HR), information technology, and materials management. The leaders spoke of trusting and respecting each other’s leaders and organizations.

The three-year HPHA Commitment to Our Communities strategic plan is in its second year. There was broad consultation in the development phase and opportunity for feedback. Operating plans are developed based on the three pillars of people, partnerships, and performance. Goals and objectives are monitored through 90-day action plans. Initiatives include looking at a revised bed footprint for HPHA, the shift to program and/or site quality councils, and a focus on retention and recruitment.

All of the organizations demonstrate a commitment to quality as identified in their strategic plans. Performance monitoring against goals and objectives is built into operating plans. The Patient Safety Culture Survey and the WorkLife Pulse Tool Survey were completed by all seven organizations and collectively they are working together to review strengths and opportunities. Action plans have been developed. All of the leaders emphasize the importance of a just culture.

Patient-centred care is central to everything that is done throughout the organizations. A framework was

developed in 2015 focusing on patient and staff experience and engagement. There is a patient partner on the board and on the Medical Advisory Committee. Patient partners have been consulted on strategic plans; mission, vision, and values; and other projects and initiatives. Patient partners state that communication is positive and they feel supported. Education has been provided on understanding the organizations as well as quality improvement, risk identification, and other key organizational processes. Advisors are engaged in their roles and feel they are making a difference. Patients speak positively about the care they receive.

HPHA describes positive relationships with the physicians. Physicians are involved in corporate discussions and Program Councils, for example. Physicians who were interviewed spoke positively about the organization.

Areas of risk include information technology and security issues. A recent code grey in the region prompted all of the partner organizations to review their processes. Alternate level of care patients use up to 30 percent of beds and leaders are working to address this issue though surge capacity initiatives with the long-term care facilities.

The organization is encouraged to continue working on the risk management plan and populating an integrated risk register. The safety plan is in draft form and will be going to the board for approval. HPHA does not have an updated pandemic plan. HPHA has not developed a business continuity plan based on a business impact analysis and including time-sensitive critical functions and applications, associated resource requirements, and interdependencies. The partner organizations and HPHA are encouraged to work together to ensure existing plans are integrated, tested, and evaluated.

All of the organizations are congratulated for their participation in the accreditation process. As Ontario moves forward with changes to how health care is delivered, this may position them to support and work through system transformation.

Thirteen community partners participated in the focus group. They have overwhelmingly positive comments about their relationships with HPHA, the CEO, and other leaders. Words used to describe the organization included open, inclusive, honest, respectful, and collaborative. Many have long-standing relationships with all of the organizations. HPHA is seen to be visionary and a leader in partnering to “go where we need to go.” Initiatives such as Connecting the Dots are identified as system-level thinking. Participants describe the culture as one of reaching out, initiating, and working through issues and projects. HPHA’s willingness to share resources with smaller organizations, such as information technology and HR, is noted as a strength. The partners would like HPHA to continue to take a leadership role with the Ontario Health Team development. HPHA will need be mindful of the stress and impact of system change on the smaller organizations. The partners are impressed with accreditation model that is being piloted and supportive of the process. The long-term care homes, Family Health Teams (FHT), and Alzheimer societies are all considered partners and would traditionally been part of this group.

Detailed Required Organizational Practices

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

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

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Worklife/Workforce	
Patient safety plan A patient safety plan is developed and implemented for the organization.	· Leadership 15.1
Patient Safety Goal Area: Risk Assessment	
Venous Thromboembolism Prophylaxis Medical and surgical clients at risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) are identified and provided with appropriate thromboprophylaxis.NOTE: This ROP does not apply for pediatric hospitals; it only applies to clients 18 years of age or older. This ROP does not apply to day procedures or procedures with only an overnight stay.	· Perioperative Services and Invasive Procedures 11.12

Detailed On-site Survey Results

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

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

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

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

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

See Appendix B for a list of priority processes.

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

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

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

Priority Process Results for System-wide Standards

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

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

Priority Process: Governance

Meeting the demands for excellence in governance practice.

Unmet Criteria	High Priority Criteria
Standards Set: Governance	
13.7 The governing body regularly reviews the contribution of individual members and provides feedback to them.	!

Surveyor comments on the priority process(es)

During a discussion with the board chairs of the seven partner organizations, they spoke of the strength gained by working together through the accreditation process. The boards completed the Governance Functioning Tool and individual and collective results were shared with all board members. The results indicated an opportunity to improve in the area of individual performance evaluation, and this has prompted work on the development of a harmonized policy to address board effectiveness. All of the boards state that they provide oversight to their respective organizations and work to ensure they are not involved in operations.

While some boards recruit members based on geography, most are considering moving to a skills-based model. Candidates are often recruited from local advisory committees, which are subcommittees of the boards. HPHA bylaws need to be updated to reflect this change. Some board members spoke of the need to recruit a younger population as well as specific skill sets. With the upcoming changes in Ontario and the Ontario Health Teams, they are adopting a wait-and-see approach before changing bylaws and policies.

All of the boards have a Quality Committee and quality is a standing item on all agendas. HPHA has a patient partner on the board as well as on the Medical Advisory Committee. The other organizations are considering moving in this direction. HPHA board meetings are open to the public, and board minutes, bylaws, and policies are posted on the HPHA website.

New board members for all of the organizations go through an extensive orientation process. Some are assigned a mentor to support them in their first year. HPHA has a patient partner on the board, as of

September 2019, and each board meeting opens with a patient story. Patients and families are encouraged to come and tell the story themselves. Other board members see the inclusion of patient partners on their respective boards as an opportunity for improvement. The boards of the long-term care facilities will consider including members of the Resident's Council at future board meetings.

All board chairs and members spoke of the extensive review process used to evaluate the performance of their respective CEOs.

The board chairs discussed their involvement in the process to approve their quality plans. Information on critical incidents is shared with the boards and there are follow-up processes to ensure recommendations are addressed. For boards other than HPHA, talent management plans are not in place and this is an opportunity for improvement.

Board members spoke of the positive aspects of working together to address upcoming changes in how health care is delivered in Ontario. They agree that working together will help position them to address upcoming changes.

Priority Process: Planning and Service Design

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
12.1 A structured process is used to identify and analyze actual and potential risks or challenges.	!

Surveyor comments on the priority process(es)

HPHA has developed a strategic plan called Commitment to our Communities. It is focused on people, partnerships, and performance. There was widespread stakeholder involvement in the production of the plan. Staff and partners are well informed and knowledgeable about the plan and referenced it in many conversations.

The values of compassion, accountability, and integrity are visible throughout the organization. These are more than just words on paper, as demonstrated through many interactions with staff, physicians, and leaders. Operational plans are developed and shared broadly. Leaders work on 90-day action plans. Data are pushed and plans are updated and transparent. Decision support works closely with all of the teams. New leaders are provided with orientation and are mentored.

Staff forums are held quarterly where updates on organizational objectives are provided by the CEO and leadership team. All of the organizations work together to ensure they are meeting the needs of their populations.

The partners who are part of the collaborative accreditation program all have individual strategic plans that are current and have a strong emphasis on patient experience, learning and development, and performance, with up-to-date missions, visions, and values. All of the organizations have worked together to address regional issues. Many have long-standing working relationships built on trust, respect, and collaboration.

Alternate level of care patients can take up to 30 percent of the HPHA bed capacity. This area of risk will need to be continually monitored and strategies developed to reduce the volume.

All of the organizations have numerous community initiatives such as Connecting the Dots, emergency preparation codes, and support to service clubs.

The partner organizations spoke to the change impacting their organizations given their size and resources. HPHA uses the Bridge Model of Transitional Care. Patient partners are identified as helpful

during many of the change processes. This collaborative accreditation process is seen as a way to support and promote systems change and monitor quality and safety.

Priority Process: Resource Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Well-defined policies and processes are in place to guide the financial management of all of the organizations. HPHA has a team that works closely with leaders to prepare and monitor the budget on a monthly basis. Requests for budget increases must be supported by a briefing report. Budgets are mainly status quo from year to year and savings are sought at all times. Efficiencies are reviewed quarterly using the hospital indicator tool. There are systems in place to monitor variances.

The other organizations have different funding models and specific rules associated with the funding. The Alzheimer Society is funded for 60 percent and the rest must be secured through fundraising. All of the organizations use data to ensure programs are efficient. There is a St. Joe's buying group for larger purchases such as IV pumps.

Leaders are supported with orientation and online modules. Managers, directors, and other leaders meet monthly with decision support to review budgets and plan for the future.

Contingency plans are in place for a code grey although they have not been tested. Cybersecurity is a concern. The organization is encouraged to develop, implement, and test a business continuity plan.

Priority Process: Human Capital

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
2.5 A policy regarding reporting, investigating, and resolving behavior that contravenes the code of conduct is developed and implemented.	

Surveyor comments on the priority process(es)

The five-year HR plan for HPHA was developed in 2018 and approved by the board. The result was a consolidation of the many components of HR to provide a vision for the future. The plan outlines key content such as recruitment and retention, training and development, health and safety, occupational health, wellness, labour relations, and volunteers. The plan is supported by a strategy framework and a work plan.

Staff files are well organized and in a standard format. The HPHA files that were reviewed contain up-to-date performance evaluations and many staff confirm that they have had regular performance reviews. Electronic reference checks are used to obtain references in a timelier manner. Exit interviews have increased from 30 percent to 80 percent with the introduction of an online survey. HPHA minimized collective agreements and this has improved relationships and issue management. HR staff describe their relationship with the unions as positive.

There are numerous means of employee recognition such as awards and peer-to-peer recognition. Working closely with the numerous joint health and safety committees has improved working relationships, promoted a safety culture, and allowed a proactive approach to safety in the workplace. A pilot on innovative processes to address staff shortages in long-term care settings has been successful in the short term. The organizations are encouraged to spread their successful projects to maintain safe staffing levels and a safe workplace.

There will be retirements in the future and the HR department is readying itself to continue without any gaps in service. New managers receive an orientation and support from HR.

The code of conduct policy where expectations are identified does not include how to report, investigate, or follow up on behaviours that contravene the code. Other policies identify consequences of, for example, not following the policy on email practice and privacy. HPHA is encouraged to add the consequences of not following the code to the code of conduct policy.

The FHTs have talent plans embedded in their strategic plans. They are frequently bound by Ministry of Health and Long-Term Care directives on how to staff. The teams meet monthly to share HR challenges

and key issues. With the introduction of the Ontario pension plan for their staff they have seen an increase in successful recruitment. Flexible work hours and professional development are seen as recruitment strategies. The teams use the online HR Downloads to support their processes, and have access to consultants if required.

HPHA worked with the the FHTs, the long-term care facilities, and two Alzheimer societies to harmonize the workplace violence policy and procedure. HR regional sessions to look at key issues are held, with an open invitation to all partners.

The long-term care facilities have challenges with personal support worker recruitment and have had to use agency staffing. They participate in a shared services model with HPHA and have seen an improvement in HR management. Performance appraisals in long-term care have not been completed as outlined in policy. Many of the organizations are impacted by staffing shortages. The acute and long-term care teams are challenged with filling personal support worker positions while the FHTs are focused on recruiting more family physicians.

Occupational health and safety is involved with all new hires. A pre-placement health form that includes required vaccinations is completed. Clearance is required from occupational health to ensure fitness to work. Numerous wellness programs such as employee assistance and attendance support are available.

HPHA is now including patient partners on hiring panels for some positions. It is encouraged to continue to expand on this initiative.

Priority Process: Integrated Quality Management

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
12.2	The organization's leaders implement an integrated risk management approach to mitigate and manage risk.	!
12.3	As part of the integrated risk management approach, the organization's leaders develop risk mitigation plans.	!
12.4	The risk management approach and contingency plans are disseminated throughout the organization.	!
12.5	The effectiveness of the integrated risk management approach is regularly evaluated and improvements are made as necessary.	
15.1	A patient safety plan is developed and implemented for the organization.	ROP
15.1.2	There is a plan and process in place to address identified patient safety issues.	MINOR

Surveyor comments on the priority process(es)

The quality department has undergone significant change in the past two years. Quality was previously structured as corporate planning and is now a distinct department with dedicated staff and leaders. It is supported by decision support through performance monitoring, a dashboard, and the use of business intelligence tools. The quality improvement plan was developed to align with Health Quality Ontario and had input from patient partners. The safety plan is in draft format and at this time has not been approved by the board.

A philosophy of integrating patient and staff safety is evident. A risk management plan has been developed and the next steps are to develop the integrated risk register. A consultant will be working with specific teams to begin the process next month. These teams were identified through a risk management assessment. While organizational, facility, and information technology risks have been identified, there is no overall integrated plan.

