ACCREDITATION CANADA

Driving Quality Health Services

Accreditation Report

Huron Perth Healthcare Alliance

Stratford, ON

On-site survey dates: October 5, 2014 - October 10, 2014

Report issued: December 19, 2014

ACCREDITATION CANADA
AGRÉMENT CANADA

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

Accredited by ISQua

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 2014. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

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

Confidentiality

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

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

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

A Message from Accreditation Canada's President and CEO

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

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

Your Accreditation Specialist is available if you have questions or need guidance.

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

We look forward to our continued partnership.

Sincerely,

Wendy Nicklin
President and Chief Executive Officer

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Section 1 Executive Summary

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.

1.1 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.

1.2 About the On-site Survey

- **On-site survey dates: October 5, 2014 to October 10, 2014**

- **Locations**

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

  1 Clinton Public Hospital
  2 Seaforth Community Hospital
  3 St. Marys Memorial Hospital
  4 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 Leadership
  2 Governance
  3 Infection Prevention and Control

  Service Excellence Standards

  4 Operating Rooms
  5 Surgical Care Services
  6 Critical Care
  7 Emergency Department
  8 Point-of-Care Testing
  9 Diagnostic Imaging Services
  10 Medicine Services
  11 Rehabilitation Services
  12 Obstetrics Services
  13 Mental Health Services
  14 Transfusion Services
  15 Biomedical Laboratory Services
  16 Medication Management Standards
  17 Reprocessing and Sterilization of Reusable Medical Devices

- **Instruments**

  The organization administered:

  1 Governance Functioning Tool
  2 Patient Safety Culture Tool
  3 Worklife Pulse
  4 Client Experience Tool

1.3 Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
 Population Focus (Working with communities to anticipate and meet needs)	53	8	0	61
 Accessibility (Providing timely and equitable services)	86	0	0	86
 Safety (Keeping people safe)	568	11	14	593
 Worklife (Supporting wellness in the work environment)	137	0	0	137
 Client-centred Services (Putting clients and families first)	154	6	0	160
 Continuity of Services (Experiencing coordinated and seamless services)	51	0	2	53
 Effectiveness (Doing the right thing to achieve the best possible results)	842	15	19	876
 Efficiency (Making the best use of resources)	64	2	1	67
Total	**1955**	**42**	**36**	**2033**

1.4 Overview by Standards

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

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

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

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

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Leadership	45 (97.8%)	1 (2.2%)	0	83 (98.8%)	1 (1.2%)	1	128 (98.5%)	2 (1.5%)	1
Governance	44 (100.0%)	0 (0.0%)	0	32 (94.1%)	2 (5.9%)	0	76 (97.4%)	2 (2.6%)	0
Infection Prevention and Control	47 (94.0%)	3 (6.0%)	3	39 (92.9%)	3 (7.1%)	2	86 (93.5%)	6 (6.5%)	5
Medication Management Standards	73 (100.0%)	0 (0.0%)	5	60 (100.0%)	0 (0.0%)	4	133 (100.0%)	0 (0.0%)	9
Biomedical Laboratory Services **	69 (100.0%)	0 (0.0%)	0	98 (100.0%)	0 (0.0%)	0	167 (100.0%)	0 (0.0%)	0
Critical Care	30 (100.0%)	0 (0.0%)	0	92 (98.9%)	1 (1.1%)	0	122 (99.2%)	1 (0.8%)	0
Diagnostic Imaging Services	64 (95.5%)	3 (4.5%)	0	59 (98.3%)	1 (1.7%)	1	123 (96.9%)	4 (3.1%)	1
Emergency Department	30 (100.0%)	0 (0.0%)	1	83 (87.4%)	12 (12.6%)	0	113 (90.4%)	12 (9.6%)	1
Medicine Services	26 (100.0%)	0 (0.0%)	1	68 (98.6%)	1 (1.4%)	0	94 (98.9%)	1 (1.1%)	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
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Mental Health Services	31 (100.0%)	0 (0.0%)	1	85 (96.6%)	3 (3.4%)	0	116 (97.5%)	3 (2.5%)	1
Obstetrics Services	61 (100.0%)	0 (0.0%)	2	74 (100.0%)	0 (0.0%)	1	135 (100.0%)	0 (0.0%)	3
Operating Rooms	65 (98.5%)	1 (1.5%)	3	30 (100.0%)	0 (0.0%)	0	95 (99.0%)	1 (1.0%)	3
Point-of-Care Testing **	38 (100.0%)	0 (0.0%)	0	48 (100.0%)	0 (0.0%)	0	86 (100.0%)	0 (0.0%)	0
Rehabilitation Services	26 (100.0%)	0 (0.0%)	1	63 (92.6%)	5 (7.4%)	0	89 (94.7%)	5 (5.3%)	1
Reprocessing and Sterilization of Reusable Medical Devices	35 (94.6%)	2 (5.4%)	3	56 (98.2%)	1 (1.8%)	2	91 (96.8%)	3 (3.2%)	5
Surgical Care Services	28 (100.0%)	0 (0.0%)	2	63 (96.9%)	2 (3.1%)	0	91 (97.8%)	2 (2.2%)	2
Transfusion Services **	69 (100.0%)	0 (0.0%)	2	66 (100.0%)	0 (0.0%)	0	135 (100.0%)	0 (0.0%)	2
Total	**781 (98.7%)**	10 (1.3%)	24	1099 (97.2%)	32 (2.8%)	11	1880 (97.8%)	42 (2.2%)	35

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

1.5 Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Safety Culture			
Adverse Events Disclosure (Leadership)	Met	3 of 3	0 of 0
Adverse Events Reporting (Leadership)	Met	1 of 1	1 of 1
Client Safety Quarterly Reports (Leadership)	Met	1 of 1	2 of 2
Client Safety Related Prospective Analysis (Leadership)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Communication			
Client And Family Role In Safety (Critical Care)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Diagnostic Imaging Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Medicine Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Mental Health Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Obstetrics Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Rehabilitation Services)	Met	2 of 2	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client And Family Role In Safety (Surgical Care Services)	Met	2 of 2	0 of 0
Dangerous Abbreviations (Medication Management Standards)	Met	4 of 4	3 of 3
Information Transfer (Critical Care)	Met	2 of 2	0 of 0
Information Transfer (Emergency Department)	Met	2 of 2	0 of 0
Information Transfer (Medicine Services)	Met	2 of 2	0 of 0
Information Transfer (Mental Health Services)	Met	2 of 2	0 of 0
Information Transfer (Obstetrics Services)	Met	2 of 2	0 of 0
Information Transfer (Rehabilitation Services)	Met	2 of 2	0 of 0
Information Transfer (Surgical Care Services)	Met	2 of 2	0 of 0
Medication reconciliation as a strategic priority (Leadership)	Met	4 of 4	2 of 2
Medication reconciliation at care transitions (Critical Care)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Emergency Department)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Medicine Services)	Met	5 of 5	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Mental Health Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Rehabilitation Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Surgical Care Services)	Met	5 of 5	0 of 0
Safe Surgery Checklist (Obstetrics Services)	Met	3 of 3	2 of 2
Safe Surgery Checklist (Operating Rooms)	Met	3 of 3	2 of 2
Two Client Identifiers (Biomedical Laboratory Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Critical Care)	Met	1 of 1	0 of 0
Two Client Identifiers (Diagnostic Imaging Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Emergency Department)	Met	1 of 1	0 of 0
Two Client Identifiers (Medicine Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Mental Health Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Obstetrics Services)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Two Client Identifiers (Operating Rooms)	Met	1 of 1	0 of 0
Two Client Identifiers (Point-of-Care Testing)	Met	1 of 1	0 of 0
Two Client Identifiers (Rehabilitation Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Surgical Care Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Transfusion Services)	Met	1 of 1	0 of 0
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management Standards)	Met	4 of 4	1 of 1
Concentrated Electrolytes (Medication Management Standards)	Met	3 of 3	0 of 0
Heparin Safety (Medication Management Standards)	Met	4 of 4	0 of 0
High-Alert Medications (Medication Management Standards)	Met	5 of 5	3 of 3
Infusion Pumps Training (Critical Care)	Met	1 of 1	0 of 0
Infusion Pumps Training (Emergency Department)	Met	1 of 1	0 of 0
Infusion Pumps Training (Medicine Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Obstetrics Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Operating Rooms)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Infusion Pumps Training (Rehabilitation Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Surgical Care Services)	Met	1 of 1	0 of 0
Narcotics Safety (Medication Management Standards)	Met	3 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Client Safety Plan (Leadership)	Met	2 of 2	2 of 2
Client Safety: Education And Training (Leadership)	Met	1 of 1	0 of 0
Preventive Maintenance Program (Leadership)	Met	3 of 3	1 of 1
Workplace Violence Prevention (Leadership)	Met	5 of 5	3 of 3
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Compliance (Infection Prevention and Control)	Met	1 of 1	2 of 2
Hand-Hygiene Education and Training (Infection Prevention and Control)	Met	2 of 2	0 of 0
Infection Rates (Infection Prevention and Control)	Met	1 of 1	3 of 3
Reprocessing (Infection Prevention and Control)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Falls Prevention			
Falls Prevention Strategy (Diagnostic Imaging Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Medicine 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: Falls Prevention			
Falls Prevention Strategy (Mental Health Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Obstetrics Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Rehabilitation Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Surgical Care Services)	Met	3 of 3	2 of 2
Patient Safety Goal Area: Risk Assessment			
Pressure Ulcer Prevention (Critical Care)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Medicine Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Rehabilitation Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Surgical Care Services)	Met	3 of 3	2 of 2
Suicide Prevention (Mental Health Services)	Met	5 of 5	0 of 0
Venous Thromboembolism Prophylaxis (Critical Care)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Medicine Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Surgical Care Services)	Met	3 of 3	2 of 2

1.6 Summary of Surveyor Team Observations

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

The organization, Huron Perth Healthcare Alliance (HPHA) is commended on preparing for and participating in the Qmentum survey program. The board of HPHA is an active and engaged group of people from the various geographic areas and numerous communities that are serviced by the four community hospital sites that comprise the Alliance. There is diversity on the board and members possess varying lengths of service and experience in health care governance. The board is supported by active local advisory committees (LACs) at each of the sites. The HPHA board has a strategic plan and there is a well-communicated mission, vision and values which guide decisions and the activities of senior leadership.

