ACCREDITATION CANADA

Driving Quality Health Services

Accreditation Report

North Bay Regional Health Centre

North Bay, ON

On-site survey dates: November 25, 2012 - November 30, 2012

Report issued: December 14, 2012

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

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About the Accreditation Report

North Bay Regional Health Centre (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 November 2012. 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.

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

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.

Accreditation Canada is a not-for-profit, independent organization that provides health services organizations with a rigorous and comprehensive accreditation process. We foster ongoing quality improvement based on evidence-based standards and external peer review. Accredited by the International Society for Quality in Health Care, Accreditation Canada has helped organizations strive for excellence for more than 50 years.

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 North Bay Regional Health Centre on your participation in the Qmentum accreditation program. Qmentum is designed to integrate with your quality improvement program. By using it 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 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

Table of Contents

Section 1 Executive Summary

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. Organizations that are accredited by Accreditation Canada undergo a rigorous evaluation process. Following a comprehensive self-assessment, trained surveyors from accredited health organizations conduct an on-site survey to evaluate the organization's performance against Accreditation Canada's standards of excellence.

North Bay Regional Health Centre (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. This Accreditation 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.

North Bay Regional Health Centre 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

North Bay Regional Health Centre has earned the following accreditation decision.

Accredited (Report)

1.2 About the On-site Survey

- **On-site survey dates: November 25, 2012 to November 30, 2012**

- **Locations**

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

  1 ACTT 1 and ACTT 2
  2 Choices
  3 Kirkwood Place
  4 Mental Health Clinic
  5 NBRHC-Main SIte
  6 Nipissing District Diabetes Centre
  7 North Bay Detox and Substance Abuse Center
  8 Regional Outreach
  9 Wordplay Jeux de mots

- **Standards**

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

  System-Wide Standards

  1 Governance
  2 Leadership

  Service Excellence Standards

  3 Managing Medications
  4 Operating Rooms
  5 Reprocessing and Sterilization of Reusable Medical Devices
  6 Surgical Care Services
  7 Critical Care
  8 Emergency Department
  9 Infection Prevention and Control
  10 Ambulatory Care Services
  11 Biomedical Laboratory Services
  12 Laboratory and Blood Services
  13 Medicine Services
  14 Rehabilitation Services
  15 Substance Abuse and Problem Gambling Services

16 Mental Health Services
17 Blood Bank and Transfusion Services
18 Community-Based Mental Health Services and Supports Standards
19 Obstetrics Services
20 Diagnostic Imaging Services

- **Instruments**

  The organization administer:

  1 Governance Functioning Tool
  2 Patient Safety Culture 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 lists the quality dimensions and shows how many of the criteria related to each dimension were rated as met, unmet, or not applicable during the on-site survey.

Quality Dimension	Met	Unmet	N/A	Total
 Population Focus (Working with communities to anticipate and meet needs)	66	10	0	76
 Accessibility (Providing timely and equitable services)	121	1	0	122
 Safety (Keeping people safe)	569	23	19	611
 Worklife (Supporting wellness in the work environment)	174	4	0	178
 Client-centred Services (Putting clients and families first)	205	1	0	206
 Continuity of Services (Experiencing coordinated and seamless services)	74	0	0	74
 Effectiveness (Doing the right thing to achieve the best possible results)	864	48	7	919
 Efficiency (Making the best use of resources)	78	4	0	82
Total	**2151**	**91**	**26**	**2268**

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 contribute to achieving the standard as a whole.