Quality is a component of the strategic plan for the FHTs and the Alzheimer societies, rather than being a separate plan. A successful FHT initiative is the implementation of a seven-day follow-up appointment after discharge from the hospital. This has had notable success for chronic obstructive pulmonary disease patients.

The seven organizations have worked together to harmonize certain policies such as governance effectiveness, safety incidents, workplace violence, and an ethics framework. Before they work collaboratively on other policies, they are encouraged to ensure that these are implemented and used by staff. This will provide valuable insight as they move to system transformation and potential consolidation of policies. Quality leaders are encouraged to continue to use performance data, the accreditation report, and information on the upcoming Ontario Health Teams to identify other priority areas. There is recognition of the impact of change on all staff. Leaders need to look at ways to support staff in all of the organizations.

HPHA monitors the quality plans and provides updates on an annual basis. There has been noted success in the development of critical care indictors, the alternate level of care long-term care pilot plan to address surge issues, the national early warning score and provider. Other key initiatives are leader rounding.

There is a defined process to report and follow up on incidents. While HPHA is the only organization with an electronic version, the other organization describe robust processes. All of the organizations spoke of the importance of follow-up and learning. There has been a greater emphasis on promoting a just culture and a safety incident policy has been developed collaboratively. The organizations have seen an increase in reporting and a decrease in severe incidents. However, there are some clinical areas that leaders know need to be encouraged to report all incidents, such as a code white in emergency.

Program councils are being implemented throughout HPHA as the organization moves away from care teams. Stratford General Hospital will have program councils for different programs while the smaller sites will have one council for the site. Terms of reference are being developed and patient partners will be included. The councils will be supported by decision support and quality.

There is a defined process for patient complaints and compliments, as per Ontario's Excellent Care for All Act. Information about compliments and complaints is posted on the HPHA website. There are opportunities to speak with managers during rounding. Patient experience survey data are shared bi-weekly and quarterly with the managers. An area of focus is professional staff communication. An HPHA feedback working group that includes patient partners, staff, and physicians will begin discussions on how to make improvements. The organization is encouraged to consider training modules on the e-Train.

HPHA has worked to meet the tests for compliance for the Required Organizational Practices. It is encouraged to take a consistent and comprehensive approach to evaluating Required Organizational Practices such as venous thromboembolism prophylaxis, transfer of information, and infusion pump training. Leaders are encouraged to proactively use the data to ensure compliance with the audit aspects of their activities. This will help the partner organizations as they continue through the accreditation process.

Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organizations have worked to harmonize a new ethics framework that has gone to their respective boards. The framework has been approved and an implementation plan to operationalize the policy will be developed. All of the organizations are encouraged to work together and learn from each other as they work to implement the new policy and framework. The use of mock case studies may help staff by increasing ethical knowledge. It will be important to evaluate the process to ensure staff understand the policy and processes. There has been some good uptake in HPHA with actual case studies. The organizations may want to consider using staff who were involved as champions to spread the ethics framework and policy.

HPHA has an Ethics Committee that meets every two months. The role is to advance ethics in the organization, develop policies and procedures, and review and advise on case studies. Urgent reviews or issues can be addressed in a timely manner by contacting the ethicist. Staff are aware of how to address ethical issues and how to get assistance. Cases brought to the committee have come from a variety of disciplines including physicians. The other organizations have various means of addressing ethical issues without the committee structure.

Long-term care leaders discussed the review of the medical assistance in dying legislation and the development of a process for their facilities based on the resident choice. Trends in ethics that may have impact, such as resource allocation issues with the Ontario Health Teams, complex care patients, and the frail elderly, were also raised.

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 its first formal communication plan and finds it to be a helpful roadmap to remain on track. The plan was developed in 2018 and passed by the board in January 2019. The team is rolling it out and while they feel somewhat at the infancy stage, they also feel proud of the initiatives that have been accomplished.

As the team progresses with the Ontario Health Team proposal, it recognizes the multitude of initiatives that will need to be implemented to initiate a system-wide communication pathway.

The team currently serves the alliance but realizes that it will be the lead to assist with all communication strategies for the health team group. The team recognizes that are many variations in systems and programs and a great deal of work and money will be needed to standardize this information roadway.

The team communicates with the partners via face-to-face presentations, email, and print, and this has been effective to date. The team is finding that face-to-face is the most effective in soliciting feedback and direction. Internal communication has been easier, as email goes to all. Huddles, staff forums, bulletin boards, and newsletters are used to communicate effectively.

Cybersecurity is one of the largest threats to the information systems. There is a semi-specialist on staff and a contracted service provides testing and oversight. This has been effective to date.

The privacy office has completed a great deal of education for staff, managers, and partners related to privacy and confidentiality. It uses a variety of modes to deliver this education, including online, verbal, newsletters, and scenarios. This has been effective as no breaches have occurred to date.

There are policies and procedures to collect, enter, report, and retain information. These are reviewed annually and revised as necessary by the team.

Patients can access information in their chart easily. The team realizes the implications of My Chart to its workflow. Directions to patients on how to obtain their medical record are on the hospital website. The organization has contracted an external organization to update the website and the social media accounts so they are more user-friendly and more easily accessed by the community and external partners.

Priority Process: Physical Environment

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Collaborative team work is evident. The team is focused on what is best for the patient and is committed to ensuring the environments are safe.

Despite the aging infrastructures at the hospitals, overall, the physical environments of all of the Huron Perth sub-region accreditation prototype facilities are well maintained and housekeeping practices provide very clean and inviting atmospheres.

There is clear signage for patients and families to locate the facilities. Parking and other areas are clearly identified. The entrances have hand-hygiene stations to support effective infection prevention and control (IPAC), and more hand-hygiene stations are located throughout the facilities. It was observed and also reported that wayfinding and signage to assist patients and families is helpful. Evacuation routes are clearly identified.

Preventive maintenance processes are in place and monitored closely. Most of the preventive maintenance is done in-house. Currently, there are over 400 outstanding preventive maintenance demands at HPHA. Staff report that many of them are outstanding due to “unable to locate” and they feel that this is likely because they were “probably disposed of.” An outside company (TRH) has been retained to help with the backlog. HPHA is encouraged to review the process for disposing of assets, to ensure preventive maintenance reports are accurate.

The facilities are clean and environmental staff take pride in their work and understand their role in patient safety. Staff and patients report that housekeeping staff are very thorough and complete their roles well. This was evident during the tours of the various facilities.

Quarterly visual inspections are done by environmental services leaders to evaluate the quality of the cleaning and disinfecting of the physical environment of the hospitals. This process is not standardized. It is suggested that the organization conduct regular and standardized, perhaps by using a checklist, evaluations of cleaning and disinfecting. There are plans to incorporate UV gel testing into evaluations to enhance the efforts.

The dietary departments are clean and comply with all regulations with regard to safe handling of food. Staff members are dedicated and know how important food is to patients, residents, staff, and visitors.

Staff report that facilities maintenance is responsive to requests and needs. Work orders are generated electronically and turnaround times are tracked and trended.

Priority Process: Emergency Preparedness

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

Unmet Criteria		High Priority Criteria
Standards Set: Infection Prevention and Control Standards		
2.11	Input is gathered from the IPC team when planning for pandemics at the organizational level.	
13.1	There are policies and procedures for identifying and responding to outbreaks in line with applicable regulations.	!
13.7	Policies and procedures are regularly reviewed and improvements are made as needed following each outbreak.	
Standards Set: Leadership		
14.8	An emergency communication plan is developed and implemented.	
14.9	A business continuity plan is developed and implemented in order to continue critical operations during and following a disaster or emergency.	

Surveyor comments on the priority process(es)

The HPHA Emergency Preparedness Committee is an interdisciplinary committee that meets monthly. Committee members report that the committee is in a state of flux due to the absence of a member who recently left the organization.

Various teams across the Huron Perth sub-region accreditation prototype facilities conduct regular reviews of universal codes and conduct exercises as actual emergency events with external partners, including police, fire, other health care agencies. Each event provides improvement opportunities that are used to revise emergency preparedness documentation, knowledge, and training.

Front-line staff members receive mandatory training on all universal codes via e-learning (e-Train) modules, and this is documented. However, the level of general knowledge of emergency management at the front-line varies across the teams. The organizations are encouraged to expand training, tests, desk top exercises, and policy education to build capacity in emergency management throughout the teams.

HPHA has a clear and comprehensive incident management system (HECCS) with clear roles and contingency plans for various threats and losses. However, there is no equivalent to HECCS that could be used as an emergency communication plan for most of the member sites. The plan should identify the essential information and messages that must be sent and received, to whom they should be communicated, and how the organization will send communications internally and externally, including to

the public.

HPHA is encouraged to review its pandemic plan. HPHA is using the 2007 pandemic toolkit for small, rural, and northern hospitals as its plan. However, the toolkit is intended to supplement the information presented in the Ontario Health Pandemic Influenza Plan (OHPIP) that was also published by the Ministry of Health and Long-Term Care in 2007. While this toolkit provides a framework to assist hospitals in planning, it was developed under the assumption that as the OHPIP is updated (2013), hospitals will update their respective pandemic plans. In addition, many of the outbreak policies at the HPHA are from 2009 and have not been updated.

While some of the member organizations have lived experience in dealing with floods, contaminated water, loss of utilities, malicious IT viruses, and mass casualties, to mention a few, it is suggested that the organizations develop and implement a specific business continuity plan that is based on the results of a business impact analysis and identifies time-sensitive critical functions and applications, associated resource requirements, and interdependencies among the seven member sites.

Priority Process: People-Centred Care

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

Unmet Criteria		High Priority Criteria
Standards Set: Community Health Services		
2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
16.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Mental Health Services		
3.15	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
Standards Set: Primary Care Services		
2.5	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	

Surveyor comments on the priority process(es)

Patient and family engagement is fully demonstrated at Stratford General Hospital. Patient partners sit on all teams throughout the hospital and review multiple aspects of operations. Communication is vertical and horizontal from the governing body to patient partners. One of the patient partners who was interviewed has been in the role since 2012 and states that he feels like a valued member of the team. He feels that patient partner input has helped the hospital become truly patient- and family-centred in all aspects of care and service. The partners need to work together to standardize patient and family involvement in the use and co-design of space.

The two Alzheimer societies use information from satisfaction surveys but have not formally used client and family input regarding co-design of space.

Knollcrest Lodge and Ritz Lutheran Villa/Mitchell Nursing Home involve residents and families in the decision-making processes of the homes. Knollcrest Lodge is in the process of maturing its actions into a formal process.

Patient, client, resident, and family involvement in quality initiatives is inconsistent within the partnership.

All partners are encouraged to standardize their approach to including these groups in quality processes.

A cross-section of all partners was present for the discussion, namely Clinton Public Hospital, Alzheimer's Society of Huron and Perth, Clinton FHT and North Perth FHT, Ritz Lutheran Villa/Mitchell Nursing Home, and Knollcrest Lodge. All participants are extremely positive about this union and identify many positive outcomes, such as the support from the hospital group with regard to shared resources and knowledge, and the collaboration and co-operation among the partners. All are reaching out to their contacts to enhance membership in the Ontario Health Team proposal and process.

All members who were present identified that there is a positive flow of communication among all the members. All have had input into and knowledge of the strategic planning process, and feel that this has expanded their knowledge and skill regarding quality improvement, safety, and risk as well as involvement with patient partners. All are extremely proud of the journey they have been on and the direction they are heading.

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 optimization of patient flow and the efficient use of beds and resources is a priority for the HPHA team members, physicians, and leaders. The goal is to ensure the right patient in the right bed at the right time for the right length of time. Patient flow is seen as the responsibility of the entire care team.

A patient flow strategy was developed in 2018 after considerable discussion and feedback. Other patient flow processes include the HPHA bed flow and gridlock algorithm for medicine and surgical, the algorithm for minor surge, the algorithm for intensive care unit gridlock, the index hospital moderate surge escalation, the moderate surge response card, and an index hospital SBAR (situation, background, assessment, recommendation) form. The team has done significant work to develop and implement the strategy and assessment tools. Additionally, a pilot project has commenced with the team leader on the inpatient medicine unit fostering discharge planning for complex care patients. The leaders are encouraged to evaluate the patient flow strategy and make changes as appropriate.

The team has initiated processes to support patient flow. Discharge rounds involving the interdisciplinary team are held daily on the clinical units. A daily bed management meeting is held with representation from all sites and clinical areas. This information is used to identify bed and staffing concerns. The bed management report is provided by the bed allocator. It is action oriented, concise, and informative. A visual presentation will be included in the bed management meetings with the purchase of large screens to enable a verbal and visual presentation. If there is limited bed availability following the bed management meeting, an email is sent to the physician, team members, and leaders.