The leadership in the organization has undertaken environmental scans and recognize significant challenges facing their populations and health organizations in the coming years. The HPHA has undertaken several significant and innovative initiatives to enhance quality and safety, access and viability. This is to be achieved by reducing service duplication, realigning programs and services, and introducing new models of care designed to enhance the patient experience. Considerable engagement and consultations have been undertaken with internal and external stakeholders to build understanding and support for the changes and innovations that are being implemented. The HPHA has demonstrated openness, transparency and a willingness to listen to stakeholders. It is clear the HPHA aspires to be recognized as a leading organization among its peers and regularly shares its experiences and insights with others.

The organization has earned a solid reputation among those whom it serves. The communities and community partners speak highly of HPHA and have generously supported the organization's foundations and capital acquisitions. In recent years the organization has demonstrated solid financial stewardship and will need to continue strong budgetary acumen in the face of changes in volumes and health care funding methodologies as well as expectations for programs and services.

Staff members display obvious pride in the facilities of HPHA and the services they provide to patients. Quality improvement and LEAN methodologies have been embraced and there is clear evidence of commitment to education and finding better ways to benefit patients and providers. With a focus on being part of the patient experience, the staff members, physicians and volunteers have accomplished much and are well-positioned to achieve goals and objectives. Investments in infrastructure, medication management, technologies, communication and learning are all built on a legacy of caring established at the respective sites in the alliance, and contribute to new era of exceptionally positive health care experiences for the approximately 130,000 people in the areas served by HPHA.

Section 2 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

2.1 Priority Process Results for System-wide Standards

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

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

2.1.1 Priority Process: Governance

Meeting the demands for excellence in governance practice.

Unmet Criteria		High Priority Criteria
Standards Set: Governance		
10.3	The governing body works with the CEO to establish, implement, and evaluate a communication plan for the organization.	
10.4	The communication plan includes strategies to communicate key messages to staff, stakeholders, and the community.	

Surveyor comments on the priority process(es)

The board composition is relatively larger than many boards but makes effective use of its committee structure. Contributing to its size is the large number of physicians from various sites that are also appointed to the board. Medical involvement at the board level is significant and noteworthy. Board committees do 'deeper dives' into issues and reports to the board on a regular basis. The board has many interested and engaged members that have served their respective communities and the Huron Pert Healthcare Alliance (HPHA) for many years. It would appear however, there is a distinct emphasis on geographic representation that may pose a challenge to the industry's move to competency-based boards. Despite the potential for geographic priorities to prevail it appears the board membership is diverse and functions as a cohesive unit that acts in the best interest of the Alliance. The Alliance agreement is a primary document that governs the board and leadership.

There is a satisfactory process to orient new members to the board which includes informal and formal learning opportunities and mentorships. Although recognizing how intimidating it may appear to join the board, new members report being extremely well supported and set-up for success. There are a series of comprehensive policies regarding board member terms and duties. The local advisory committees (LACs) serve as a 'training ground' and are a source of potential new board members. As the board and Alliance matures, there may be opportunities to move to a competency-based board which is regarded as best practice in governance.

The board is well-versed in the development and understanding of its strategic plan and the process it went through to arrive at its current foundational statements. The board through the chief executive officer (CEO) and senior staff members make significant efforts to promote caring and a positive patient experience and open communication with stakeholders. The board is encouraged to continue its plans to refresh the 2011-2014 plans. It is further suggested that the board members remain significantly involved in the development of their quality improvement plans [QIPs] and stay conversant with the QIPs, which are submitted yearly to the Local Health Integrated Network (LHIN) and the Ministry of Health and Long-term Care.

Of note is that considerable effort recently culminated in a renewed set of board policies and the board is deservedly proud of its accomplishment. The board is reflective of its performance and seeks opportunities for improvement. Its audit committee coordinates a regular and comprehensive review of the CEO's performance, which includes a 360-degree feedback component. A clear policy for succession has been developed.

The board also has the means to conduct a "board only" meeting and has held such sessions when warranted.

The local advisory committees (LACs) are significant structures linked to the organization and the constituents it serves. It appears these LAC groups play a significant role and are quite active.

2.1.2 Priority Process: Planning and Service Design

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The board participated in a formal strategic planning process several years ago and is now preparing to undertake a refresh that will again involve internal and external stakeholders. The plan is consistent with the board's mission, vision and values that were also developed collaboratively with constituents and stakeholders. The strategic plan is the 'touchstone' for all activities. Board members are keenly aware of these documents and aspirations and seek opportunities to reinforce and model the values.

There is a culture of significant community engagement in planning and such partnerships have proven successful. The leadership continually seeks opportunities for new partnerships. The Community Care Access Centre (CCAC) is a major partner and liaison meetings have proven productive in enhancing understanding and co-operation which in turn, is beginning to help solve system issues. Significant pressures exist for Mental Health services and the organization has worked with the Local Health Integrated Network (LHIN) to obtain funds for emergency department (ED) crisis workers.

There is awareness of volume pressures in several programs and the leadership is exploring ways to grow programs and establish service-specific niches at various sites within the Alliance. Environmental scans have been undertaken and also accessed from agencies such as the LHIN. Consultants will be engaged to help assess future needs and opportunities.

The board and leadership have decided that bed re-allocation among the four sites is the major preoccupation in the coming months and financial modelling has been attempted to better predict this innovative but challenging initiative. The initiative was planned using a multitude of data sources, systems thinking and guiding principles. Physicians and a myriad of others have been involved. A framework with a series of indicators has been developed to evaluate and report. Considerable efforts have been made to communicate the changes to stakeholders however, there remains uncertainty and fear amongst staff members and providers. This initiative will be a significant change management endeavour and it is suggested a formal communication audit be undertaken and a communication plan be developed and adhered to when changes begin to take effect.

Concern with falling volumes and the need to 'grow the business' to maintain funding has been recognized and noted.

2.1.3 Priority Process: Resource Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Although this past fiscal year the organization achieved a surplus on operations, it was unsuccessful in defending against a ministry claw back of Post Construction Operating Plan (PCOP) dollars. This has resulted in a significant shortfall. Permission from the Local Health Integrated Network (LHIN) to run a deficit has been obtained but the organization will be significantly challenged, despite having maintained a contingency. Concerns exist for maintaining working capital and the need to generate operational surpluses is understood and being pursued in the coming years.

Case costing is a noted strength and the investment in it years ago is helping prepare for the future funding regimes. The leadership is aware of declining volumes that will intensify the need to grow the business if recent trends continue. Bed re-allocation also represents a significant budgetary challenge. Financial modelling and shifting of resources will create uncertainty. The leadership has wisely chosen to budget conservatively as it enters into a future fraught with uncertainty and possible unintentional costs and program volumes.

The organization has found several creative revenue generation opportunities, using assets that serve a need in the community. The Alliance agreement also governs financial matters and how costs and revenues are allocated. There is adequate financial controls and reporting. External auditors are engaged and operational routines include appropriate checks and balances.

Program directors are significantly engaged in understanding their respective budgets and are supported in monthly reviews of anomalies and variances. Reporting has been simplified and new leaders receive education in financial matters.

Policies guide procurement and the selection and negotiation of contracts. Mechanisms exist to evaluate existing contracts. Processes align with the specifications of the broader Public Sector guidelines for procurement.

The organization is encouraged to explore opportunities beyond the Alliance for shared services and group purchasing.

2.1.4 Priority Process: Human Capital

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

There is evidence that those responsible for the human capital do work as a cohesive team where collaboration and collegiality has cultivated a culture best described as a sense of 'community'. Human resource and professional practice practitioners are connected to regional and provincial networks where concerns, insights and resources are shared. A culture of learning is promoted and there is co-operation between the organization and several academic agencies.

The needs of the multi-generational workforce and of an aging workforce are recognized by the organization. Relationships among staff members, leadership and the unions are strong and productive. All groups spoke highly of the vital roles volunteers play and the need to engage them in meaningful endeavours. The organization is commended for implementing a patient concierge service utilizing volunteers. Inviting volunteers to participate on the unit action committees is also recognized and commended.

Training and education opportunities exist but uptake from the front-line staff members is challenged by the heavy workload demands. Resolving such barriers is vital, especially in light of policies which require annual training and updates in areas such as client safety and workplace violence. Tracking and ensuring staff training is the responsibility of department managers and the organization compiles Alliance-wide reports. At the time of the on-site survey, there were wide ranges in the percentage of staff members having completed assigned courses. Attending annual fire training has a low percentage and needs to be addressed.

The recruitment of 2.5 clinical educators will advance the learning environment across the organization and is expected to facilitate a review of the orientation program. The organization is commended for value stream mapping the on-boarding process and this will complement the orientation review when it begins.

Required organizational practices for preventing workplace violence have been met. Risk assessments for all sites have been completed. A matrix of results and action plan are due for completion in the fall for presentation to leadership team in December. The non-violent crisis intervention (NVCI) model is well-subscribed and supported.

Issues related to large spans of control are being addressed with the hiring of more managers. A focus on performance appraisals is becoming the norm and has resulted in increased quality interactions between supervisors and staff. Job descriptions and position profiles are reviewed during such meetings which are carried out every two years.

2.1.5 Priority Process: Integrated Quality Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The leadership clearly articulates the need for improvement and innovation to ensure quality care and viability of the organization. Quality reports are regularly provided and reviewed by the board and local advisory committees (LACs). The medical advisory committee (MAC) also has developed a quality focus in its meetings.

Significant investments have been made in quality improvement capacity-building training. There is evidence of investments in leadership and medical leadership training to build capacity in LEAN and process improvements to improve the patient and staff experience. The organization is commended for its investment in and utilization of Lean training and methodologies to advance the patient experience. Several Kaizan events have been held and staff members were seconded to attend. Several quality initiatives such as hourly rounding, patient experience video and antimicrobial stewardship were identified and shared.

There is a framework for risk management which devolves responsibility to all levels in the organization. The risk management framework document notes there is still work to be done for implementing and refining a risk management culture, and four critical steps are outlined. The organization is encouraged to accelerate these efforts.

Client safety is a priority across the organization. There is increased client involvement and the voice of the client is heard, especially via local advisory committee structures and more recently, via the many unit action councils that are gaining traction. In these structures staff members hear what defines quality for the patients and this will help move the organization further towards a clear definition of quality, based upon agreement on what the patient actually values.

There is also evidence of physician commitment to quality improvement, with grand rounds, video conferencing availability of rounds and presentations and multidisciplinary rounds. Physician-driven events such as the "ER Round Table" and "Intensive Tuesdays" were highlighted. The orthopaedic group also identified their initiative to develop care maps that reduce length of stays for total joint replacements. Congestive obstructive pulmonary disease (COPD) order sets were also developed in the emergency department and were found to be workable and useful. Frameworks for the development of order sets exist and have proven successful when led by physician champions.

The recently revised disclosure policy is comprehensive. It was suggested during the survey that physicians are quite receptive to disclosure. The organization is encouraged to ensure there is clear and consistent documentation of disclosures and that disclosure is seen as an organization responsibility, and that it does not merely default to physicians. Physicians are encouraged to seek support when disclosing and ensure there is proper documentation.

Quality of care reviews and case reviews are increasingly common and there are strong turnouts for such events.

The organization hosts many students/learners and this is seen as a positive development for advancing the quality agendas. Staff members and physicians make a commitment to learners who in turn help keep their mentors aware of advances in the field and thus afford fresh perspectives on quality.

Orientation of new staff members includes sessions on quality and risk and a culture of no blame. In addition, there appears to be a growing trust within the Alliance and the support for safety for patients and for a safe work environment is clear. In fact, it appears that a true culture of safety, with patient and workplace blended together is taking hold and the organization is commended and encouraged in this regard.

The root cause analysis (RCA) model has yet to be fully implemented. This model represents a huge opportunity to bolster the quality agenda of the organization.

An area requiring extra encouragement and attention relates to the quality of handovers between nursing and physicians. This matter is on the radar of the chief of staff who clearly recognizes that technology may at times be as much an inhibitor as well as an enabler. Several initiatives to minimize this challenge have been undertaken to enhance communication and accountability.

The organization has accomplished significant and commendable advancements in client safety. It has presented several initiatives where the Alliance undertook extensive quality improvements subsequent to analysis of an incident. Unfortunately, this approach does not meet the required organizational practice (ROP) criteria for being a prospective analysis. This ROP requires a proactive and prevention-oriented approach every year and as a result, the ROP did not meet the tests of compliance.

2.1.6 Priority Process: Principle-based Care and Decision Making

Identifying and decision making regarding ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The Huron Perth Healthcare Alliance (HPHA) followed a deliberate and successful process to establish its values. These values have been communicated widely across the organization.

Although there is no formal ethics committee as yet, there is a well-developed and comprehensive framework that has been reviewed and approved and is being presented to groups in the HPHA. It was suggested that structures exist on an ad hoc basis and key members are brought to the ethical processes when required and it is said this has served the organization well. Several ethical challenges in recent years were identified. Tracer reviews revealed a commitment to an ethical resolution of a longstanding client matter. The HPHA is encouraged to accelerate its efforts to formalize and 'hard wire' its ethical framework across the organization.

There is a longstanding relationship with, and easy access to an ethicist for consultations. The organization has also developed and nurtured external partnerships and has availed itself of many resources in the development of the HPHA framework.

Leaders in HPHA believe an ethical lens permeates all clinical efforts. This view was reinforced by the medical leadership involved with ethics. Opportunities for dialogue on ethical matters exist and are well-structured, and the unit action councils are an example. There appears to be many invested champions of increasing ethical awareness and considerations. There are strong commitments among the medical and nursing memberships and many are motivated to engage further.

2.1.7 Priority Process: Communication

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
7.4	The organization's leaders work with the governing body to develop and implement a communication plan to disseminate information to and receive information from internal and external stakeholders.	

Surveyor comments on the priority process(es)

The organization is encouraged to fill the communications position which it has posted. Although the organization does not have a formal communication plan, it does use a template for communications and appear to do an excellent job of sending key messages to internal and external stakeholders. All messages are compiled and circulated. It is suggested that attention be paid to the impact of messages sent and whether, in fact, the messages are reaching the intended audiences, and whether the messages are understood. There exists a multitude of means for receiving feedback from the internal and external stakeholders and these are utilized. This includes huddles, quarterly forums, surveys, the web, and Foundation.

A communication audit is suggested for the organization to validate the desired impact and effectiveness of messages and hopefully, it will lead to the development of a communication plan. As yet there is no comprehensive social media plan but the organization indicates it is on their radar. The organization is encouraged to pursue this emerging medium.

The organization is commended for developing a video promoting the patient experience. Not only was the message important it also promoted morale and injected a sense of fun into the workplace. The HPHA can be proud of this initiative.

There have been significant investments in information management (IM) systems. Leadership and capacity in this area is evident. The support to facilitate improvements in medication management has been substantial and highly successful and clearly demonstrates a link between technology and patient safety and quality care. In addition to recent investments, information technology (IT) personnel and leadership have a keen insight to emerging needs and possible new technologies. Initiatives such as the electronic health record (EHR) roadmap, computerized physician order entry (CPOE) module implementation, wireless updates at the Stratford site and eventually, the development of a true patient portal. All of this indicates the organization has a vision of where it needs to move. Despite the recognition afforded to technologies, team members and the leadership of HPHA understand some of the limits and barriers of over-reliance on technology, especially during times of significant change and upheaval. Balancing technologies and face-to-face interactions is practiced.

The organization is also commended for utilization of the Ontario Telehealth Network (OTN) for facilitating meetings and clinical encounters. Controls exist for privacy and confidentiality of patient information. Scanning of clinical records has been accomplished and these are available electronically.

The organization makes use of a variety of information sources including its own and information from external partners locally, within the Local Health Integrated Network (LHIN) and the provincial and national agencies. The HPHA is recognized among its partners as open and approachable, transparent, sharing and collaborative.

The organization invests in information, learning and professional support materials.

It is recognized that staff members, physicians and partners have indicated that the CEO is accessible and is a good communicator and listener. The Foundations and HPHA also have a mutually supportive role that promotes the HPHA brand.

The role of the board in promoting communication efforts is understood and appreciated. Board members are encouraged to be ambassadors for HPHA and are supported, briefed and supplied with key messages on important matters.

2.1.8 Priority Process: Physical Environment

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The physical environment is well maintained and it is evident that staff members take pride in their facilities. Facilities vary in age and most sites have had renovations to help meet new roles and/or needs. Grounds are well-appointed and maintained. There is a definitive commitment to the environment and recycling across the organization. Waste disposal and recycling equipment is evident and abundantly placed for ease of use.

Volunteers are commended for their commitment to helping maintain the facilities and equipment in a clean and inviting way. Volunteers are also well-identified and were frequently noticed supporting staff members and patients in many ways including doing a preliminary cleaning of wheelchairs. They appeared ever-present and ready to help.

The efficiency of the power plant was noted and regarded as being a high efficiency performer. Improvements in preventive maintenance since the previous survey have been noted. Maintenance staff members are shared across the Alliance sites and this initiative appears to have been working well.

During the on-survey it was apparent that staff members and patients all felt the facilities were safe, accessible and clean. A hazard and risk reporting system exists. Housekeeping has developed an impressive huddle board and is encouraged to continue the development and discussion of meaningful metrics that link to overall objectives of the HPHA.

2.1.9 Priority Process: Emergency Preparedness

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
14.2	The organization's leaders develop, implement, and evaluate an all-hazard disaster and emergency response plan to address the risk of disasters and emergencies.	!

Surveyor comments on the priority process(es)

The organization is involved with a variety of necessary community agencies for disaster and emergency planning. A representative of Huron Perth Healthcare Alliance (HPHA) sits on the Perth County planning group that meets 7-8 times per year. A local sharing and coordination of partners' mock disasters has occurred. The HPHA has not held a mock disaster for almost two years and it may be some time before a significant mock event is staged. It is concerning that for several years now there have been no evacuation opportunities either simulated or real, and doing so would have afforded the chance to demonstrate effective responses or opportunities for improvements. It is suggested that the organization host a mock event that includes an evacuation or simulated evacuation and debrief as soon as possible thereafter.

Several emergency codes have been revised or are being revised. Staff members that were interviewed during the survey indicate regular drills are held. It is also noted that the organization has responded admirably to several community incidents over the years and has earned the confidence and trust of many community partners.

There were examples of the successful use of code whites. Relations with local police are strong in this domain. Common training opportunities are pursued together and there is a high degree of co-operation and support for one another.

The local Public Health Unit (PHU) indicated that there is excellent resources and cooperation between the PHU and HPHA regarding infection prevention and control. It was felt they work well together when issues are identified. Local authorities and the organization have prepared for a potential Ebola outbreak. There has been widespread involvement of key partners. Train-the-trainer for proper use of personal protective equipment (PPE) is being prepared for roll-out and people are expected to be trained by the end of October 2014.

The organization is commended for ensuring that 100% of staff members and physicians have been fit-tested for N95 masks and the staff responsible for this initiative demonstrated great passion for ensuring this standard is maintained.

The organization is moving to the health emergency coordination centre (HECC) model, with job action sheets which replaces the information management system (IMS) model. Although partners expressed some concerns that the models vary slightly, they will continue to co-operate and work together successfully. There is an abundance of emergency equipment available to the organization.

There has been a significant investment in non-violent crisis intervention (NVCI) training and procedures. Evidence exists depicting the use of this model and approach.

2.1.10 Priority Process: Patient Flow

Assessing the smooth and timely movement of clients and families through service settings

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The health-based allocation methodology (HBAM) funding formula has driven a review of client activity and how patient access needs to be optimized. The organization is moving towards a model of functioning as one hospital with four wings, with each hospital wing having a specialized focus. This is being carried out during the next few months and involves major bed realignment. The process has been extensively analysed and reviewed and consulted upon. The organization is encouraged to monitor the success of the strategy in terms of optimizing patient access and ensuring that contingencies are in place to handle overcrowding and surges when they occur during this change period.