There are strong partnerships with community and health care organizations to work together on creative solutions to ensure services are available for patients across the continuum of care. The partners report that there are strong communication processes and effective working relationships to collectively address patient flow. The partners have implemented initiatives such as ensuring same day primary health care access to relieve pressure on the emergency departments, streamlining the admission processes for long-term care, and sharing resources and programs across the partnership. The partners recognize the need to think upstream and be proactive.

The team and leaders are acknowledged for their commitment to optimal patient flow. They are encouraged to continue with their work to ensure innovative solutions to meet the goal of the optimization of patient flow and the efficient use of beds and resources.

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		
8.5	The team ensures the staff involved in cleaning and reprocessing diagnostic devices and equipment are qualified and competent.	
8.12	The individual responsible for the overall coordination of reprocessing and sterilization activities within the organization oversees the team's compliance with the organization's policies and procedures on cleaning and reprocessing.	
Standards Set: Reprocessing of Reusable Medical Devices		
2.4	A designated individual is accountable for quality oversight and for coordinating all reprocessing services across the organization, including those performed outside the MDR department.	!
3.1	The layout of the MDR department is designed based on service volumes, range of reprocessing services, and one way flow of medical devices.	
3.2	The MDR department is designed to prevent cross-contamination of medical devices, isolate incompatible activities, and clearly separate work areas.	!
3.4	The MDR department has an area for decontamination that is physically separate from other reprocessing areas and the rest of the facility.	!
3.5	Appropriate environmental conditions are maintained within the MDR department and storage areas.	!
3.6	The MDR department has floors, walls, ceilings, fixtures, pipes, and work surfaces that are easy to clean, non-absorbent, and will not shed particles or fibres.	!
5.1	Position profiles with defined roles, responsibilities, and scope of employment or practice exist for all positions.	
5.2	Qualifications, training, and education are defined for all team members with input from stakeholders.	!
5.3	Qualifications, requirements, and competencies are verified, documented, and up-to-date.	!

8.9	Workplace assessments of the MDR department are regularly conducted for ergonomics and occupational health and safety.	!
11.3	All flexible endoscopic reprocessing areas are equipped with separate clean and contaminated/dirty work areas as well as storage, dedicated plumbing and drains, and proper air ventilation.	

Surveyor comments on the priority process(es)

The medical device reprocessing department (MDRD) supervisor is formally trained, certified, and experienced in reprocessing of medical devices and equipment. She provides oversight for most but not all reprocessing activities across HPHA, with the support of the senior leadership team.

There are 13 MDR-certified staff at the Stratford site and two at the Clinton site. Certified staff undergo annual competency testing as per standards. Ultrasonographers who reprocess ultrasound probes in diagnostic imaging complete an online e-learning module annually. This module does not include a competency testing or assessment component. The manufacturer provides training to MDRD staff for new equipment and the supervisor provides training on significant changes to standard operating procedures.

Utilization data are collected and have been used to support necessary equipment purchases. Tray audits are conducted daily to evaluate compliance with MDRD policies, procedures, and standard operating procedures. Findings are used to enhance staff training and to make changes to the procedures if indicated.

A quality initiative at the Stratford site will see the introduction of an electronic reprocessing management system for bronchoscopes, colonoscopes, duodenoscopes, and gastroscopes by the end of 2019. The new system will support reprocessing activities in real time and will also include support for inventory control to mitigate associated risk. The team plans to evaluate the impact of this process change. The organization has undertaken a comprehensive review of the Clinton site MDRD with findings and recommendations summarized in the revised briefing report of September 2019.

In addition to mandatory training of staff, the service supports optional professional development activities undertaken by staff. Performance appraisals are done every two years and are reported to be up to date.

The CensiTrac surgical instrument management system is in place at Stratford General Hospital. Tracking and recall processes are in place to allow tracking of sterilized items to the service area and in some cases, to the patient. A rapid biological indicator system is used and results are available in 24 minutes, so sterilized materials are not released from the department until sterility is confirmed.

The physical layout at the Stratford site supports one-way flow to prevent cross-contamination, but this is not the case at the Clinton site due to the endoscope reprocessing area lacking environmental controls and one-way flow. Dirty and clean work areas are not separated.

Staff comply with required dress code and wear appropriate personal protective equipment. Staff state that regular workplace assessments of the MDRD for ergonomics and occupational health and safety are not done, and it is unclear when the last ergonomic assessment took place.

Environmental parameters are measured in the reprocessing and sterile storage areas and out-of-range alerts are sent to switchboard and appropriate staff are notified. The ranges for alerts do not comply with recommendations as per standards. The team is encouraged to work with perioperative services, IPAC, and facilities management to clarify water quality and environmental controls (e.g., temperature, humidity, air exchanges, air pressure gradients) in the operating rooms, sterile storage areas, and the MDRD. Alert ranges need to be clarified. Facilities management and IPAC were investigating this at the end of the on-site survey.

Elements of reprocessing activities across HPHA are carried out by various personnel including certified MDRD technicians, registered nurses and registered practical nurses at the FHTs, housekeeping staff, operating room staff, and diagnostic imaging staff, for example. Ultrasonographers reprocess ultrasound probes using a high-level disinfection system if MDRD staff are unavailable at the Clinton site and routinely at the Seaforth and St. Mary’s sites. The MDRD supervisor does not oversee reprocessing of ultrasound probes at Clinton, Seaforth, and St. Mary's Hospitals, nor at the FHTs where reprocessing is done. FHT nursing staff reprocess using a tabletop sterilizer. Housekeeping staff clean equipment and devices prior to disinfection at Seaforth and St. Mary’s Hospital, and those at St. Mary’s operate a washer disinfector without appropriate qualifications according to standards.

At the Clinton FHT, there is a tabletop autoclave sterilizer in an area of the nursing station. The environment to reprocess medical devices is not ideal as there is potential for cross-contamination with clean and dirty in the same physical space. It is suggested that organizational staff with MDR expertise consult and review the current setup for compliance with established MDRD standards.

Non-MDR staff who reprocess outside of the MDRD (e.g., diagnostic imaging staff, registered nurses, registered practical nurses, housekeeping staff, porters) do not have position profiles that define their roles, responsibilities, qualifications, or scopes as they pertain to reprocessing of medical devices and equipment. Role clarity is essential to promote team and patient safety and a positive work environment.

It is not clear whether required training and competency testing for staff other than MDRD techs and ultrasonagraphers has been specified, standardized, or approved to ensure compliance with established MDRD standards. Ultrasonographers outside of the Stratford General Hospital site do not receive annual written competency testing.

It is suggested that a comprehensive environmental scan be conducted to identify where reprocessing is done across the HPHA and by whom, and that the necessary training and competency testing be clearly defined and standardized, with oversight by qualified MDRD staff (a certified supervisor) and with input from IPAC personnel as appropriate.

All reprocessing activity should be overseen by personnel with training and expertise in MDRD to ensure

that practices align with established standards.

Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Point-of-care Testing Services

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

Clinical Leadership

- Providing leadership and direction to teams providing services.

Competency

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

Episode of Care

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

Decision Support

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

Impact on Outcomes

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

Medication Management

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

Organ and Tissue Donation

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

Infection Prevention and Control

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

Diagnostic Services: Imaging

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

Diagnostic Services: Laboratory

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

Transfusion Services

- Transfusion Services

Standards Set: Biomedical Laboratory Services - Direct Service Provision

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

Surveyor comments on the priority process(es)
Priority Process: Episode of Care
No issues noted.
Priority Process: Diagnostic Services: Laboratory
An inter-hospital lab partnership has been in place since 1958. Twelve partner hospitals have the legal partnership to provide laboratory services with Stratford General Hospital as the hub hospital. Each of the smaller sites has a core laboratory. Hours of operation have been cut back at some sites due to decreased volume. A dedicated courier system brings laboratory samples to Stratford twice daily. Some tests are referred to London and others to Life Labs; this is guided by a contractual relationship. There has been 2 to 3 percent growth per year, primarily due to practice changes for acute patients. Leaders are always looking to improve turnaround times. Standard operating procedures are reviewed and updated annually. The laboratory facility is old and makes the best use of the space. Recruitment for medical laboratory technologists poses problems. This has led to ensuring that medical laboratory assistants work to their full scope of practice. With this change there has been an improvement in granting staff time off.

Numerous quality indicators are tracked and the team is proud of the improvements that have been made. Incidents are tracked and reviewed.

Standards Set: Community 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 Alzheimer Society of Huron County and the Alzheimer Society of North Perth are non-profit charitable organizations dedicated to helping people affected by Alzheimer's disease and related dementia. The societies are committed to providing education, support, and social and recreation services to people with Alzheimer's disease and other dementia, their care partners, and the general public. In addition to providing programs to the community, the societies support research through the Alzheimer Society of Canada and the Centre for Research in Neurodegenerative Diseases.

The societies are affiliated with the Alzheimer Society of Ontario and the Alzheimer Society of Canada. Both societies are funded by the Local Health Integration Network (LHIN) but rely heavily on donations, grants, and special event fundraising to maintain their many program and services.

The societies have partnered with a number of agencies, societies, teams, and providers over the years to provide the client-centred programs that their clients require. On a regular basis, leadership meets with other Alzheimer societies to share best practices. In particular, since 2013, the six Alzheimer societies in the South West LHIN have entered into a Memorandum of Understanding to "formalize their collaborative efforts in order to enhance services to persons with Alzheimer's disease and other dementias and their families in the south east."

The societies are members of the newly formed Huron Perth and Area Ontario Health Team, which is a collaboration of health care organizations and providers who have started to work together to improve the coordination of care along the continuum of care.

Both societies are proud to be part of the Huron Perth sub-region prototype accreditation.

Priority Process: Competency

The Alzheimer Society of Huron County serves all of Huron county with a population of 58,000. It is governed by a ten-member volunteer board of directors and has over 100 volunteers. The board is skills based with representatives from each area of the county (Clinton, Exeter/Grand Bend, Goderich, Seaforth, and Wingham). The society served approximately 600 clients in 2018 – 2019.

The Alzheimer Society of Perth County serves all of Perth county with a population of 75,000. It is governed by an eight-member volunteer board of directors and has 350 volunteers. The board is skills based. The society cared for over 1,500 clients in the past year, and has already seen an increase from the previous year.

Each society has its own executive director, who is visibly engaged with the teams.

The interdisciplinary teams clearly demonstrate enthusiasm and an eagerness to serve the population. These are high-functioning teams that are dedicated to providing the best client and caregiver care possible.

The team members have the appropriate competencies and certifications where applicable. Educational opportunities and courses are available and supported internally and externally to ensure staff are qualified and prepared. Staff validate this and appreciate the ongoing education opportunities.

Performance appraisals are regularly performed and add significant value to the organizations and the professional development of the staff. All staff who were interviewed had a performance appraisal in the past year.

The staff work in a collaborative fashion and always with the client and caregiver at the centre of their activities. There is good communication at transition points and among the staff.

Staff are fully aware of all corporate policies such as health and safety and workplace violence prevention.

Priority Process: Episode of Care

It was a pleasure to visit the societies and speak with team members, clients, and caregivers. The environments are inviting and promote a calming effect.

Referrals come in a variety of methods such as through the South West LHIN; the client, family, or

caregiver; or the Community Support Services Network, a group of 11 agencies. The intake process is somewhat similar at both societies. It involves setting up a client file in the electronic database (Nesda) that is linked to a central intake electronic database called Total Healthcare. The first link care navigator then meets with the client and makes a determination, in partnership with the client and caregiver, as to what services and programs would be beneficial. Written consent is obtained to access the services and programs.

As a member of the Community Support Services Network, the societies work with central intake to help connect clients and caregivers to a full range of community support services in Huron and Perth. These services include meals, transportation, support programs, health and wellness, and adult day programs, to mention a few.

Documentation of all touch points is recorded using D.A.R.E (data, actions, responses, evaluation).

The societies offer numerous programs and services to help clients and caregivers live safely in the community (e.g., Finding Your Way, Medic Alert, vulnerable persons registry, Behavioural Supports Ontario mobile team). They also offer education (e.g., Learning the Ropes, First Link Learning Series, First Steps, Care Essentials, Monthly Caregiver); support groups for caregivers and respite; and social and recreational programs (e.g., Minds in Motion, Boost Your Brain Brunch).

The leaders are aware of opportunities and challenges and appropriately involve the clients and caregivers. The societies have had a history of partnering with clients and caregivers for feedback and evaluation of programs and services. Both societies have formed Client Advisory Councils to further the client and caregiver experience. The councils have met twice and will continue to meet at a minimum of three times per year at the Alzheimer Society of Huron County and and twice a year at the Alzheimer Society of North Perth. It is suggested that the societies use the Client Advisory Councils in a more in-depth manner, to encompass all aspects of decision making, policy creation and review, and future planning.