The patient flow initiative has and continues to evolve. Currently, there are regular 0830 hours discharge meetings at the unit level to identify discharges. These are followed by 1030 hours bed meetings which are attended by front-line clinical leaders from all clinical areas as well as the 'bed allocator'. Bed capacity is regarded as a corporate resource and patient flow is planned so that the right patient is accommodated in the right bed. Physician feedback to date indicates improvements are being noticed in terms of better understanding of patient discharge status, along with experiencing more focused and less disruptive communication patterns. The initiative aims to allow for an average of 85% occupancy in the clinical areas to allow for the ability to 'flex' should that be required.

This winter will be the first experience of making seasonal adjustments to staffing. For example, critical care based on an analysis of two years' of data and impact on critical capacity with two long-term ventilated patients occupying acute beds.

The team is achieving the target of two-hour time to admit from the emergency department. Housekeeping is actively involved in making process changes to help achieve this target.

Multiple improvements are being made to support the bed changes. These include strengthening the professional accountability model with shift-to-shift reports involving patients and improving processes associated with referrals and transfers of patients to tertiary providers.

Overall, the patient flow initiatives have strengthened relationships and collaboration with community partners as both work together to try to ensure seamless access to care in the right place and right location.

2.1.11 Priority Process: Medical Devices and Equipment

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

Unmet Criteria		High Priority Criteria
Standards Set: Diagnostic Imaging Services		
8.1	The individual responsible for the overall coordination of reprocessing and sterilization activities within the organization reviews and approves the team's set up and policies and procedures for cleaning and reprocessing.	
8.2	If the team does not have access to the resources needed to safely clean and reprocess diagnostic devices or equipment at the point of use, the team sends them to the medical device reprocessing department or an external provider.	!
8.6	All diagnostic imaging reprocessing areas are physically separate from client service areas.	!
8.7	All diagnostic imaging reprocessing areas are equipped with separate clean and decontamination work areas as well as separate clean storage, dedicated plumbing and drains, and proper air ventilation and humidity levels.	!
Standards Set: Reprocessing and Sterilization of Reusable Medical Devices		
3.3	The medical device reprocessing department is designed to prevent cross-contamination of sterilized and contaminated devices or equipment, isolate incompatible activities, and clearly separate different work areas.	!
5.2	The medical device reprocessing department's hand hygiene facilities are equipped with faucets supplied with foot-, wrist-, or knee-operated handles, or electric eye controls.	!
12.2	As part of the quality management system, the team engages in an annual review of reprocessing and sterilization activities, with formal reports provided to the organization's senior management.	

Surveyor comments on the priority process(es)

The centralization processing department (CPD) at the Stratford Hospital site has state-of-the-art facilities and equipment to support medical devices reprocessing and sterilization. The department looks after all hospital reprocessing. The Stratford location looks after the reprocessing function not only for itself but also for the St. Mary's facility. It is suggested that there is capacity for undertaking even more activity at the Stratford Hospital site. Both Seaforth and Clinton sites currently have CPD operations. The intent is for Clinton to shortly assume CPD services for the Seaforth site.

Staff members that work in the medical device and reprocessing areas are experienced and many have completed formal training in reprocessing and sterilization. There are separate and dedicated elevators to handle clean and dirty items from the operating room (OR) to CPD. This allows for efficient movement of equipment and instrumentation between the two areas without going through client or traffic areas.

Technology is in place to enable the preparation of sterile trays and to pick supplies for the OR and bar coding allows for effective tracking of supplies prepared by the department. There is further functionality that can be used with the current systems that are in place and the team is encouraged to explore the feasibility of doing so.

There is a robust preventive maintenance program that covers all equipment used in the CPD.

Endoscopy reprocessing and sterilization has been well thought out and staff members have been trained to perform the required processes particularly at the Stratford Hospital site.

Ultrasound probes are currently being cleaned and disinfected within their respective areas at the sites providing ultrasound services. The organization will need to consider whether or not to move cleaning and reprocessing to CPD, or maintain the existing system with modifications made to air ventilation and humidity levels.

Cleaning and disinfection of instruments and scopes at the Clinton site takes place in a separate small room across from the OR suites, in what is a sterile corridor at the Clinton site. Although controlled with scheduling procedures and activities in the area, essentially decontamination processes are taking place within the OR environment. Further, the work space is such that it is limited in supporting the growth of an ambulatory surgical outpatient program. Conversations with the staff members during the on-site survey further indicated that the OR suites have not been exclusively used for only minor procedures. Inguinal hernias and some bowel surgery have been performed, highlighting concerns around the CPD activity.

It was noted that housekeeping cleaning materials including a dirty mop were outside the entrance to one of the OR's during a tracer observation.

Surgical instrumentation brought in by a surgeon for a procedure was noted as being cleaned and disinfected in the Clinton CPD. This practice poses a significant risk and requires review to verify that compliance with hospital policy and measures are in place, and that traceability is assured.

In light of the above noted concerns there are serious issues regarding patient safety and risk management and the organization is advised to address this as a priority.

2.2 Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Point-of-care Testing Services

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

Clinical Leadership

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

Competency

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

Episode of Care

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

Decision Support

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

Impact on Outcomes

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

Medication Management

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

Organ and Tissue Donation

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

Infection Prevention and Control

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

Surgical Procedures

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

Diagnostic Services: Imaging

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

Diagnostic Services: Laboratory

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

Transfusion Services

- Transfusion Services

2.2.1 Standards Set: Biomedical Laboratory Services

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

Surveyor comments on the priority process(es)
Priority Process: Diagnostic Services: Laboratory
The laboratory is part of an umbrella group supplying services to many hospitals in this region. Each of the smaller sites has a core laboratory and the Stratford site manages most of the remaining tests. Standard operating procedures (SOPs) are reviewed and updated annually. The laboratory is responsible for point-of-care testing equipment. Most supplies are now prepared before they are delivered to the laboratory. The team has many quality indicators, and these are monitored on a regular basis.

2.2.2 Standards Set: Critical Care

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	
3.5 An intensivist or critical care specialist is available daily to consult with admitting physicians in open ICUs.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	
Priority Process: Organ and Tissue Donation	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The team is aware of certain high-risk clients in the community and plans for their likely intensive care needs. Patients are admitted from the emergency department (ED), hospital inpatient units, other hospitals and occasionally, from the operating room (OR).

The team has goals and objectives for the current year. These are aligned with the corporate priorities. The goals and objectives are measurable and specific. They are aligned with priorities of the organization.

Coverage is managed differently at the smaller sites. Staff members can be called in if more help is needed.

Priority Process: Competency

The team is organized to support staff members to work to their full skills capacity. Multidisciplinary rounds are held every morning. These are attended by the physician, nurse, physiotherapist, dietician, pharmacist and respiratory therapist. There is a full review of the patient status, prognosis and an estimate of their progress. Specifically, there is a good summary page that captures the patient's status every day and identifies their goals.

Staff members have various opportunities to develop their skills. There are regular meetings to support quality improvement and also regular staff huddles.

Priority Process: Episode of Care

This team is essentially a 'code blue' team and responds immediately when called. The code blue team responds to cardio-respiratory arrests in the organization. Inpatients are generally managed by medical or surgical specialists and will be immediately seen by them in the case of an urgent or acute medical event. The team is aware of the sensitive issue of end-of-life decisions.

The organization has a 'bed allocator' person that centralizes and coordinates all pertinent data and this optimizes patient flow. At the time of the survey a patient had recently transferred to a weaning centre. The team will follow this patient's progress and evaluate if he will need to return to the intensive care unit (ICU). It might be possible to explore options for alternate placement for this patient if weaning is not achieved.

Priority Process: Decision Support

The critical care unit is an open unit rather than a closed critical care unit. Consultation services are provided by internal medicine specialists and surgeons or internists may be the most responsible physician for any of the patients.

The team is assessing the need for new infusion pumps.

Priority Process: Impact on Outcomes

Benchmarking is done with some similar-sized units. The daily team huddle includes discussion of potential safety problems, errors and quality issues.

Ventilator association pneumonia (VAP) and central line (CLI) bundle numbers are tracked carefully. The critical care area has many ways to track and record outcomes.

Priority Process: Organ and Tissue Donation

The team has reached an arrangement with Trillium Gift of Life. The organ donation team has undertaken most of the necessary tasks for the donation and harvesting to take place.

2.2.3 Standards Set: Diagnostic Imaging Services

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 (DI) services are well-developed for the Huron Perth Healthcare Alliance (HPHA). There is high-quality and up-to- date equipment which is complemented with trained professionals that are providing a substantial breadth of service in a rural setting. Equipment is ever changing and plans exist for a refresh program that follows appropriate timelines.

Challenges to standardize and fully automate digital systems are recognized by service leadership and key enablers are the Foundations which have been avid supporters in the past. The DI service also feels supported by the administration. Ultrasound probes are currently being cleaned and disinfected within this area at the sites providing ultrasound services. The organization will need to consider whether or not to move cleaning and reprocessing to CPD, or maintain the existing system with modifications made to air ventilation and humidity levels.

There is considerable pride in the service. Bookings follow proper procedures yet there is also flexibility to accommodate urgent and emergent cases. As a result, access to most services is a noted strength. Ultrasound waits are currently a 'pain-point' that is being actively addressed. Otherwise, wait times are good when compared with the Local Health Integrated Network (LHIN) and province.

Turnaround times for test reports are consistently within 24 hours. Radiologists work as a team and are involved in operations of the service. Regular audits are performed and a peer review process has been established with the quality of reports regularly reviewed by colleagues. Discrepancies are brought to the radiologist's attention at radiologist meetings and often used as learning cases. Appropriate information in requisitions continues to be a challenge and the medical leadership in DI shares these concerns with physicians on a regular basis. A recent change in the form has made a significant improvement.

Clients are appropriately screened and guidelines are followed. Inpatients and outpatients spoke highly of the service and the opportunity to receive these services so close to home.

Worthy of recognition is the commitment to students and learners and which has created a high demand for student placements at HPHA. This also serves as a recruitment strategy and of note is that several current technicians were once students here. Existing staff members work hard to ensure quality learning experiences exist. Also worthy of special recognition is the Breast Screening Centre where there is a nurse navigator that supports patients during their encounter with the service. Special patient-focused amenities are in place such as a special entrance and a pleasant ambiance in the procedure rooms.

Huddle boards are regularly utilized and radiologists are commended for their engagement in the huddles and for their commitment to quality improvement. The DI services have demonstrated significant leadership by proactively considering ethics issues related to matters such as religious beliefs and Ebola preparations and equipment testing. In addition, there is a well-defined process to disclose when errors are made and these are treated as learning opportunities.

Impressive brochures have been developed in-house and they describe a range of services and inform patients about what to expect and as well, serve to answer many questions.

2.2.4 Standards Set: Emergency Department

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		
9.1	The team works with the ICU, organ recovery centre, or tissue recovery team to establish time frames for the timely transfer of potential organ and tissue donors from the emergency department.	
9.2	The organization has established clinical referral triggers to identify potential organ and tissue donors.	
9.3	The team receives training and education on the definition of imminent death, the use of clinical referral triggers, who to contact when potential organ and tissue donation opportunities arise, how to approach families about donation and other donation issues.	
9.4	The organization has a policy on neurological determination of death (NDD).	
9.5	The team follows a written protocol for NDD that includes accessing the people qualified to determine neurological death.	
9.6	The physicians that are accessed to determine neurological death must be independent of the procurement and transplant process.	
9.7	The team provides the family with the appropriate information about the implications of neurological death.	

9.8	The team notifies the Organ Procurement Organization (OPO) in a timely manner when death is imminent or established for potential donors.	
9.9	The team checks the provincial donor registry, where one exists, to determine if the patient is a registered donor.	
9.10	Before approaching the family, the team and the donation coordinator discuss how they will approach the family about donation.	
9.11	When approaching families about donation, the team uses a decoupling approach.	
9.12	The most qualified team member follows a written process when approaching families about organ and tissue donation.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The team collects data from multiple sources. Service provision is carefully matched to the population served.

The patient management software used in the emergency department (ED) allows the team to measure many different parameters. Some physical changes have already been implemented at the Stratford Hospital site although the department is fairly new. For example, the medication room was moved and is now much more accessible to the area where most acute care is provided. This is a good example of a practical approach to problem solving. It undoubtedly represents process optimization.

Construction is underway in the EDs at the Seaforth and Clinton sites.

There are negative pressure rooms in several departments. The team has contingency plans for use in the event of a patient suspected of infection with the Ebola virus.

Priority Process: Competency

Team huddles are used for team evaluation, quality improvements, error prevention and so on. During the survey one staff member reported a six-month orientation process as part of the 'new grad' program. This staff member found this comprehensive and effective. Staff recognition is offered across the organization, and there are long service awards and other similar acknowledgments.

Priority Process: Episode of Care

It is noted the ambulance off-load times are short, with the median at about 10 minutes. Waits of more than 30 minutes are unusual.
The team has access to comprehensive information about wait times for service and length of stay. This is enabled by the computer patient tracking software in place.

There is a good triage area at the Stratford Hospital site. The space provides sufficient privacy while allowing the triage nurse to see patients in the waiting room. The reception and triage areas are being renovated at the other sites. The Canadian Triage Acuity Scale (CTAS) scores are reassessed and changed if necessary.

There is a visual pain scale is in each of the patient care areas.

At night, at the Clinton site, staff members may not be in the emergency department at all times. Patients can use the intercom system to make their presence known and to speak to the nurse on duty. The nurse will then let the patient enter and provide the necessary triage assessment, registration and so on.

Priority Process: Decision Support

The client/patient record remains partly paper based and this record is readily accessible at the nursing station. Most results of laboratory testing and diagnostic imaging can be seen using the electronic medical record (EMR). This is accessible from any desktop computer.

The client/patient progress in the emergency department can be monitored and measured using the patient tracking software. The patient flow coordinator benefits from this tracking software.

Evidence-based guidelines are in use for patients with stroke and also with acute coronary syndrome. The organization is encouraged to expand its use of guidelines to other commonly encountered diagnoses. The team considered using order sets that are available online however, these were found to be insufficiently flexible for this organization.

Priority Process: Impact on Outcomes

Staff huddles are used to provide regular safety briefings, to share information about potential safety problems, to reduce the risk of error and to improve quality. While these are relatively informal the huddles have proved practical and useful. By way of example, a patient was inadvertently given an excessively high dose of intravenous medication. While no lasting harm was done to the patient, the error was disclosed to the immediate family. The family were grateful for the information. The staff members involved understood their error and received appropriate training to avoid a recurrence. The type of error was also highlighted for other staff members so that no- one else would make this mistake.

Priority Process: Organ and Tissue Donation

The team has reached an arrangement with Trillium Gift of Life. The organ donation team has undertaken most of the necessary tasks for the donation and harvesting to take place.

2.2.5 Standards Set: Infection Prevention and Control

Unmet Criteria		High Priority Criteria
Priority Process: Infection Prevention and Control		
2.2	The organization collaborates with its partners to engage the community in infection prevention and control initiatives and activities, including hand hygiene initiatives, education, and awareness campaigns.	
5.5	The organization offers IPAC education and training to partners, other organizations, and the community.	
11.2	The organization considers used equipment and devices to be contaminated and potentially infectious, and transports them appropriately to a designated decontamination or disposal area.	!
12.13	The organization's policies and procedures include traceability for all loaned, shared, consigned, and leased medical devices.	!
13.4	All endoscope reprocessing areas are equipped with separate clean and decontamination work areas as well as storage, dedicated plumbing and drains, and proper air ventilation.	!
13.9	Following disinfection or reprocessing, a qualified staff member flushes all channels with 70% isopropyl alcohol followed by forced medical grade air to facilitate drying.	
Surveyor comments on the priority process(es)		
Priority Process: Infection Prevention and Control		

The infection control team is two full-time staff members with part-time help. The team covers all four sites of the Huron Perth Healthcare Alliance, not only undertaking the infection prevention and control (IPAC) function but also covering occupational health and safety activities during periods of absence in that area. The team is involved in the flu immunization program. There is an active infection control committee in place. A pathologist services as chair of the infection control committee and the chair along with the Medical Officer of Health (Public Health) are the key physicians that provide medical direction to the IPAC program. Consideration needs to be given to developing access to infectious diseases expertise, as feasible.

There are protocols in place outlining actions to be taken for outbreak management. An external review by the infection control resource team (ICRT) was conducted mid 2013 to review and provide recommendations on the management of a lengthy outbreak of vancomycin resistant enterococci (VRE) in a facility; recommendations were made and subsequently, most were implemented.

Hand-hygiene audits are done on a regular basis and there has been steady improvement over the years. A cadre of 90 staff members have been recruited and trained to conduct hand-hygiene audits using iPad technology. The team is encouraged to review audit results to determine what moments require further reinforcement in terms of performance compliance.

Educational programming for IPAC is available and e-learning is utilized. It is suggested that refreshers in terms of real-time demonstrations and feedback sessions be provided for the proper donning and doffing of personal protective equipment (PPE) as several staff members and family members where observed doing this incorrectly. The re-introduction of the quick-tip card on doffing and donning gowning should also be considered.

The infection control team is encouraged to ensure a presence and provide support to clinical areas such as the operating room (OR) central processing (CPD) and diagnostics imaging (DI) where medical equipment and device reprocessing require ongoing oversight to ensure standards are being met. The Clinton site in particular requires attention to ensure that the CPD function is able to support the current and future growth of ambulatory services planned for that site.

It is suggested that consideration be given to ensuring that capacity continues to be built in terms of knowledge and skills in the areas of IPAC as it pertains to construction and renovation.

It is recommended that investments be undertaken to develop more expertise and capacity across the organization specific to medical device reprocessing and sterilization.

Senior management is seen as being supportive of the IPAC program and its practitioners.

2.2.6 Standards Set: Medication Management Standards

Unmet Criteria	High Priority Criteria
Priority Process: Medication Management	

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)
Priority Process: Medication Management

The pharmacy and therapeutics committee is in place and its functions cover all four sites of the Huron Perth Healthcare Alliance (HPHA) as well as the pharmacy functions at the Alexandra Marine and General Hospital (AMGH). Providers are generally very receptive to assistance in managing antimicrobial stewardship. The Alliance plans to invite an infectious diseases (ID) specialist to speak on this topic and to help implement further improvements to the existing process.

There are discussions occurring about forming a separate committee to focus on medication safety which would act as a more 'front line' group. High-alert medications are managed better with the assistance of the technology used in medication storage and administration. Technology has also greatly improved the tracking of all controlled or narcotic substances. There are no sample medications in this organization. Medication shortages are generally managed well, without too much disruption. Staff members are comfortable reporting medication errors.

Allergies can be recorded and then tracked across admissions and sites. All changes are recorded and can be tracked. Many updates about medications are provided automatically by the system. The organization has yet to implement computerized physician order entry (CPOE). Urgent medication orders are automatically moved to the top of the list by the medication management software.
Numerous quality indicators are in place.

Very little compounding is done in-house. The organization has carefully assessed the management of easily-confused medications. It found that separating different concentrations of the same high-risk of medication for example, heparin results in staff members using the first concentration they find, rather than looking for the best concentration for their purpose. Clearly, this was not satisfactory. As a consequence, storing the different concentrations side-by-side is done, with clear labelling to distinguish between them. This allows staff members to find the best concentration for the patient, and this is a sensible conclusion.

A copy of the 'Do Not Use' list is found in the front of every patient chart.

There are a number of automatic substitutions or previously agreed changes that may be made without the need to contact the prescriber.

2.2.7 Standards Set: Medicine Services

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	
17.5 The team shares evaluation results with staff, clients, and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The team is undertaking several significant restructuring initiatives at this time. The first is a collaborative care model which aims to ensure that all providers, especially nurses, work to their full scope of practice. Secondly, the complex continuing care team will relocate from the Stratford Hospital site to the Seaforth site. Bed designations will change across all sites. Thirdly, the acute medicine service will relocate from the first to third floor at Stratford.