Priority Process: Decision Support

The Alzheimer Society of Perth County is a fully digital organization, with no part of the chart being in paper format. At Alzheimer Society of Huron County, documentation is a hybrid model, with some access to electronic information and some on paper, and the organization has identified gaps in technology that need to be addressed to improve access and availability of client information.

The societies respect clients' dignity and the privacy of their information. Record-keeping practices are respected.

Caregivers who were interviewed feel that they are well informed about all aspects of programs and services and "what to expect next" as the dementia progresses. They describe the care as excellent and the staff as responsive and compassionate.

Staff indicate that they rely on and use the chain of command when they encounter ethical issues. It is suggested that education about the recently created ethical framework be provided, to build capacity and greater awareness of the tool and highlight the availability of the tool as a resource for making difficult decisions.

Priority Process: Impact on Outcomes

The team is willing to tackle tough issues collaboratively to provide best care possible. The change made to how the first link care navigator processes referrals in the face of rising wait times is an example of how the Alzheimer Society of Perth County is working collaboratively to provide the best care possible.

The societies have quality improvement plans with indicators, goals, and timelines. Quarterly reports are provided to the boards and quality indicator data are shared with the teams. Data about unit-based issues are communicated and used to stimulate improvement strategies.

All team members spoke positively about the team dynamics and the supportive, just culture.

Standards Set: Critical Care Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

A strong and cohesive interdisciplinary team supports the critical care area. The critical care team is led by a passionate group of clinical and physician leaders. The unit is a closed unit with co-medical directors. There are nine general internists to support the critical care area. There is a strong level of engagement of the team and physicians and they work hard to find creative solutions to challenges.

Leadership rounding occurs on a regular basis and this is viewed positively by patients and families. A warm and open approach is evident during leadership rounds. Concerns are acted on and feedback is provided to team members, patients, and families. Team members report that they have the resources to do their work.

Service-specific goals are developed and monitored. A quality improvement board is used to support communication, quality improvement, and patient safety. The team has worked hard to implement surge protocols, including a change in bed allocations and the use of processes such as discharge planning, bed management, and patient rounding. There are partnerships and relationships with other health care

organizations to support surge protocols. The team and leaders are encouraged to continue to develop innovative solutions to support surge capacity and patient flow.

The critical care unit is well organized and the hallways are free from clutter. The patient rooms are bright, with windows and natural sunlight. The team and leaders are encouraged to continue to involve patient partners in future design of the area.

Priority Process: Competency

A strong interdisciplinary team supports the provision of quality critical care services. The leaders, team members, and physicians are commended for their commitment to providing quality and safe care. The leaders are acknowledged for their commitment to supporting the education and learning needs of the team. Team members speak highly of the education and training, including clinical care days, staff huddles, educators, e-learning, and conference attendance. The physicians value the journal clubs and sharing best practices with the team.

The leaders and team are commended for their commitment to infusion pump safety.

Education and training are provided on ethical decision making. The team is familiar with the process to follow if ethical issues arise.

Team members report that the orientation is important and valuable, and that mentorship is important in supporting them. They feel safe at work and there are initiatives to support staff safety.

Staff are recognized for their accomplishments. This includes asking patients and families during leadership rounding if they feel a team member needs to be recognized. A family member described the team as “absolutely amazing.”

Performance appraisals are completed for team members.

Priority Process: Episode of Care

An engaged interdisciplinary team works collaboratively with partners to deliver quality critical care services. Physicians are highly visible and engaged members of the critical care team. The team values the collaborative, respectful working relationships throughout the team. The strong working relationships are described as a reason why team members want to work in the critical care area. The team notes the value of having a clinical pharmacist as a member of the care team.

Patients note that they are treated with care, dignity, and respect. They describe receiving excellent care, with one saying, “They are absolutely wonderful. They are calm and helpful during difficult times.”

Patients and families see the bedside whiteboards as excellent communication tools. A pain management scale is also a component of the bedside whiteboards. Family conferences are held. Patient and leadership

rounding occurs. Bed management and discharge meetings occur. Daily patient keeper reports are completed.

The team and leaders are commended for their commitment to ensuring patient and family satisfaction surveys are completed prior to discharge, using iPads. The information collected is shared with the team and improvements are made and communicated to patients and families. One such improvement was the change in heating for patient rooms. The team and leaders are encouraged to continue these important efforts to work with patients and families on the co-design of critical care programs and services.

The team is commended for its commitment to medication reconciliation, pressure ulcer prevention, and venous thromboembolism prevention.

Priority Process: Decision Support

The team and leaders are committed to using decision support to enable quality patient care. Education and training are provided to the team on the use of technology. Paper and electronic charting is used in the critical care area. It is planned that computerized provider order entry will be implemented in February 2020 and this is encouraged.

Comprehensive, standardized, and up-to-date patient information is collected, with the input of patients and families. Care plans are developed and updated with the input of patients and families. Chart auditing occurs. Education is provided to the team on protecting the privacy of patient information.

Priority Process: Impact on Outcomes

Team members and leaders are acknowledged for their commitment to quality improvement. Huddles, family conferences, journal clubs, patient rounding, leadership rounding, bedside whiteboards, and quality improvement boards are used to support safety and quality.

The teams are engaged with quality improvement. Family and patient satisfaction surveys are completed with the results shared with the team and patients. The results are also posted on the quality improvement boards.

A surge protocol has been developed and implemented.

The team supports best practices and fosters an environment that is future directed and focused on using best evidence for critical care. The team and leaders are encouraged to continue their commitment to best practices and quality improvement, with input from patients and families.

There is access to evidence-based guidelines to support care. The redesigned Critical Care Program Council supports the selection of evidence-based guidelines. A patient partner is being recruited to participate on this council. Medical directives and order sets have been developed. The leaders and team are encouraged to continue to develop and implement evidence-based guidelines with input from patients and families.

Priority Process: Organ and Tissue Donation

The team and leaders are proud of their work in supporting organ and tissue donation. Policies and procedures have been developed and implemented. Teaching and education on organ and tissue donation is provided to team members, and support is provided to families.

There is a strong working relationship with the Trillium Gift of Life Network. Information on lost opportunities for donation is shared and discussed with the team. The team and leaders are encouraged to continue to support organ and tissue donation.

Standards Set: Diagnostic Imaging Services - Direct Service Provision

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

The organization has met all criteria for this priority process.

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

Diagnostic imaging at Stratford is spacious, bright, and well laid out. A ramp provides access for people with disabilities. The waiting room uses a numbering system and patients are moved through in a timely manner. Comprehensive services include ultrasound, CT scan, MRI, and nuclear medicine. While there is a defined process for booking procedures, urgent cases can be accommodated.

There is a capital plan to replace equipment. There is concern that some equipment is outdated and needs to be replaced.

The department has a new director who is engaged and supportive. Physician recruitment has been good, with interventional radiology being an area of focus for the future. Students are supported and this becomes an opportunity for recruitment.

Staff take great pride in their work and are proud to talk about their accomplishments. They feel supported by the leaders.

Ethical issues related to gender issues and the need to check for pregnancy were discussed. Staff are comfortable bringing the issue to the Ethics Committee. This is seen to be a helpful process and leaders are looking at educational opportunities to manage future cases.

Scorecard indicators are tracked on a regular basis, displayed on the quality board, and discussed regularly with staff and physicians. Wait times are tracked and reviewed regularly including at daily huddles. Incidents are posted on the quality boards and reviewed and discussed openly. Staff shortages and illness have an impact on some of the wait times, such as ultrasound. While there has been some improvement, this is an area that needs continued attention.

Quality boards are visible and include incident reports. Numerous quality improvement initiatives are in place and ongoing. The unit is a District Stroke Centre and staff are proud of the work done to ensure patients are treated within 10 minutes of arrival.

Mock codes are completed.

There are safe work practices in the area of nuclear medicine and the use of contrast. Staff are well informed of areas of risk.

Patients have waiting rooms close to their respective examinations. There are numerous patient brochures available in the waiting rooms.

Standards Set: Emergency Department - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
2.6 Seclusion rooms and/or private and secure areas are available for clients.	!
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

Emergency departments are located at four sites across HPHA. Committed clinical and physician leaders work collaboratively to set direction for emergency services. There is a strong level of engagement with the team members and physicians. They work collectively to address challenges across the system. Leadership rounding occurs on a regular basis. Concerns are acted on and feedback is provided. An interdisciplinary team supports the emergency departments.

Service-specific goals are developed and monitored. An emergency quality improvement board used to share information during huddles.

The leaders work collaboratively to ensure appropriate staffing of the emergency departments.

Partnerships and relationships have been formed with other health care organizations to support the appropriate transfer of patients. The team and leaders have real time information regarding the availability of bed resources across HPHA.

The emergency departments are clean and the housekeeping staff are proud of their work in ensuring a safe and clean environment for patients and families. Team members state that they have the resources to do their work.

Seclusion rooms and/or private and secure areas are not available for patients at all of the emergency departments. The organization is encouraged to develop seclusion or private and secure areas for short-term interventions, to protect the safety of the patient or others in the emergency department. The team and leaders are encouraged to continue to involve patient partners in any co-design of the emergency departments.

Priority Process: Competency

The emergency departments throughout HPHA have committed interdisciplinary teams providing emergency care to patients and families. Team members value the education and training provided.

Education and training are provided on ethical decision making. Staff are familiar with the process to follow if ethical issues arise.

Infusion pump training is provided to the team members. The leaders are encouraged to continue with the plan to ensure infusion pump training is completed.

The team speaks highly of the value of the orientation process.

Staff are recognized for their accomplishments.

Required competencies are identified for the team members. The team members are supported by a nurse educator and team leaders. Education and training are provided to team members on how to prevent and manage workplace violence. Safe workplace strategies have been implemented.

The organization is encouraged to continue to develop and implement innovative solutions to enhance staff safety, with the input of team members.

Priority Process: Episode of Care

The emergency department team is collaborative and well engaged in providing care to patients and their families. This is a committed interdisciplinary team that works collaboratively with partners to ensure quality services, including creating effective working relationships with emergency medical services providers and the police force. The partners state that they value working with the emergency department team and feel respected for their contributions to the team. The team members feel supported and appreciate the strong working relationships with co-workers.

Patient and family satisfaction surveys are completed. The information collected is shared with the team

and improvements are made. Patients note that they are treated with care, dignity, and respect, with one saying, “We get excellent care.”

The entrances to the emergency departments are clearly marked. The physical spaces are clean and organized. All patients are triaged using the Canadian Triage and Acuity Scale. The triage areas allow for private conversations.

Medication reconciliation is initiated for all patients with a decision to admit. Laboratory and diagnostic imaging resources are available. In-person and telephone consultations are available with specialists.

There are surge response protocols in the emergency departments. A bed management meeting occurs daily and provides situational awareness of and opportunities to ensure that effective patient flow occurs at the emergency department and across HPHA. The leaders are encouraged to continue their work to ensure the effective use of the emergency departments to meet the needs of the people served.

Priority Process: Decision Support

The emergency departments have electronic patient boards that are used to assist with flow. The Canadian Triage and Acuity Scale scores for patients are visible on the electronic patient boards.

The patient record includes an electronic and paper-based component. The charts are accurate and up to date. Standardized information is collected.

Education and training on the electronic system is provided to the team. Computerized provider order entry will be implemented in 2020. The leaders are encouraged to continue to support the development and implementation of electronic information systems.

Priority Process: Impact on Outcomes

The team, physician, and leaders are committed to quality improvement. An Emergency Department Program Council supports the work of the emergency department. This includes the development of medical directives and order sets, and the selection of evidence-based guidelines that includes a review of best practices including those from other health organizations. Physician champions support the implementation of evidence-based guidelines. A patient partner is being recruited for the Emergency Department Program Council. The leaders are encouraged to continue to seek the input of clients and families.

Team members use the electronic incident reporting system. The leaders review incidents and make changes as appropriate. Patients and families are involved in this process. Learnings from patient safety incidents are used to improve the quality of the service.

Patient and family satisfaction surveys are completed on a regular basis. The leaders and team members are responsive to patient feedback and have made improvements based on the surveys.

Emergency department quality information boards are present in the emergency departments.

Wait times in the emergency departments are tracked. The bed management meetings support the flow of patients throughout the system and provide the team with information on the availability of beds throughout the system. Patient-oriented discharge summaries are being implemented. The leaders are encouraged to continue to implement and evaluate quality improvement initiatives.

Priority Process: Organ and Tissue Donation

The team and leaders are proud of their work in supporting organ and tissue donation. The emergency department team has completed significant work since the last on-site survey. Policies and procedures have been developed and implemented. Teaching and education on organ and tissue donation is provided to team members, and support is provided to families.