The team has established four goals and four objectives for the year just finished. These are derived from corporate priorities. The objectives are listed on the notice board where the daily huddle takes place. The goals and objectives are both measurable and specific.

Both students and volunteers work within the medicine services team. The volunteers are an integral part of the team and provide much appreciated services to team members and to patients.

Priority Process: Competency

Skills development is encouraged. The team has embarked on an effort to ensure that all members work to their full scope of practice. Team meetings are held daily, there are discharge rounds and there are team huddles. A meeting of the full medicine team takes place every month.

Performance appraisals are done regularly. These are widely viewed as a positive experience. At the time of the survey the spaces available for staff members are sub-optimal at all sites. This will improve with the moves to new space.

Priority Process: Episode of Care

The discharge rounds and the bed management meeting are excellent examples of how the organization optimizes patient flow and facilitates bed availability for admissions. The Huron Perth Healthcare Alliance has developed an imaginative view of itself as 'one hospital with four wings'. This permits the location of specialized services in the different sites thereby benefiting from critical mass and maintaining availability of beds for patients.

There is use of the visual pain scale in every room. Translation services are available for non-English speaking patients and their families. Patients and families report that they are kept well informed by staff. Patients and their families report good information flow regarding their care.

The Omnicell dispensing system is in use and allows for access to medications after hours. Medication errors are tracked and discussed at the daily huddle meetings.

Follow-up of patient outcomes after discharge is primarily via physician-to-physician contact.

Priority Process: Decision Support

It is noted that one of the team members had an imaginative suggestion for maintaining patient confidentiality. This related to the requests for information that come from apparent family members. This suggestion was passed on to the patient care manager.

There are numerous practice guidelines are accessible to team members. These are available on the Internet via specific sites that have been approved by the organization. Nursing staff members and physicians demonstrated confidence and competence in accessing this resource. Nursing staff members are confident in giving input to the applicability and use of guidelines.

Priority Process: Impact on Outcomes

Falls prevention and skin ulcer prevention are core concerns that are reviewed every day by the team. Deep vein thrombo-embolism (DVT) prophylaxis is measured and monitored.

The staff member that was interviewed during the on-site survey felt completely confident and comfortable with the process for identifying near misses and adverse events. A no-blame culture is successfully embedded across this organization.

2.2.8 Standards Set: Mental Health Services

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
2.2 The team's objectives for mental health services are specific and measurable.	
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	
15.2 The organization's process for selecting guidelines includes seeking input from clients, families, staff, and service providers about the applicability of the guidelines to client recovery.	
Priority Process: Impact on Outcomes	
18.7 The team shares evaluation information with staff, clients, and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The clinical leadership group is experienced in the mental health field. Most of the psychiatrists that practice in the community have some affiliation with the organization. Leadership of various mental health program components is shared among the psychiatrists that have a relationship with the program. General practitioners are able to admit to the mental health inpatient beds and look after the medical needs of their patients throughout the course of their stay. Urgent/emergent psychiatric patients are seen in a timely manner via the scheduling system that has been developed to facilitate access for psychiatrist consultation.

With a few exceptions, most of the mental health programs have no wait, or reasonable waiting periods for access to services. There is good collaboration and planning with community partners and providers in the catchment area. London Health Sciences has recently started to send patients to the Stratford unit when in a surge situation.

There is expertise available in the community to deal with child and adolescent issues and when hospitalization is required these cases are referred to London.

The team is justifiably proud of its use of Ontario Telehealth Network technology in service provision. This technology has been in place for some time and is extensively used, including for monitoring clients in their home settings.

The team members are encouraged to develop measurable and specific, annual goals and objectives for the mental health program and refresh their visual presentation. Goals and objectives and metrics should also be considered for the various programming elements.

Priority Process: Competency

There is evidence that staff members are trained in coping with crisis escalation techniques, as well as for dealing with violent patients. Seclusion and restraint policies are well known and followed. Inservice and continuing medical education (CME) attendance is encouraged and supported in the program. The psychiatrists have access to monies to support educational sessions and are now considering using some of these resources to also allow for patient/family education.

Staffing appears appropriate and is adjusted based on acuity. The front-line clinicians in the program are experienced in mental health service delivery. There is a formal competency orientation program in place. A customized manager orientation program has been provided to the new manager of the inpatient mental health unit.

The team is encouraged to further develop skills/expertise to deal with the psycho-geriatric and elderly medical-psychiatric population whose presence is expected to increase given the demography of the catchment area.

Priority Process: Episode of Care

The physical layout and design of the inpatient mental health unit incorporates many practical safety features to prevent self harm. The unit is clean, spacious and designed to support the delivery of mental health services.

There is evidence of good teamwork and interdisciplinary functioning in the program, both for the inpatient and outpatient areas. Staff members utilize the various discipline expertise available to them appropriately, including outside expertise for discharge and transition planning. The team is engaged in many forums and with many community partners to help plan for seamless transitions in care.

There is good hand-off of information to those involved in the circle of care. Medication reconciliation has been worked on since the previous accreditation survey and the process of medication reconciliation truly is an interdisciplinary effort. There is a dedicated staff pharmacist assigned to the unit, which is appreciated by all members of the team. There are good reviews of medication regimes particularly for the elderly clients.

Emergency/urgent cases are accommodated quickly in both the inpatient and outpatient programs and via crisis intervention. There are surge protocols in place should these need to be acted on. The program is responsive to the issue of access to service. Scheduling and other strategies have been implemented, resulting in no wait, or very little wait times or wait-lists for service in most of the program service areas.

There is good involvement of clients/patients and their families, as appropriate, in the care planning process.

Priority Process: Decision Support

Electronic charting is in place and risk of falls and other safety assessments are being documented electronically.

The team is well-versed in the use of Ontario Telehealth Network (OTN) technology and is receptive to its further use to enhance service delivery, as well as for enhanced communication between various clinical teams and partner organizations involved in the care of the patient.

There is evidence of various assessment tools in place which are based on best practice literature. A more formal process for selecting, using and updating evidence-based practice guidelines for all aspects of the program is an area for improvement.

Priority Process: Impact on Outcomes

The process for reporting incidents and adverse events is well known, as is the policy on disclosure. Medication audits are undertaken on a regular basis by the manager, with results shared with staff. The falls prevention strategy has resulted in dialogue and anticipatory planning with the Community Care Access Centre (CCAC) for discharge of elderly patients back to the community/home, with options determined and strategies in place of how the environment is to be modified to prevent falls after discharge.

The mental health program has served as a beta site for a client satisfaction feedback form to be used as a standard in the South West Local Health Integrated Network (SW LHIN). The team is encouraged to implement the tool on a regular basis and use the findings to improve services and enhance the patient experience with the program.

Regular evaluation of process and outcome indicators specific to mental health are in the beginning stages and need to further evolve. The sharing of the evaluative results with clients and their families is supported.

2.2.9 Standards Set: Obstetrics Services

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 team's goals and objectives are derived from the organization's priorities. Reprocessing of devices is not done in the service area; this is undertaken in the central reprocessing area.

Priority Process: Competency

Team leaders are currently planning a reformatting of staffing arrangements. This will be accompanied by careful study to avoid staff overload and burnout.

Priority Process: Episode of Care

The team and the team manager are aware of the need to monitor the workload, stress and fatigue risks for team members. Some staffing mix changes are being contemplated. These changes will necessitate careful focus on the accompanying changes in workload. The team currently uses staff members from the operating room when performing a Cesarean section. The team has embarked on a program to train some of their own staff to take over this role.

A comprehensive information package advises patients and families of what they need to know prior to admission. Translation services are available if the patient and their family do not speak English. The team has embarked on creating a baby friendly hospital. This will support breast-feeding.

Clients/patients that require a level of care not available at this organization are generally transferred to the London Health Sciences Centre.

An ultrasound machine is available on the unit and can be used by the medical staff. More detailed scanning can be done in the diagnostic imaging department as required. Reprocessing is done in the central reprocessing area. Flash sterilization is not done in this area.

Priority Process: Decision Support

The team is aware of new technologies that may support improved patient care. These technologies will be assessed and may be of benefit to the team and their patients.

Priority Process: Impact on Outcomes

Several indicators are measured by the team. Cesarean section rates are slightly below provincial averages.

2.2.10 Standards Set: Point-of-Care Testing

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 team is responsible for all technical and quality aspects of point-of-care testing.

2.2.11 Standards Set: Rehabilitation Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
3.7	The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	
Priority Process: Episode of Care		
8.9	The team responds to client and family complaints in an open, fair, and timely way.	
11.5	Following transition or end of service, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
17.2	The team monitors clients' perspectives on the quality of its rehabilitation services.	
17.5	The team shares evaluation results with staff, clients, and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Clinical leadership has stabilized in the last years, and the leadership team is meeting on a regular basis to implement a major change initiative related to the relocation of the rehabilitation beds to the Seaforth site. This move is based on analysis of data and major consultation with key stakeholders. There is evidence of a formal unit relocation and redesign project plan that the team is now acting on. There are processes for consultations with the physicians that will be affected by the change, and the family physicians seem to be in support of the new direction.

LEAN training has been made available to the new leadership and there has been some experience with value stream mapping and Kaizen events. It is suggested that the team consider introducing strategic planning retreats for the program, or have planning days to mobilize interdisciplinary input and build team capacity and commitment for the changes being implemented.

Priority Process: Competency

There is evidence of training to enable staff members to deliver basic care to the patients that they serve. Further education is required on rehabilitation best practices for this to become a more specialized focus when the program is relocated. The team has timely access to specialists when required for medical issues. As well, there are plans to replace the nurse with expertise in skin care, which is encouraged.

Priority Process: Episode of Care

Overall, the care provided is safe and appropriate. The data presented to the surveyor during the on-site survey suggests that there are efficiencies to be had in the delivery of care, and the team is in the process of implementing some of these. There are opportunities for reducing length of stay (LOS) without compromising patient quality, safety, and these require a review of practices of all disciplines operating within the rehab program.

It was observed that family physicians are engaged in medical management of their patients and provide a timely response to patients. Pain management is looked at and managed appropriately. Although there is a perceived complaint process, interviews with families suggest that it is not robust and resolution of complaints is not consistently addressed. As the program evolves, it needs to strengthen its transition processes and evaluate them formally in a timely way.

The protocol for pressure ulcer prevention is systematically applied on the unit. A number of clients with pressure ulcers on the unit had them prior to transfer to the unit and staff members are now working to improve skin integrity. Good work is being done. It is suggested that the team would benefit in having performance indicators developed specific to ulcers. This way the team can better monitor progress and the impact of their efforts. Incidence and prevalence of pressure ulcer development review should be considered.

A tremendous amount of work is underway to reconfigure the rehabilitation beds and provide a more specialized focus on restorative rehabilitation. Good communication is in evidence to support this change for staff members impacted. The collaborative care planning initiative is also well underway in terms of planning. There is evidence of good collaboration and partnerships with community agencies in helping to provide for discharge planning.

Priority Process: Decision Support

The team is aware that it needs to do more work with regards to evidence-based guidelines and is formalizing the process to facilitate this work. Education on best practices specific to rehabilitation care needs to become more generally available.

Priority Process: Impact on Outcomes

Process and outcomes indicators are in the beginning stages of development, implementation and utilization. It is suggested that the team reviews and shares information on change initiatives with staff members and partner organizations. It must be assured that change initiatives are effective and move the program not only to best practices in rehabilitation services but also to achievement of the results expected of the redesign initiative.

Although there is evidence of some patient satisfaction being solicited, the tools and the process require review to make them more robust and timely and that tools generate the type of information the team can act on. It is also suggested that the team develop a formal system of obtaining feedback from their partners, staff members and family on the quality of the service that is being provided. More effort needs to be placed on sharing the results once these become available.

2.2.12 Standards Set: Transfusion Services

Unmet Criteria	High Priority Criteria
Priority Process: Transfusion Services	

The organization has met all criteria for this priority process.

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

The organization does not have a stand-alone transfusion committee. However, the transfusion service is a standing item for the full laboratory committee. As such, matters pertaining to the transfusion service are fully discussed and the appropriate management decisions are made. This effectively fills the role of a transfusion committee.

The team effectively acts as a conduit in the provision of home transfusion services. The team itself is not involved in or responsible for the actual home transfusions. Team involvement is almost entirely confined to the provision of RhoGAM for the patients of midwives. Otherwise, the questions regarding home transfusion services are not applicable in this situation.

The team is actively involved in studying the use of the transfusion/blood components. Wastage is reduced by careful management.
The laboratory team is about to implement an information bulletin for clinicians to provide to their patients, explaining the potential risks of transfusion and the relatively small likelihood of adverse events.

2.2.13 Priority Process: Surgical Procedures

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

Unmet Criteria		High Priority Criteria
Standards Set: Operating Rooms		
12.11	The team is able to track all reprocessed or sterilized items so they can be recalled in the event of a breakdown or failure in the sterilization system.	!
Standards Set: Surgical Care Services		
2.2	The team's goals and objectives for its surgical care services are measurable and specific.	
16.5	The team shares evaluation results with staff, clients, and families.	

Surveyor comments on the priority process(es)

The surgical procedures clinical leadership team has breadth and depth of experience. The clinical leadership is currently challenged with operating in the new funding environment which has become a driver at looking at both quality and cost of the services provided.
The surgical program has good resources with a full complement of surgical specialists providing orthopedics, gynecology, general surgery, plastics, otolaryngology (ENT) and urology and ophthalmology services. There is good anesthesia support to the program.

The medical and clinical leadership is currently focused on efficiencies and strategies to increase appropriate activity and funded cases. A request for proposal (RFP) is to be issued to assist the team in determining what actions are most appropriate to ensure that the surgical program can strategically increase its volumes. This data-driven approach is supported as are various measures to improve efficiencies, the patient experience and eliminate waste such as late starts and last minute cancellation of blocks. It is noted that the team has already demonstrated good results in decreasing length of stay (LOS), as reflected in orthopedics.

The Stratford General Hospital, in its role as the surgical inpatient site, is on a path to reconfigure its existing space so that surgical clinics and outpatients can be better located to provide for a better patient experience, improved way-finding and better utilization and deployment of staff. Seventeen surgeons provide services not only in Stratford, but also have their own clinics in various locations of the catchment area. Thirteen surgeons now avail themselves of operating room (OR) time at the Clinton site as this location takes on the lead role for ambulatory surgical services. It is suggested that the clinical leadership ensure appropriate standardization of practices and rules of engagement for those clinicians that will be practicing in the area. It is strongly recommended that mechanisms be put in place to ensure that procedures which do not fall within the parameters of what is acceptable to be performed at the Clinton site are instituted.

The Clinton site will be specializing in the provision of ambulatory surgical outpatient care. Cataracts have been consolidated at this site and the transition appears to have gone relatively well, although there are still issues that may require monitoring from a behavioural perspective. Major work has been undertaken to upgrade and improve the ability to perform the central processing and sterilization (CPD) function on the site. However, the location of the operating room (OR) and CPD, the type of procedures being performed, expectations of growing the outpatient surgical volumes, real and potential traffic issues, infection control awareness and contemporary CPD design are 'drivers' for reassessing the appropriateness of the CPD function at the site in its current configuration.

Infection prevention and control support for the surgical services is required as it undergoes some of its change projects. There is a particular need to provide guidance in the area of medical device reprocessing and sterilization. It is recommended that the Huron Perth Healthcare Alliance (corporation) consider investing in further upgrading expertise and building capacity for those providing leadership and consultation in this area.

Overall, staff members are both experienced and trained. Staffing flexibility is maintained by way of deliberate cross-training strategies. Collaborative care model planning is well-advanced and at the Clinton site, a pilot of the model is already in progress.

Attention to patient safety is clearly evident and observed by all staff members working in all areas and sites providing surgical services. This is especially notable in the inpatient surgical unit and in the OR with the surgical checklist. Handouts and patient education material are provided for required organizational practices (ROPs) for example, vancomycin resistant enterococci (VRE) and falls prevention for the outpatient population.

The organization has adopted the best possible medication history (BPMH) protocol but this has not been implemented at the Stratford or Clinton sites in the day surgery areas. A medication history is taken for the surgical day surgery population. The plan for online implementation is November at the Clinton site. Currently, a document entitled: "Pre-Operative/Pre-Procedural Patient Questionnaire" is used to document medications. The document contains the question: "What medications are you taking regularly" including puffers, eye drops, herbal remedy, vitamins, and so on and asks for the dosage and frequency. The document is reviewed pre-operatively and on discharge. It is recommended that the team make the Alliance BMPH protocol implementation a priority. During the on-site survey the BPMH was observed on the online documentation system in the Stratford OR and inpatient surgical unit.

During the on-site survey good interdisciplinary functioning was in evidence. Also, there was good feedback from clients interviewed as to their satisfaction with the care provided.

The surgical inpatient team as well as the peri-operative service is encouraged to develop dashboards and metrics to track progress on achieving Alliance and program objectives with goals and objectives that are specific and measurable. The bed redesign project will impact the inpatient surgical unit. Collaborative care model implementation will also be undertaken by the entire surgical service across the sites.

It was observed by way of interaction and interviews with Alliance personnel that there are issues in managing professionals that might be considered 'senior senators'. It is recognized that dealing with individuals with stature, seniority and a long history with the organization is a sensitive issue. It is recommended that performance expectations and competency requirements be monitored and addressed.

Section 3 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.

3.1 Governance Functioning Tool

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

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

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

- **Data collection period: September 4, 2013 to September 15, 2013**
- **Number of responses: 13**

Governance Functioning Tool Results

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1 We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations.	0	8	92	89
2 Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	0	0	100	93
3 We have sub-committees that have clearly-defined roles and responsibilities.	0	0	100	93
4 Our roles and responsibilities are clearly identified and distinguished from those delegated to the CEO and/or senior management. We do not become overly involved in management issues.	0	0	100	90
5 We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decision-making.	0	23	77	89

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
6 Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	92
7 Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	94
8 Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	0	0	100	93
9 Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	0	0	100	92
10 Our governance processes make sure that everyone participates in decision-making.	0	15	85	90
11 Individual members are actively involved in policy-making and strategic planning.	0	31	69	88
12 The composition of our governing body contributes to high governance and leadership performance.	0	8	92	89
13 Our governing body’s dynamics enable group dialogue and discussion. Individual members ask for and listen to one another’s ideas and input.	0	8	92	92
14 Our ongoing education and professional development is encouraged.	0	0	100	87
15 Working relationships among individual members and committees are positive.	0	0	100	96
16 We have a process to set bylaws and corporate policies.	0	0	100	91
17 Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	95
18 We formally evaluate our own performance on a regular basis.	0	15	85	78
19 We benchmark our performance against other similar organizations and/or national standards.	0	36	64	66
20 Contributions of individual members are reviewed regularly.	8	38	54	61

		% Disagree	% Neutral	% Agree	%Agree * Canadian Average
		Organization	Organization	Organization	
21	As a team, we regularly review how we function together and how our governance processes could be improved.	15	23	62	77
22	There is a process for improving individual effectiveness when nonperformance is an issue.	8	50	42	53
23	We regularly identify areas for improvement and engage in our own quality improvement activities.	8	25	67	78
24	As a governing body, we annually release a formal statement of our achievements that is shared with the organization's staff as well as external partners and the community.	27	9	64	81
25	As individual members, we receive adequate feedback about our contribution to the governing body.	23	8	69	64
26	Our chair has clear roles and responsibilities and runs the governing body effectively.	0	15	85	92
27	We receive ongoing education on how to interpret information on quality and patient safety performance.	0	0	100	78
28	As a governing body, we oversee the development of the organization's strategic plan.	0	8	92	92
29	As a governing body, we hear stories about clients that experienced harm during care.	8	23	69	81
30	The performance measures we track as a governing body give us a good understanding of organizational performance.	8	0	92	88
31	We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	0	15	85	84
32	We have explicit criteria to recruit and select new members.	8	15	77	79
33	Our renewal cycle is appropriately managed to ensure continuity on the governing body.	0	8	92	86

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
34 The composition of our governing body allows us to meet stakeholder and community needs.	0	0	100	91
35 Clear written policies define term lengths and limits for individual members, as well as compensation.	0	15	85	92
36 We review our own structure, including size and sub-committee structure.	15	8	77	86
37 We have a process to elect or appoint our chair.	0	0	100	90

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2013 and agreed with the instrument items.