There is a strong working relationship with the Trillium Gift of Life Network. The team honors organ and tissue donors by having a pause to acknowledge thanks for the donor.

The team and leaders are supportive of organ an tissue donation. They are encouraged to develop strategies to increase organ and tissue donation at all sites.

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

Unmet Criteria		High Priority Criteria
Priority Process: Infection Prevention and Control		
4.1	A risk assessment is completed to identify high-risk activities, and the activities are addressed in policies and procedures.	!
4.7	IPC policies and procedures are updated regularly based on changes to applicable regulations, evidence, and best practices.	!
5.6	The effectiveness of the multi-faceted approach for promoting IPC is evaluated regularly and improvements are made as needed.	

Surveyor comments on the priority process(es)

Priority Process: Infection Prevention and Control

There are 2.2 FTE infection control practitioners; two are CIV certified, and one is in progress. Each site in the alliance has a site IPAC representative. Once the exact role of IPAC team across the alliance is better defined, the organization is encouraged to review volumes and activities to ensure there is an adequate number of IPAC staff, as per Provincial Infectious Diseases Advisory Committee (PIDAC) guidelines, in order to deliver safe, quality IPAC services.

Medical support is provided by a pathologist from Stratford General Hospital who chairs the Infection Control Committee and provides medical leadership to the IPAC program. There is access to expertise through the public health departments, and medical microbiology support is provided by London Health Sciences Centre.

An HPHA IPAC service plan is in draft form. The plan outlines the scope of the program, describes key components and activities, and affirms accountability. Policies and procedures are evidence based and incorporate recommendations from leading infection control agencies including PIDAC, the Public Health Agency of Canada, CSA Group, and the Association for Professionals in Infection Control and Epidemiology, for example. They are updated regularly as per PIDAC recommendations and the vast majority are up to date. Policies and procedures at Knollcrest Lodge have not been updated, some since 2009. At Knollcrest Lodge, the effectiveness of the multi-faceted approach to promote IPAC has not been evaluated and there is no evidence of improvements being made.

Since the last on-site survey, the IPAC team is now appropriately consulted for construction and renovation projects and the consulting services appreciate this input. There is evidence that IPAC is involved in the renovation that was underway at the time of the on-site survey.

The team has developed a comprehensive IPAC education program that includes self-assessment questionnaires. The program is delivered broadly across the organization and is available online. In response to a suggestion from the last on-site survey that training in donning and doffing personal protective equipment could be enhanced, instructional videos were created and are included as part of the training.

Although hand-hygiene compliance rates are provided twice monthly to managers, it does not appear that the results are being shared with front-line staff, patients, and families. It is suggested that the team work with unit leaders to post hand-hygiene compliance rates on the units in order to share them with team members, patients, families, and volunteers.

Quarterly visual inspections are done by environmental services leaders to evaluate the quality of the cleaning and disinfecting of the physical environment of the hospitals. This process is not standardized. It is suggested that the organization conduct regular and standardized, perhaps by using a checklist, evaluations of cleaning and disinfecting. There are plans to incorporate UV gel testing into evaluations to enhance the efforts.

The team conducts comprehensive active and passive surveillance, which allows it to respond quickly to potential clusters and outbreaks. Data sources include laboratory results, physical walkabouts, electronic medical record reviews, pharmacy data, and communication with clinical staff. The team has well-established working relationships with public health officials to facilitate timely reporting and to receive outbreak investigation and management support when required.

The team is encouraged to work with the MDRD, perioperative services, and facilities management to clarify water quality and environmental controls (e.g., temperature, humidity, air exchanges, air pressure gradients) in the operating rooms, sterile storage areas, and the MDRD. Alert ranges need to be clarified. Facilities management and IPAC were investigating this at the end of the on-site survey.

Standards Set: Inpatient Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The medical inpatient service is delivered at four sites across HPHA. The clinical and physician leaders are passionate about providing excellent care to patients and families. Team members acknowledge the support of the leadership team. There is evidence of a strong and engaged interdisciplinary team supporting the medical service including nurses, social workers, dietitians, physiotherapists, occupational therapists, nurse educators, physicians, and team leaders. Team members state that they have the appropriate resources to do their work. Partnerships have been developed with community groups and other health and community organizations.

Service-specific goals are developed and monitored. A medical quality improvement board is used to support communication, quality improvement, and patient safety. A team lead pilot project has been implemented to focus on discharge planning and patient flow. Leadership rounding occurs on a regular basis. Some team members participate on a senior-friendly care team that includes the involvement of patients and families. The teams are encouraged to continue with this important work.

Priority Process: Competency

A strong interdisciplinary team supports the provision of quality medical inpatient services. The leaders and team are committed to providing quality and safe services for patients and families. The leaders are

acknowledged for their commitment to supporting the education and learning needs of staff. Team members speak highly of the education and training provided.

The leaders and team are commended for their commitment to infusion pump safety.

Education and training is provided on ethical decision-making. Staff are familiar with the process to follow if ethical issues arise.

The team speaks highly of the value of the orientation process. Staff state that they feel safe at work and that the organization supports a safe workplace.

Staff are recognized for their accomplishments.

Required competencies are identified for team members. The team is supported by a nurse educator and team leaders. The leaders are commended for their commitment to completing performance appraisals.

Priority Process: Episode of Care

Medical inpatient services are provided at four sites throughout HPHA. Engaged interdisciplinary teams are committed to providing quality care for clients and families. Physicians are valuable and engaged members of the teams.

Patients describe receiving excellent care, describing it as outstanding and exceptional, with one patient saying “The staff come to work in the morning and they are kind, cheerful, and will do anything for you. At the end of the twelve-hour shift they are the same way. They will do anything to make you comfortable. I have absolutely no concerns about my care.” Patients and families describe being treated with care, dignity, and respect.

There are bedside whiteboards in all patient rooms. There is a feeling of pride in the hospitals. One patient said, “I didn’t know anything about this hospital until I was transferred here. I will certainly be singing its praises.” Patients describe the food as “super” and there are options to choose.

Leadership rounding, huddles, and discharge planning rounds are held. Family and patient satisfaction surveys are completed with the results shared. The team is committed to senior friendly care. Education is provided to families and patients to prevent delirium and functional decline during hospitalization.

The team is committed to effective discharge planning. A pilot project is being implemented where a team leader has a focus on complex continuing care patients and ensuring effective discharge and transitional care planning. Plans are ongoing to implement post-discharge telephone calls. Patient-oriented discharge instructions are being implemented.

The acute medical units are clean, with hand-hygiene products and handwashing sinks available. There is work space for staff and private spaces for private conversations. There are also private spaces for

patients and families. The medication rooms are locked and an automated medication dispensing system is used. The team sees the value of the automated medication dispensing system to patient safety.

The teams are committed to medication reconciliation, pressure ulcer prevention, and venous thromboembolism prevention. The organization is encouraged to continue to track and audit compliance with processes.

Priority Process: Decision Support

The staff and leaders are committed to using decision support to enable quality patient care. The patient record includes an electronic and paper-based component. The charts are accurate and up to date. Standardized information is collected.

Education and training are provided to team members on the use of technology. There are adequate work stations for team members.

Leaders and team members are committed to protecting the privacy of patient information.

Priority Process: Impact on Outcomes

There is a strong commitment to patient safety and quality. Huddles, family conferences, leadership rounding, bedside whiteboards, and medicine quality improvement boards are used to support safety and quality. The team has access to evidence-based guidelines to support care.

The Medical Program Council supports the selection of evidence-based guidelines including medical directives and order sets. Discharge rounds are held daily and attended by the interdisciplinary team. Post-discharge telephone calls are planned. Patients report that they are involved in their plan of care and discharge planning.

Patient and family satisfaction surveys are completed and the results are shared with the team and patients. The actions are also visible on the medical quality improvement boards located on the medical inpatient units. The teams are engaged in quality improvement. The leaders are encouraged to continue to involve team members, patients, and families in quality improvement initiatives.

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

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

At Knollcrest Lodge, residents and families are surveyed once per year and provide input through the Residents' Council and face-to-face meetings with managers. Management is trying to set up a Family Committee but due to the rural location it is difficult to obtain consistent and long-term membership. The home is bright and cheerful, with wide corridors. It was retrofitted in the 1970s. Residents like the home cooked food and the staff. They feel very at home and are well cared for and very comfortable. The home has developed many partnerships with other health care organizations in the area.

Ritz Lutheran Villa is an 83-bed long-term care in Mitchell, Ontario. While it is an older facility, the design is current and it is very clean, warm, and inviting. All areas are decorated in a home-like fashion. Housekeeping is excellent in all areas. Staff are very caring and considerate of residents and families. The Resident Council and Family Committee function well. There are many unique programs to stimulate residents, such as the chicken coop where residents gather eggs daily, a gardening group, and multiple indoor craft and music programs. Residents and their families are very positive about the home and how well the residents are cared for. This home is part of a campus of care that houses multiple community programs (e.g., Meals on Wheels, transportation services, apartments, life lease housing, laboratory services, a falls prevention program with physiotherapy). Plans for a new building include the current programs plus repurposing the existing building for assisted living and retirement home space.

Mitchell Nursing Home is a 41-bed long-term care home located approximately 10 minutes from Ritz Lutheran Villa. The home will be rebuilt adding to the beds at Ritz Lutheran Villa. Managers are shared between the two homes and policies are standardized, and the same board and pharmacy serve both locations.

Priority Process: Competency

Knollcrest Lodge provides education to staff and will pay for external education when staff make an application. This is very positive. A full orientation is provided to all staff including agency workers, and this is documented in their personnel record and with each manager. Infusion pumps are not used at this organization at all, and it does not conduct hypodermoclysis.

Ritz Lutheran Villa provides a full orientation and education to all staff, including agency workers, at hire and annually thereafter. All education is tracked in the personnel file. Infusion pumps are not used at the site.

Mitchell Nursing Home is the mirror image of Ritz Lutheran Villa with regard to staff competency. All education is recorded in the personnel file. Infusion pumps are not used at the site.

Priority Process: Episode of Care

All services can be accessed 24 hours per day. A complete assessment is completed at admission and documented using PointClickCare.

Residents and families are included in all aspects of care and service. Information regarding the resident's capabilities are obtained during the process.

Priority Process: Decision Support

Knollcrest Lodge uses PointClickCare to document all resident information. Policies are in place with regard to retention and destruction of resident records in accordance with regulations and legislation.

Ritz Lutheran Villa uses PointClickCare as its documentation system for all resident information. There are policies regarding the retention, destruction, and storage of information and they are aligned with provincial legislation. The ethics framework is adapted from the Huron Perth sub-region and is very complete.

Mitchell Nursing Home uses the same policies as Ritz Lutheran Villa and there is a joint management team.

Priority Process: Impact on Outcomes

There is no ethical research policy in place and research is not being done. The organization has a quality improvement program but it needs further refinement to take the program to a more mature level and

make better use of indicators.

Residents and families have input into decisions but is done informally. The home plans to formalize processes in the future.

Standards Set: Medication Management Standards - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Medication Management		
2.4	The interdisciplinary committee establishes procedures for each step of the medication management process.	!
13.3	Chemotherapy medications are stored in a separate negative pressure room with adequate ventilation, and are segregated from other supplies.	!
13.4	Anesthetic gases and volatile liquid anesthetic agents are stored in an area with adequate ventilation, as per the manufacturer's instructions.	!
16.3	There is a separate negative pressure area with a 100 percent externally vented biohazard hood for preparing chemotherapy medications.	!
Surveyor comments on the priority process(es)		
Priority Process: Medication Management		

The leaders and team members are committed to quality medication management. The leaders, physicians, and team members are enthusiastic and work collaboratively as a part of a strong interdisciplinary team. The clinical pharmacists and pharmacy technicians work to their full scopes of practice. Team members speak highly of the education and training opportunities provided by HPHA, and state that they feel safe at work. The team members find the orientation process and job shadowing to be valuable. There is a quality improvement board and a shoutout board.

The Pharmacy and Therapeutics Committee demonstrates leadership in promoting medication safety. Terms of reference for the committee are available and reviewed regularly. Medical directives and order sets are developed. Plans are ongoing for the implementation of computerized provider order entry in 2020.

An antimicrobial stewardship program has been developed and implemented. The organization is encouraged to continue to evaluate the program and make changes as appropriate.

The leaders and team are committed to enhancing the quality of medication management processes, including the implementation of the automated medication dispensing system, the automated medication dispensing system for narcotics, and having clinical pharmacists in the patient areas. The interdisciplinary committee has established procedures for each step of the medication management process. However, medication storage is inconsistent across the organization. The pharmacy team and leaders have identified the need for an automated medication dispensing system for anaesthesia to use in the operating and procedure rooms. The organization is encouraged to explore the implementation of an

automated medication dispensing system for anaesthesia.