3.2 Patient Safety Culture Tool

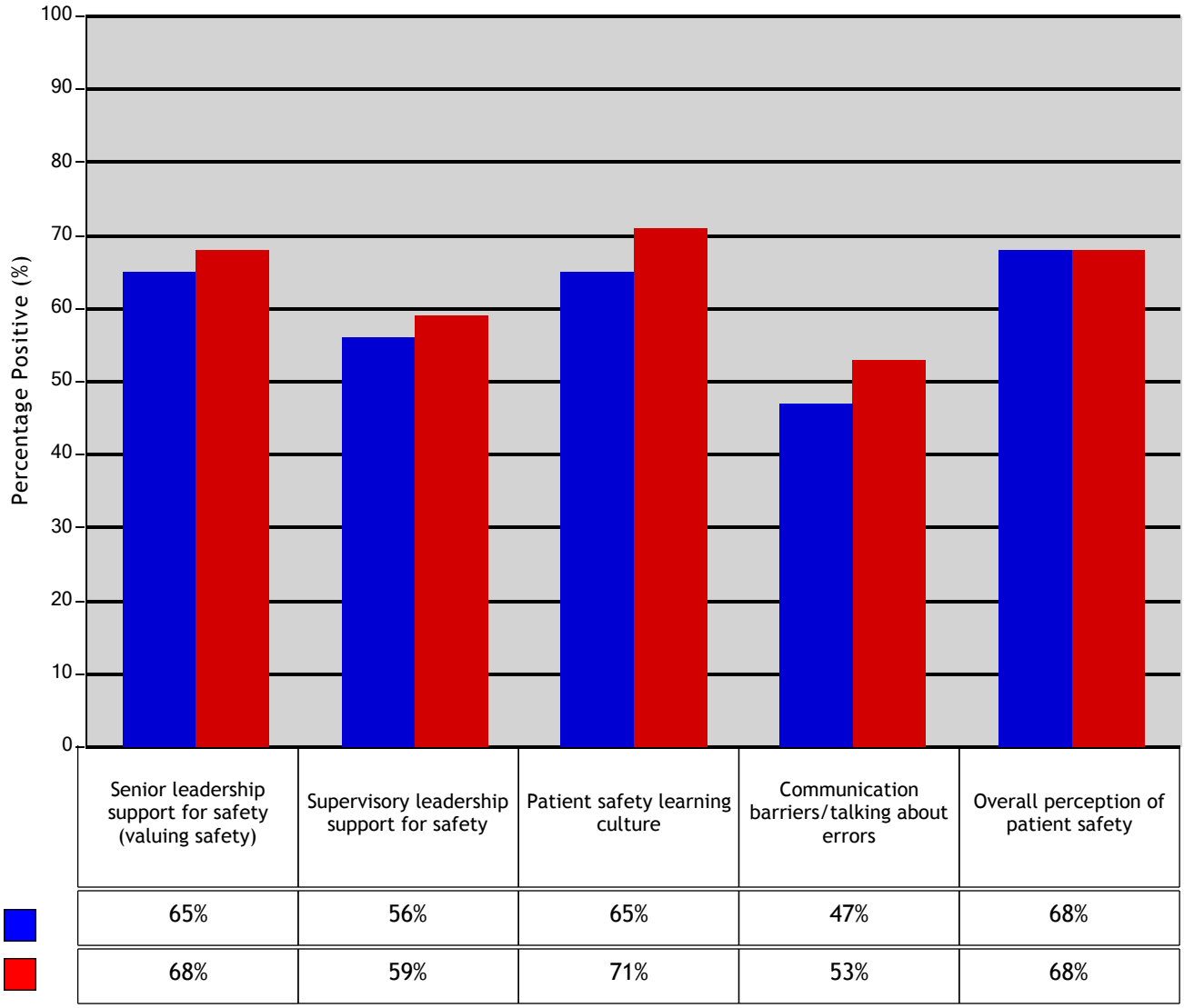
Organizational culture is widely recognized as a significant driver in changing behavior and expectations in order to increase safety within organizations. A key step in this process is the ability to measure the presence and degree of safety culture. This is why Accreditation Canada provides organizations with the Patient Safety Culture Tool, an evidence-informed questionnaire that provides insight into staff perceptions of patient safety. This tool gives organizations an overall patient safety grade and measures a number of dimensions of patient safety culture.

Results from the Patient Safety Culture Tool allow the organization to identify strengths and areas for improvement in a number of areas related to patient safety and worklife.

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

- **Data collection period: August 5, 2013 to August 23, 2013**
- **Minimum responses rate (based on the number of eligible employees): 275**
- **Number of responses: 314**

Patient Safety Culture Tool: Results by Patient Safety Culture Dimension



	Senior leadership support for safety (valuing safety)	Supervisory leadership support for safety	Patient safety learning culture	Communication barriers/talking about errors	Overall perception of patient safety
	65%	56%	65%	47%	68%
	68%	59%	71%	53%	68%

Legend

Huron Perth Healthcare Alliance

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2013 and agreed with the instrument items.

3.3 Worklife Pulse

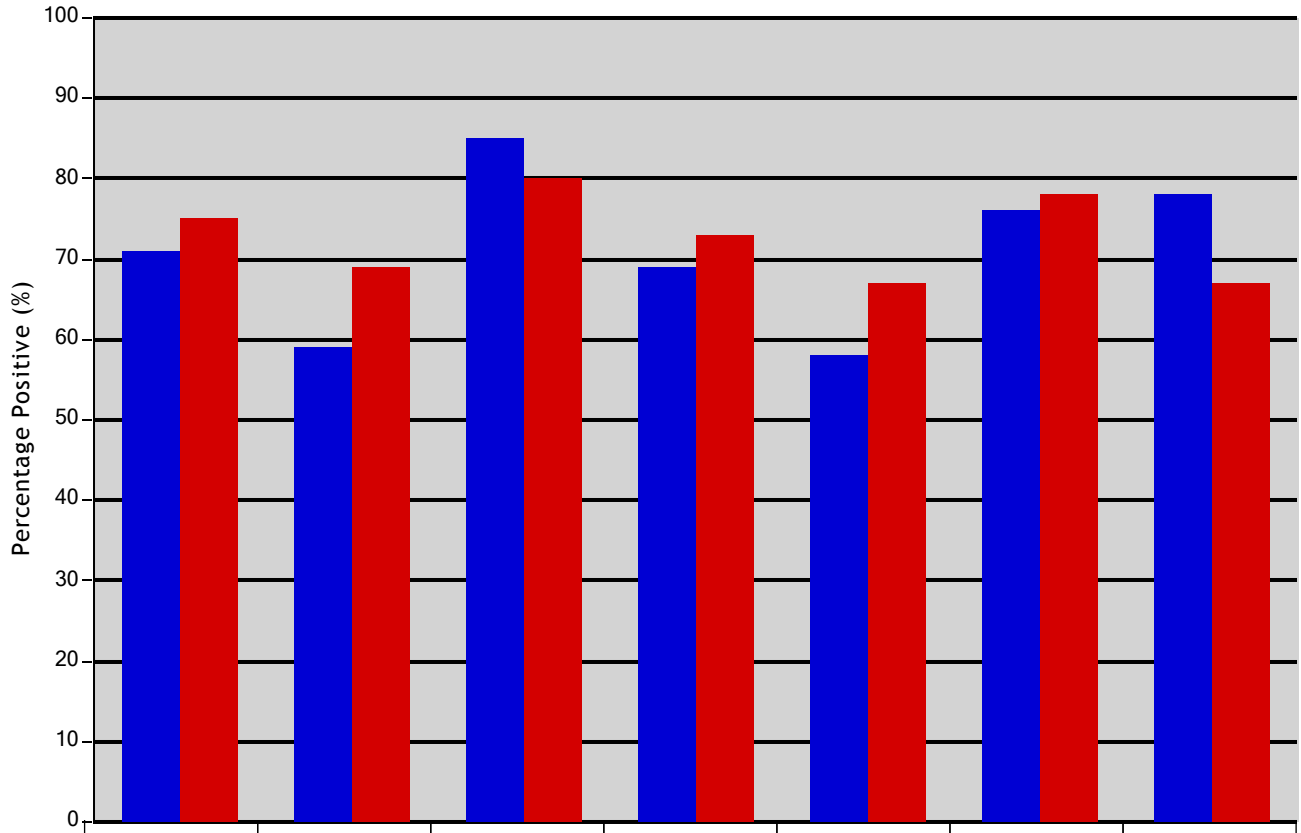
Accreditation Canada helps organizations create high quality workplaces that support workforce wellbeing and performance. This is why Accreditation Canada provides organizations with the Worklife Pulse Tool, an evidence-informed questionnaire that takes a snapshot of the quality of worklife.

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

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: July 8, 2013 to July 26, 2013**
- **Minimum responses rate (based on the number of eligible employees): 283**
- **Number of responses: 472**

Worklife Pulse: Results of Work Environment



	Job	Training and Development	Coworkers	Immediate Supervisor	Senior Management	Safety and Health	Overall Experience
	71%	59%	85%	69%	58%	76%	78%
	75%	69%	80%	73%	67%	78%	67%

Legend

Huron Perth Healthcare Alliance

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2013 and agreed with the instrument items.

3.4 Client Experience Tool

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

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

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

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

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

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

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

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

Appendix A Qmentum

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

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

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

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

Action Planning

Following the on-site survey, the organization uses the information in its Accreditation Report and Quality Performance Roadmap to develop action plans to address areas identified as needing improvement. The organization provides Accreditation Canada with evidence of the actions it has taken to address these required follow ups.

Evidence Review and Ongoing Improvement

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

Appendix B Priority Processes

Priority processes associated with system-wide standards

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

Priority processes associated with population-specific standards

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

Priority processes associated with service excellence standards

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

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