The medication management area is clean and well organized with good lighting. The controlled substance area is locked with swipe card access. However, there is limited space in the pharmacy area. Anaesthetic gases and volatile liquid anaesthetic agents are not stored in an area with adequate ventilation, although shatterproof bottles are used. And, while chemotherapy medications are stored in a separate room, it is not a negative pressure room. Chemotherapy medications are prepared in the cancer care unit. There is a separate negative pressure area to prepare chemotherapy medications, with an externally vented biohazard hood to prepare chemotherapy medications; however, this is not 100 percent externally vented. The organization is encouraged to ensure that the biohazard hood for preparing chemotherapy is 100 percent externally vented. The organization is also encouraged to continue with plans to redesign the pharmacy department to address work flow, storage, and future demands.

Standards Set: Mental Health Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.5	Service-specific goals and objectives are developed, with input from clients and families.	
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		
13.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
13.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

There are strong and engaged clinical and administrative leaders who advocate for and support service delivery from a patient-directed, recovery-oriented framework. Physician leaders are engaged in program evaluation and development, and support program design from a best practice perspective. There are currently two FTE psychiatrists with plans to recruit a third in the near future and possibly a fourth after that to adequately meet the needs of the service.

The team has developed many strategic partnerships across the alliance and within the community to facilitate access to care and the smooth transition of patients across the continuum, and to fill recognized service gaps.

Although the team embraces corporate objectives at the service level, it is encouraged to develop service-specific goals and objectives that align with the organization's Commitments to Our Communities strategic plan.

Priority Process: Competency

In addition to the general organizational orientation and mandatory annual recertification, staff receive additional training appropriate to the provision of safe, quality mental health services including, for example, crisis prevention and Gentle Persuasive Approach training in dementia care. Staff are also trained on appropriate use of restraints and seclusion.

Opportunities for staff professional development are available in the organization and across the alliance. Staff are familiar with the ethics framework and know how to access ethical support if needed. They are also familiar with the policy on and how to report workplace violence.

Although performance appraisals are to be done at probation and every two years, completion rates could be improved.

Priority Process: Episode of Care

The team continues to prioritize recognizing and removing barriers to accessing its services. There is 24/7 access to emergency mental health services for those in its catchment area. A crisis team and seniors mental health services are available to initiate the consultation pending review with a psychiatrist. If admission is not deemed necessary initially, the teams continue to follow these clients and evaluate for a change in status pending formal psychiatric consultation. There is a weekly urgent care clinic to accommodate more urgent referrals. Consults are triaged weekly by the team and e-consults are accepted.

Patients receive a verbal orientation to the inpatient unit and are provided with written materials to reinforce this information. Orientation materials are comprehensive and address many aspects of the inpatient service including rights and responsibilities, hand hygiene, and safety. A schedule of group activities is also provided, and attending group is an expectation during admission. Patients and their families are actively engaged in care and there is a standardized process to grant off-unit leave. Daily huddles allow for information exchange related to safety issues as well as quality initiatives.

Medication reconciliation is completed at admission, transfer, and discharge. The patient-oriented discharge summary, with planned rollout in December 2019, offers a simplified and clear summary of admission, follow-up plans, and discharge medications. Patients, families, and community partners are engaged in the discharge planning process as appropriate and with patient consent. The team follows up with patients and providers to evaluate the effectiveness of the discharge process.

Risk of readmission is assessed informally. The team is encouraged to explore the use of evidence-based tools or indicators to predict psychiatric readmission after discharge, which may suggest possible interventions to reduce readmission rates.

Priority Process: Decision Support

A standardized assessment completed for each client includes risk assessments for falls, pressure ulcers, and suicide. Although the medical record remains hybrid (paper and electronic), patient records are comprehensive, up to date, and readily available to team members who require access. Chart audits are done by clinical leaders to evaluate completeness and compliance with organizational policies and procedures related to documentation.

Patients are able to access information in their record using My Chart.

Priority Process: Impact on Outcomes

Patient safety incidents are reviewed daily and disclosure to patients and families, when required, follows organizational procedures.

The team has undertaken several quality improvement initiatives to improve access to care and care delivery. Examples include the patient-oriented discharge summary to be implemented in December 2019, a standardized and centralized intake form, the patient-developed safety plan, and the psychiatrist-as-MRP model of care delivery. The team is encouraged to continue to measure the impact of its initiatives and to share findings widely, including with patients and families.

Nursing staff use Registered Nurses' Association of Ontario best practice guidelines in care delivery when appropriate, and physicians select evidence-informed guidelines to integrate into care delivery and standardize practices when appropriate and feasible. The team is encouraged to review its procedure to select evidence-informed guidelines, with input from patients and families.

Although the service has not yet embedded patient and family representatives into the team, there are plans to do by the end of 2019 and to heavily engage these representatives in many aspects including service design, care provision, and quality initiatives.

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 maternal child team is led by committed clinical and physician leaders. The team members are engaged and passionate about providing quality care to patients and families. The strong and cohesive interdisciplinary team supporting the maternal child program includes nurse educators, nurses, social workers, lactation consultants, dietitians, and physicians. Team members work to their full scope of practice and have the resources to do their work. This includes the replacement of the infant care centres. The Teddy Bears and Friends fundraising initiative was established to support special equipment needs for the special care nursery; this illustrates the team's commitment to the maternal and child program.

Service-specific goals are developed and monitored. A maternal child quality improvement board is used to support communication, quality improvement, and patient safety. Leadership rounding occurs on a regular basis. Partnerships and relationships exist with public health, midwives, and other health care organizations.

The unit is clean and well organized, and the hallways are free from clutter. The rooms are bright with windows and natural sunlight. There is a neonatal nursery and an operating room for procedures such as caesarian sections. There are spaces for private conversations, breastfeeding support, and group sessions.

The number of births at Stratford General Hospital has increased. The leaders are encouraged to continue

to review birth rate trends and plan the service and space design accordingly. Additionally, the team and leaders are encouraged to continue to involve patient partners in future design of the maternal child area.

Priority Process: Competency

The leaders, team members, and physicians are commended for their commitment to providing quality and safe care. A strong interdisciplinary team supports the provision of quality maternal and child services.

There is a strong commitment from the leaders to support education and training for the team members. A learning environment is fostered. An e-learning system is available to support the educational needs of the team. The team members are commended for their commitment to attending education and training opportunities. The education and training provided includes violence prevention, Workplace Hazardous Materials Information System, fetal heart surveillance, and neonatal and cardiopulmonary resuscitation, to name a few. Some team members have completed advanced training in obstetrical care.

Team members are proud of the care they provide to patients and families. The team is supported by a nurse educator who helps the team members attain core competence. There is a strong orientation process for team members. They speak highly of the orientation program and feel it prepares them to work in the maternal child program. The leaders are encouraged to continue to support innovative educational opportunities for the team members.

The leaders and team members are commended for their commitment to infusion pump safety. There is evidence of the completion of infusion pump training and education. There are plans to introduce new infusion pumps. The leaders are encouraged to ensure that the team completes training on the new infusion pumps.

The team members are aware of the process to follow if ethical concerns arise, and can provide examples of ethical consultations. The leaders are encouraged to continue to support ethics education for team members.

The leaders are commended for their commitment to completing performance appraisals. Team members confirm that performance appraisals are done. The leaders are encouraged to continue to complete performance appraisals, to help identify opportunities for professional growth.

Priority Process: Episode of Care

The leaders, team members, and physicians are commended for their commitment to quality maternal and child care. A family member noted “We had great care” and felt that they were treated with dignity and respect.

The leaders and team members are committed to working effectively as an integrated interdisciplinary team. The team members are supported by a manager, team leader, nurse educator, social worker, and

lactation consultants. Physicians are visible and engaged members of the team. The team is described as deeply committed to best practice and seeking opportunities to improve the obstetrical service.

The team members and leaders are committed to patient and family engagement. There are examples of input from patients and families. Patient partners are being recruited to the program council. Patient and family satisfaction surveys are completed and results are used to inform program design. Examples of new initiatives include establishing a donor milk program. The team is proud of the increase in breastfeeding rates.

Patients and families view the bedside whiteboards as an excellent communication tool. The boards include a pain management scale.

Priority Process: Decision Support

The team and leaders are committed to using decision support to enable quality patient care. Education and training are provided on the use of technology. Paper and electronic charting is used on the maternal child unit.

Standardized patient information is collected. Comprehensive and up-to-date information is collected, with input from patients and families. Care plans are developed and updated, with input from patients and families. Chart auditing occurs. Education is provided to the team on protecting the privacy of patient information.

Priority Process: Impact on Outcomes

There is a strong commitment to quality improvement. Huddles, family conferences, patient rounding, leadership rounding, bedside whiteboards, and quality improvement boards are used to support safety and quality.

The leaders and team members are committed to selecting evidence-based guidelines to support obstetrical care. The Maternal Child Program Council participates in selecting evidence-based guidelines. This involves reviewing best practices, including those from other health organizations, to meet the needs of the obstetrical service. Initiatives include the use of peanut balls and reviewing the hypoglycaemia protocol. Order sets and medical directives are available and are reviewed every two years or as needed. A patient partner is being recruited for the Maternal Child Program Council.

The team uses the electronic incident reporting system. The leaders review incidents and make changes as appropriate. Patients and families are involved in this process. Learnings from patient safety incidents are used to improve the quality of the service provided. The leaders and team members are commended for their commitment to creating a culture of safety.

Patient and family satisfaction surveys are completed on a regular basis. The leaders and team members are responsive to patient feedback and have made improvements based on the surveys. There are several

examples of changes made to the program and services based on patient feedback, including enhanced lactation consultation services and enhancements to the bereavement program including purchasing a cuddle bed.

A maternal child quality information board provides team members, patients, and families with an opportunity to view the quality improvement initiatives. A huddle is held daily to review and update the quality information board. Leadership rounding occurs. The leaders are encouraged to continue to implement and evaluate quality improvement initiatives.

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

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
1.3 Service-specific goals and objectives are developed, with input from clients and families.	
Priority Process: Competency	
6.8 Training is provided to prepare the team to respond to emergencies in the operating/procedure room.	!
Priority Process: Episode of Care	
11.12 Medical and surgical clients at risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) are identified and provided with appropriate thromboprophylaxis. NOTE: This ROP does not apply for pediatric hospitals; it only applies to clients 18 years of age or older. This ROP does not apply to day procedures or procedures with only an overnight stay.	ROP
11.12.3 Measures for appropriate VTE prophylaxis are established, the implementation of appropriate VTE prophylaxis is audited, and this information is used to make improvements to services.	**MINOR**
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	
5.2 Medications in the surgical area are stored in a locked area or similarly secured, as per the organization's policies regarding medication storage.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Staff and patients report feeling supported by strong clinical leaders who work to remove barriers to service access and care delivery. Strategic partnerships are established and nurtured to facilitate seamless transitions across the care continuum.

The team uses corporate objectives to inform service planning and delivery. The team collects and uses data from the community to plan service delivery (e.g., increasing access to joint replacement in response to increased wait times).

The team is encouraged to develop service-specific goals and objectives, in collaboration with patients and families, that align with corporate objectives and can serve as the foundation for delivering perioperative services.

Priority Process: Competency

Qualified and interdisciplinary, credentialled professional staff deliver comprehensive care to patients. In addition to required organizational training, staff receive additional training specific to perioperative services and have opportunities for additional professional development.

Staff and physicians report that they have not received training to manage fire in the operating room. The team is encouraged to develop and deliver training to operating room staff with respect to responding to emergencies in the operating room.

Performance appraisals, although not always up to date, given the large number of staff and a relatively new manager, are ongoing and tracked, and there are plans in place for timely completion.

Priority Process: Episode of Care

The team uses clinical pathways and order sets to standardize practice and improve efficiencies related to care delivery.

Anaesthetists and surgeons report appropriate and timely access to diagnostic services and consultants to facilitate patient assessment and management in the pre- and postoperative periods. Results of preoperative investigations are readily available to providers upon admission for surgery.

The team encourages patients and families to be active participants in their care. Verbal teaching and written materials are provided to orient patients and families to the service; this includes information about safety, hand hygiene, and rights and responsibilities. Patients receive preoperative information informing them how to prepare for the procedure and who to contact should their condition change while waiting for surgery.

Patients and staff who were interviewed report that the informed consent process is robust. Consents

were complete on all charts reviewed during the on-site survey.

Initial patient assessments are standardized and comprehensive, done with input from patients and families, and include components of risk assessment. Medication reconciliation is generally completed at admission, transfer, and discharge. Pressure ulcer risk is assessed and interventions are put in place to reduce risk as appropriate.

Compliance with the venous thromboembolism prophylaxis Required Organizational Practice had not been audited at the time of the on-site survey; this was discussed with clinical leadership. Charts reviewed during the on-site survey showed variable compliance.

The operating room team works well together in a collegial and respectful atmosphere, with clearly defined roles.

The safe surgery checklist, surgical pause, and surgical count are all done and documented. The checklist and antibiotic prophylaxis have been audited.

The team is encouraged to work with the MDRD, IPAC, and facilities management to clarify water quality and environmental controls (e.g., temperature, humidity, air exchanges, air pressure gradients) in the operating rooms, sterile storage areas, and the MDRD. Alert ranges need to be clarified. Facilities management and IPAC were investigating this at the end of the on-site survey.

There are standardized criteria for post-anaesthetic care unit discharge and the post-procedure care plan is clear and comprehensive. It includes symptom management and follow-up as appropriate.

Staff indicate a clear desire for training to reduce in the risk of fire in the operating room. It is suggested that the team receive training to manage emergencies in the operating room.

Priority Process: Decision Support

A standardized set of health information is collected for each patient at admission and is updated appropriately throughout their stay. The care team has timely access to the medical record and protects personal health information in the course of their duties, in keeping with organizational policies and procedures.

Priority Process: Impact on Outcomes

Medical team members collaborate effectively to develop and incorporate evidence-based practice guidelines into care delivery. There are processes to manage conflicting guidelines and for timely, regular review as new information becomes available.

Incident data are collected and shared widely. Specimen labelling errors prompted the initiation of a quality improvement initiative in the ambulatory area. Processes were mapped and subsequently

amended to include verification steps that successfully reduced the risk of error. Findings were shared with the team and strategies put into place to effectively change practice and processes.

Medical and nursing team members are aware of the policy for disclosure of patient safety incidents. The policy is applied and is noted to make the situation easier to navigate for those involved.

Priority Process: Medication Management

The content of medication carts is standardized with limited use of multi-dose vials. Medications are managed safely in the sterile field according to best practices. Medications are consistently labelled in the operating room and administration is well documented in the medical record.

In a Clinton Public Hospital operating room, after daily activity was complete, one unlocked supply cart contained a single vial of midazolam while an unlocked anaesthesia cart in the same operating room was fully stocked with medications, including high-alert and restricted medications. This was discussed with clinical leaders during the on-site survey.

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

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

The organization has met all criteria for this priority process.

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

The laboratory staff are responsible and provide oversight for all point-of-care testing. Educators train staff on the equipment and staff are not permitted to use equipment until they have completed the training.

There are standard operating procedures for staff. The glucometer is the only point-of-care equipment used. It is interfaced with the laboratory system.

Standards Set: Primary Care Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Primary care, for the purpose of the Huron Perth sub-region accreditation, encompasses two FHTs, namely the Clinton FHT and the North Perth FHT.

The Clinton FHT provides primary health care to clients and families in the Clinton, Bayfield, Blyth, and Goderich area, with patients coming from as far as Walkerton, London, and Stratford. The team cares for approximately 8,000 clients. The group practice model is that of a family health organization working in an FHT. It is governed by a volunteer, community-based board of directors.

The North Perth FHT provides primary care to clients and families of North Perth county. The group practice model is that of a family health network working in an FHT. The mixed board is made up of representatives from the community and representatives of the physicians working at the North Perth FHT.

Both FHTs are non-profit, incorporated organizations. Their boards exercise their authority in compliance with applicable legislation, letters patent of the corporation, approved bylaws, governance policies and procedures, and the body of common law applicable to directors. The boards are responsible for the governance and management of the corporation’s affairs and for all things done in the corporation’s name.

Both FHTs are set up based on local health and community needs, with a focus on chronic disease management, disease prevention, and health promotion.

The FHTs belong to the Association of Family Health Teams of Ontario that works to support the implementation and growth of primary care teams by promoting best practices, sharing lessons learned, and advocating on behalf of all primary care teams to all levels of government.

The FHTs have formed numerous partnerships and collaborations to enhance client-centred care, such as Best Care COPD program, Memory Clinics, Health Links, and the North Huron FHT. In addition, the FHTs are members of the newly formed Huron Perth and Area Ontario Health Team, a collaboration of health care organizations and providers that has started to work together to improve the coordination of care across the continuum.

Priority Process: Competency

New staff are provided with a corporate and program-specific orientation. There is orientation to the safe use and operation of equipment, devices, and supplies.

Both FHTs have a recently created ethics framework and have access to a bioethicist. This is seen as an important resource when making difficult decisions. Since the framework was just completed in September, the staff have not yet had opportunities to use it.

Staff report being supported by their managers and executive directors, and having opportunities for professional development including in-services, research presentations, and conferences.

Strong collaboration and teamwork is a strength of the FHT teams. They work interprofessionally and clients and families are the centre of all that they do.

The interdisciplinary teams at both FHTs demonstrate enthusiasm and eagerness to serve the population. The medical leaders are dedicated and have played a substantive role in advancing and promoting services. The executive directors are high functioning, visibly present, and dedicated to providing the best care possible.

The physical environments of the FHTs are well organized and all members work together to ensure clients are safe. The environment is inviting and promotes a calming effect. The design of the waiting room facilities confidentiality.

The North Perth FHT has a diverse, interdisciplinary team of physicians, registered nurse practitioners, registered nurses, a registered dietitian, a registered pharmacist, an addictions youth worker, a social worker, a mental health counsellor, a health promoter, a business manager, an executive assistant, and the executive director.

The interdisciplinary team at the Clinton FHT includes physicians, registered nurse practitioners, registered nurses, a social worker, a mental heath worker, a registered dietitian, a registered pharmacist, a psychologist, and the executive director.

Executive leadership is a shared function between the executive directors and the medical directors.

The physicians have privileges at HPHA. North Perth FHT physicians also have privileges at the Wingham and Listowel hospitals.

The teams meet at least annually to review utilization data and plan services according to needs. Areas of specialization include diabetes, maternal care, and mental health.

Priority Process: Episode of Care

Leadership, staff, and physicians have committed significant time and energy to ensure clients have comprehensive, coordinated, and timely access.

All staff are proud of their collaborative and interdisciplinary team. They speak positively about the team dynamics and the supportive just culture.

Clients are very satisfied with their care and appreciate that the teams provide personalized follow-up on diagnostic tests. Urgent cases are seen the same day.

Several of the specialized programs focus on healthy living and self management. For example, a nurse practitioner has enhanced education related to chronic disease management, helping clients with chronic disease to self-manage and live healthier.

The team reviews compliments and complaints and develops actions as necessary to address them. There are suggestion boxes in the waiting rooms.

Clients and their families are well informed and regularly consulted regarding care delivery and management plans.

Staff are well informed and equipped with knowledge and easy access to resources, including on topics such as ethics, violence prevention, and communication.

At the Clinton FHT, a tabletop autoclave is situated in an area of the nursing station. The space conditions for reprocessing medical devices are not ideal, as clean and dirty are in the same physical space. It is suggested that this situation be constantly monitored, managed, and factored into future space planning.

At the North Perth FHT, the electronic medical record uses two dangerous abbreviations in the database: OD and U. The IT Steering Committee is working with the vendor to correct this. It is suggested that this information be shared with other users of this electronic medical record (Accuro).

Priority Process: Decision Support

Staff at both FHTs are required to complete mandatory education on privacy and confidentiality.

Following the circle of care, respecting clients' right to privacy and with their consent, information is shared as required to facilitate a client-centred approach to service delivery.

Clients are also involved in sharing information such as sharing their medication list and providing a discharge summary to appropriate providers.

Both FHTs participated in their provincial association (AFHTO) Data to Decision initiative for a number of years, and the results have helped drive the conversation about quality improvement initiatives. This initiative shows how the team measures up against relevant peers, and helps create standardized care approaches for immunizations, cancer screening, and registry development, and identification of gaps in data and clinical processes.

The FHTs use an electronic health record. At the time of the on-site survey, the North Perth FHT was in a recovery phase after suffering through a two-week infrastructure loss of its IT system (code grey).

Priority Process: Impact on Outcomes

The FHTs create and submit a comprehensive annual operating plan to the Ministry of Health and Long-Term Care. The plan details client numbers, programs and service delivery targets, and thresholds for the team for the applicable year. The plan reflects the HR and budgeted resources amounts as agreed to by the Ministry, and incorporates goals and objectives to achieve the strategic direction of the organization.

In addition, the FHTs are mandated under the Excellent Care for All Act to annually create and submit a quality improvement plan to Health Quality Ontario that outlines their goals and objectives for the next fiscal year.

The FHT Quality Improvement Committee that oversees quality improvement and safety initiatives meets on a regular basis. Indicators are reviewed and improvements made.

Clients and their families are aware of the complaint process even though all who were interviewed are happy with the services provided. Clients describe the services as excellent and efficient. They are provided with individualized care and information to make informed decisions. All would recommend the FHTs to others.

Relevant policies and procedures are in place and reviewed regularly with appropriate involvement from staff, clients, and families.

Some clients may not be aware of the excellent service provided by the interdisciplinary team, and team members suggest that more education about the services offered by the different disciplines might

increase awareness.”

North Perth FHT retained an external expert to conduct a compensation review to help achieve internal pay equity within the teams. Addressing the recommendations in the review will help with recruitment and retention.

Standards Set: Rehabilitation Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
1.3 Service-specific goals and objectives are developed, with input from clients and families.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Clinical leaders in therapies and professional practice as well as rehabilitation and seniors mental health are well partnered to deliver comprehensive and integrated rehabilitation services to clients and families. Like their teams, they are passionate about client-focused rehabilitation services and have worked to achieve an appropriate skill-level and experience mix in the team to support safe and effective service delivery.

The team has cultivated many internal and external strategic partnerships, including with the Community Care Access Centre, community nursing, long-term care facilities, the Alzheimer's Society, and mental health services. To support the Connecting the Dots for Caregivers project, the team also partnered with libraries to facilitate access to information for clients, families, and caregivers. The physical space is accessible and conducive to effective delivery of rehabilitation services.

The team is encouraged to develop, in partnership with clients and families, service-specific goals and objectives that are aligned with the organization's strategic direction. These goals and objectives will help inform and focus service planning and delivery efforts.

Priority Process: Competency

The interdisciplinary rehabilitation team includes credentialled professionals in nursing, medicine, physiotherapy, occupational therapy, speech language pathology, and social work. Rehabilitation assistants and clerical staff are also members of the team. In addition to the required organizational training, team members are encouraged and support by clinical leadership to avail themselves of more comprehensive training in palliative care and end-of-life issues. The team is noticeably high functioning and very collaborative in its approach to client care. It is not unusual to hear staff say to a colleague, in a meaningful way, “How can I help you?”

The team communicates via daily huddles and discharge rounds, and transfer of accountability is done verbally and using standardized tools. Transfer documentation is audited monthly for compliance with organizational standards.

Performance appraisals are done on a regular basis and although some were outstanding at the time of the on-site survey, staff who have received them found the feedback valuable and appreciated the professional development support.

Team members feel their contributions are valued and recognized, and their efforts in the workplace are appreciated.

Priority Process: Episode of Care

The 20-bed unit consists of nine rehabilitation beds, four complex continuing care beds, and seven acute care beds, with an ability to flex to 23 beds if necessary. Occupancy rate was 70 percent on the day of the on-site survey but this was noted to be unusually low. Hospitalists from the FHT rotate coverage of the inpatient unit which is accessible 24/7. The team has worked to remove barriers to access by facilitating online referral services and timely triage.

Medications are reconciled on admission, transfer, and discharge. Falls prevention strategies are in place and pressure ulcer risk assessments are completed as per organizational policy. Charts reviewed during the on-site survey were complete.

Registered Nurses’ Association of Ontario and Rehabilitative Care Alliance guidelines, including implementation of bundled care, are used to standardize practice when possible. Order sets, care plans, and discharge protocols facilitate standardization of care.

There is a detailed transition plan with written materials provided to the client. Follow-up telephone calls are made to touch base with the client and evaluate the effectiveness of the transfer or discharge process. The organization is encouraged to, more consistently and in a standardized fashion, evaluate the effectiveness of communication at transitions of care, particularly with partners outside of HPHA (e.g., transfers to London) where access to the electronic record is not possible.

Priority Process: Decision Support

Client records are standardized and comprehensive, and are audited monthly for compliance with required documentation practices. Charts are hybrid (electronic and paper) with secure electronic access available to team members as required. Paper charts are contained and kept in an area somewhat removed from public access. Clients are able to access their clinical record should they ask.

Priority Process: Impact on Outcomes

The team incorporates .

Registered Nurses' Association of Ontario and Rehabilitative Care Alliance evidence-based practice guidelines into care delivery. Order sets, care maps, and treatment protocols are in use. Processes are in place to select and review practice guidelines with involvement of the broader team. Daily huddles and discharge rounds provide opportunities for information exchange and discussion of safety concerns. Team members are familiar with the incident reporting system and feel comfortable reporting.

The rehabilitation team uses data to plan service design and delivery. In response to an organizational call to achieve efficiencies, the team examined personal support worker hours based on the CNO 3 Factor Framework, and adjusted personal support worker hours to best meet the needs of the clients. The change is being studied for impact. The team also identified gaps in speech language pathologist services and is developing a business case to expand the service and close the gap. The team has access to population level data from the public health units and the South West LHIN, and these data could be used to strategically plan services and care delivery (e.g., an increasing need for bariatric services).

The team was an active partner in piloting the Connecting the Dots for Caregivers initiative in Seaforth. This initiative is now being rolled out to other sites in Ontario.

Standards Set: Transfusion Services - Direct Service Provision

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

Surveyor comments on the priority process(es)
Priority Process: Episode of Care
No issues noted.
Priority Process: Transfusion Services
The Laboratory Committee includes transfusion medicine. The team is not responsible for transfusion in the home and only provides the product if required. Improvements to utilization have been made with regard to reduced waste, with the redistribution of product among sites.

Instrument Results

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

Governance Functioning Tool (2016)

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

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

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

- **Data collection period: February 28, 2019 to March 29, 2019**
- **Number of responses: 49**

Governance Functioning Tool Results

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1. We regularly review and ensure compliance with applicable laws, legislation, and regulations.	6	4	90	91
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	0	2	98	94
3. Subcommittees need better defined roles and responsibilities.	61	13	26	72
4. As a governing body, we do not become directly involved in management issues.	8	8	84	84
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	6	94	93

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
6. Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	95
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	10	90	95
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	0	4	96	96
9. Our governance processes need to better ensure that everyone participates in decision making.	58	17	25	61
10. The composition of our governing body contributes to strong governance and leadership performance.	2	6	92	94
11. Individual members ask for and listen to one another's ideas and input.	2	0	98	97
12. Our ongoing education and professional development is encouraged.	2	15	83	85
13. Working relationships among individual members are positive.	0	0	100	97
14. We have a process to set bylaws and corporate policies.	4	4	91	94
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	97
16. We benchmark our performance against other similar organizations and/or national standards.	10	20	69	71
17. Contributions of individual members are reviewed regularly.	23	27	50	68
18. As a team, we regularly review how we function together and how our governance processes could be improved.	17	13	71	82
19. There is a process for improving individual effectiveness when non-performance is an issue.	20	37	43	58
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	13	15	73	84

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
21. As individual members, we need better feedback about our contribution to the governing body.	29	22	49	46
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	10	14	76	76
23. As a governing body, we oversee the development of the organization's strategic plan.	0	4	96	93
24. As a governing body, we hear stories about clients who experienced harm during care.	24	13	62	81
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	2	8	90	89
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	2	6	91	85
27. We lack explicit criteria to recruit and select new members.	63	24	12	75
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	2	10	88	83
29. The composition of our governing body allows us to meet stakeholder and community needs.	0	4	96	91
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	2	11	87	92
31. We review our own structure, including size and subcommittee structure.	13	8	79	85
32. We have a process to elect or appoint our chair.	6	9	85	84

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2018 and agreed with the instrument items.

Overall, what is your assessment of the governing body's impact over the past 12 months, in terms of driving improvements to:	% Poor / Fair	% Good	% Very Good / Excellent	%Agree * Canadian Average
	Organization	Organization	Organization	
33. Patient safety	8	17	75	77
34. Quality of care	4	14	82	78

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2018 and agreed with the instrument items.

Canadian Patient Safety Culture Survey Tool: Community Based Version

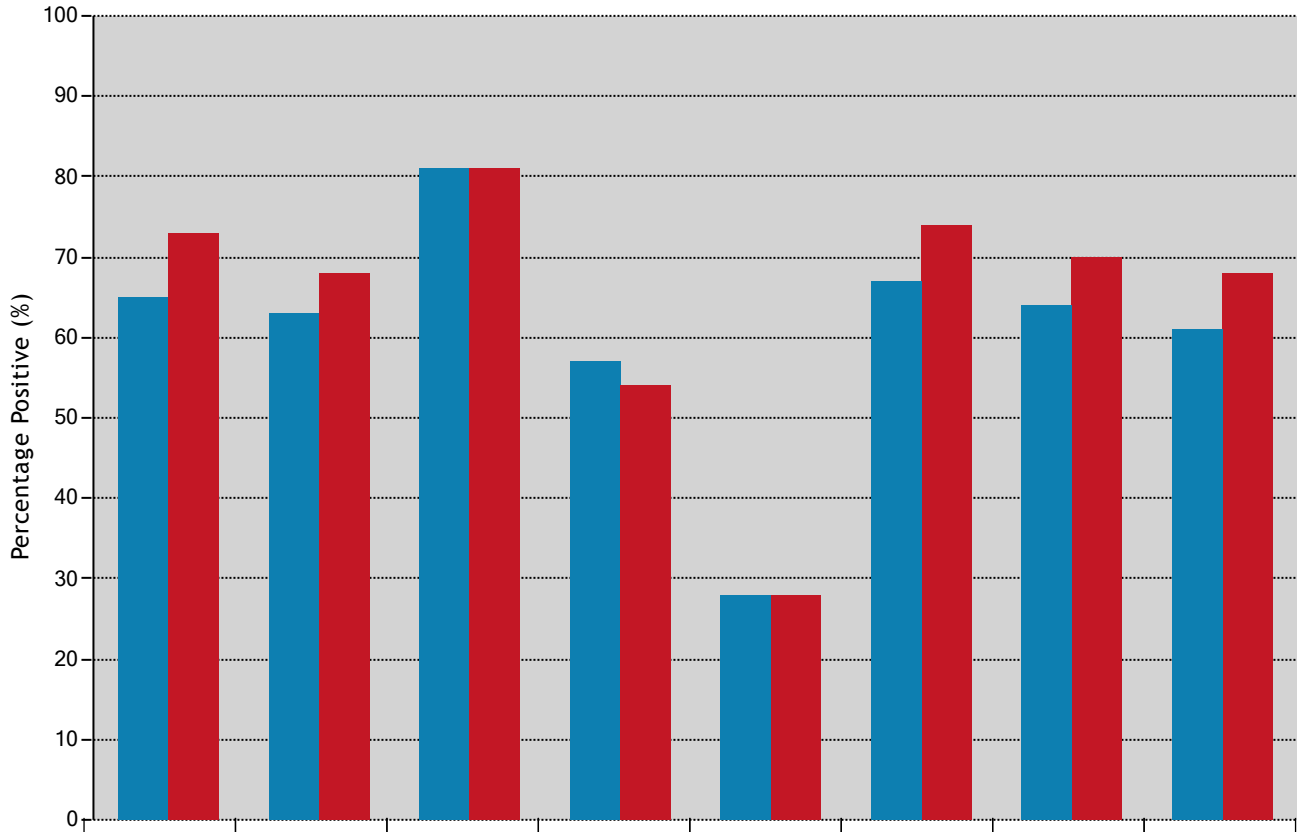
Organizational culture is widely recognized as a significant driver in changing behavior and expectations in order to increase safety within organizations. A key step in this process is the ability to measure the presence and degree of safety culture. This is why Accreditation Canada provides organizations 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: January 9, 2019 to February 18, 2019**
- **Minimum responses rate (based on the number of eligible employees): 296**
- **Number of responses: 297**

Canadian Patient Safety Culture Survey Tool: Community Based Version: Results by Patient Safety Culture Dimension



	Organizational (senior) leadership support for safety	Supervisory leadership for safety	Learning culture	Enabling Open Communi-cation I: judgment-free environment	Enabling Open Communi-cation II: job repercussions of error	Incident follow up	Stand-alone items	Overall Perceptions of Client Safety
	65%	63%	81%	57%	28%	67%	64%	61%
	73%	68%	81%	54%	28%	74%	70%	68%

Legend

Huron Perth Healthcare Alliance

* Canadian Average

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

Worklife Pulse

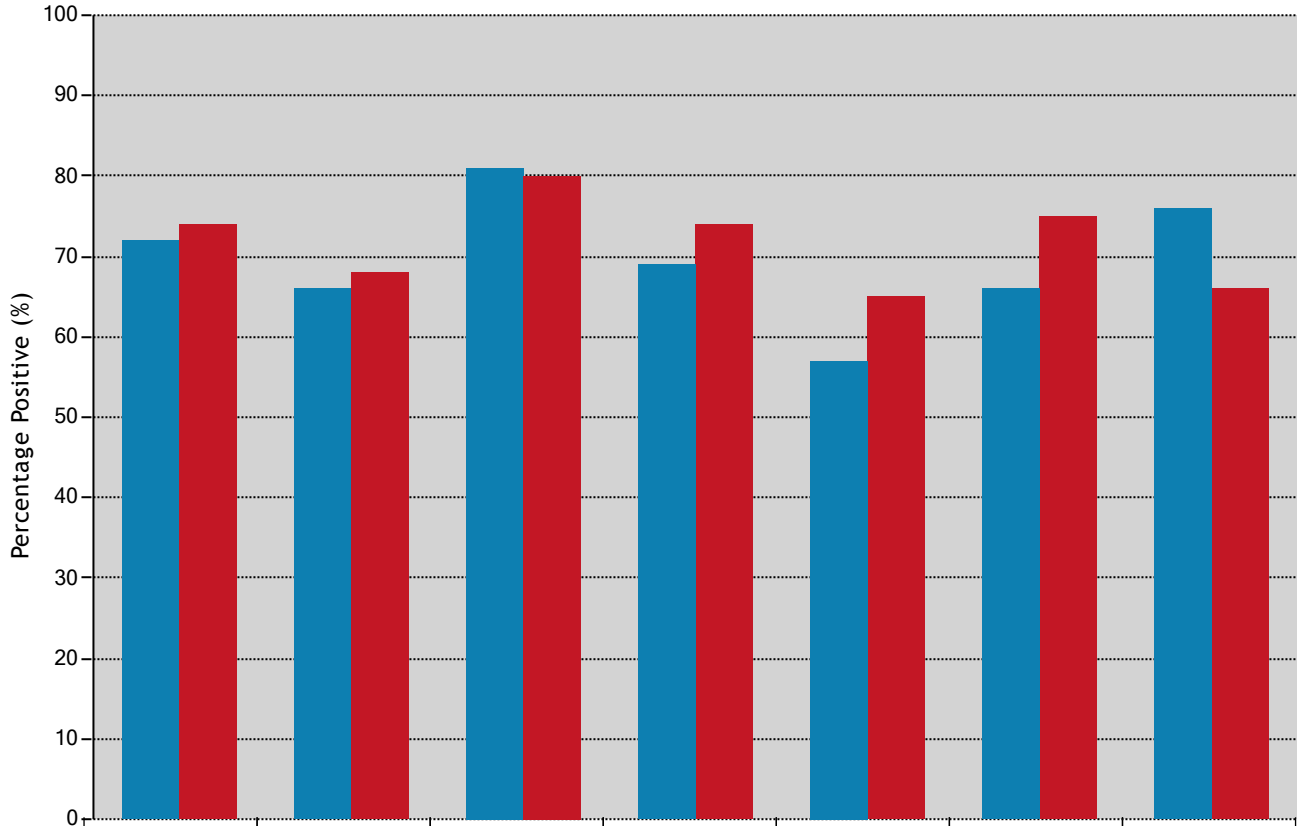
Accreditation Canada helps organizations create high quality workplaces that support workforce wellbeing and performance. This is why Accreditation Canada provides organizations with the Worklife Pulse Tool, an evidence-informed questionnaire that takes a snapshot of the quality of worklife.

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

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

- **Data collection period: December 6, 2018 to January 4, 2019**
- **Minimum responses rate (based on the number of eligible employees): 303**
- **Number of responses: 373**

Worklife Pulse: Results of Work Environment



	Job	Training and Development	Coworkers	Immediate Supervisor	Senior Management	Safety and Health	Overall Experience
	72%	66%	81%	69%	57%	66%	76%
	74%	68%	80%	74%	65%	75%	66%

Legend

Huron Perth Healthcare Alliance

* Canadian Average

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

Client Experience Tool

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

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

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

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

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

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

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

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

Appendix A - Qmentum

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

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

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

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

Action Planning

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

Appendix B - Priority Processes

Priority processes associated with system-wide standards

Priority Process	Description
People-Centred Care	Working with clients and their families to plan and provide care that is respectful, compassionate, culturally safe, and competent, and to see that this care is continuously improved upon.