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

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

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

Standards Set	High Priority Criteria			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	39 (90.7%)	4 (9.3%)	0	34 (97.1%)	1 (2.9%)	0	73 (93.6%)	5 (6.4%)	0
Leadership	37 (88.1%)	5 (11.9%)	0	79 (90.8%)	8 (9.2%)	0	116 (89.9%)	13 (10.1%)	0
Diagnostic Imaging Services	65 (100.0%)	0 (0.0%)	1	56 (94.9%)	3 (5.1%)	2	121 (97.6%)	3 (2.4%)	3
Obstetrics Services	61 (100.0%)	0 (0.0%)	1	75 (100.0%)	0 (0.0%)	1	136 (100.0%)	0 (0.0%)	2
Infection Prevention and Control	50 (100.0%)	0 (0.0%)	1	44 (100.0%)	0 (0.0%)	2	94 (100.0%)	0 (0.0%)	3
Ambulatory Care Services	36 (100.0%)	0 (0.0%)	1	71 (94.7%)	4 (5.3%)	1	107 (96.4%)	4 (3.6%)	2
Biomedical Laboratory Services **	16 (100.0%)	0 (0.0%)	0	36 (100.0%)	0 (0.0%)	0	52 (100.0%)	0 (0.0%)	0
Blood Bank and Transfusion Services **	42 (100.0%)	0 (0.0%)	0	17 (100.0%)	0 (0.0%)	0	59 (100.0%)	0 (0.0%)	0
Community-Based Mental Health Services and Supports Standards	15 (93.8%)	1 (6.3%)	1	105 (93.8%)	7 (6.3%)	0	120 (93.8%)	8 (6.3%)	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
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Critical Care	28 (100.0%)	0 (0.0%)	1	91 (97.8%)	2 (2.2%)	1	119 (98.3%)	2 (1.7%)	2
Emergency Department	28 (93.3%)	2 (6.7%)	1	95 (100.0%)	0 (0.0%)	1	123 (98.4%)	2 (1.6%)	2
Laboratory and Blood Services **	81 (100.0%)	0 (0.0%)	0	95 (100.0%)	0 (0.0%)	0	176 (100.0%)	0 (0.0%)	0
Managing Medications	66 (88.0%)	9 (12.0%)	1	46 (88.5%)	6 (11.5%)	0	112 (88.2%)	15 (11.8%)	1
Medicine Services	25 (96.2%)	1 (3.8%)	0	68 (98.6%)	1 (1.4%)	1	93 (97.9%)	2 (2.1%)	1
Mental Health Services	27 (93.1%)	2 (6.9%)	1	65 (91.5%)	6 (8.5%)	1	92 (92.0%)	8 (8.0%)	2
Operating Rooms	68 (98.6%)	1 (1.4%)	0	28 (93.3%)	2 (6.7%)	0	96 (97.0%)	3 (3.0%)	0
Rehabilitation Services	26 (100.0%)	0 (0.0%)	0	60 (88.2%)	8 (11.8%)	1	86 (91.5%)	8 (8.5%)	1
Reprocessing and Sterilization of Reusable Medical Devices	38 (100.0%)	0 (0.0%)	2	57 (100.0%)	0 (0.0%)	2	95 (100.0%)	0 (0.0%)	4
Substance Abuse and Problem Gambling Services	27 (100.0%)	0 (0.0%)	0	69 (97.2%)	2 (2.8%)	1	96 (98.0%)	2 (2.0%)	1
Surgical Care Services	28 (96.6%)	1 (3.4%)	0	61 (93.8%)	4 (6.2%)	1	89 (94.7%)	5 (5.3%)	1
Total	**803 (96.9%)**	26 (3.1%)	11	1252 (95.9%)	54 (4.1%)	15	2055 (96.3%)	80 (3.7%)	26

** 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

In Qmentum, a Required Organizational Practice (ROP) is defined as 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 how the applicable ROPs were rated during the on-site survey.

Required Organizational Practice	Overall rating	Test of 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 As A Strategic Priority (Leadership)	Met	1 of 1	1 of 1
Client Safety Quarterly Reports (Leadership)	Met	1 of 1	2 of 2
Client Safety Related Prospective Analysis (Leadership)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Communication			
Client And Family Role In Safety (Ambulatory Care Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Community-Based Mental Health Services and Supports Standards)	Unmet	1 of 2	0 of 0
Client And Family Role In Safety (Critical Care)	Unmet	0 of 2	0 of 0
Client And Family Role In Safety (Diagnostic Imaging Services)	Unmet	1 of 2	0 of 0
Client And Family Role In Safety (Medicine Services)	Unmet	0 of 2	0 of 0

Required Organizational Practice	Overall rating	Test of Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client And Family Role In Safety (Mental Health Services)	Unmet	1 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)	Unmet	1 of 2	0 of 0
Client And Family Role In Safety (Substance Abuse and Problem Gambling Services)	Unmet	1 of 2	0 of 0
Client And Family Role In Safety (Surgical Care Services)	Met	2 of 2	0 of 0
Dangerous Abbreviations (Managing Medications)	Met	4 of 4	3 of 3
Information Transfer (Ambulatory Care Services)	Met	2 of 2	0 of 0
Information Transfer (Community-Based Mental Health Services and Supports Standards)	Met	2 of 2	0 of 0
Information Transfer (Critical Care)	Met	2 of 2	0 of 0
Information Transfer (Emergency Department)	Met	2 of 2	0 of 0
Information Transfer (Medicine Services)	Met	2 of 2	0 of 0
Information Transfer (Mental Health Services)	Met	2 of 2	0 of 0
Information Transfer (Obstetrics Services)	Met	2 of 2	0 of 0
Information Transfer (Rehabilitation Services)	Met	2 of 2	0 of 0

Required Organizational Practice	Overall rating	Test of Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information Transfer (Substance Abuse and Problem Gambling Services)	Met	2 of 2	0 of 0
Information Transfer (Surgical Care Services)	Met	2 of 2	0 of 0
Medication Reconciliation As An Organizational Priority (Leadership)	Met	12 of 12	0 of 0
Medication Reconciliation At Admission (Ambulatory Care Services)	Met	5 of 5	2 of 2
Medication Reconciliation At Admission (Community-Based Mental Health Services and Supports Standards)	Met	4 of 4	1 of 1
Medication Reconciliation At Admission (Critical Care)	Met	4 of 4	1 of 1
Medication Reconciliation At Admission (Emergency Department)	Met	4 of 4	1 of 1
Medication Reconciliation At Admission (Medicine Services)	Met	4 of 4	1 of 1
Medication Reconciliation At Admission (Mental Health Services)	Met	4 of 4	1 of 1
Medication Reconciliation At Admission (Obstetrics Services)	Met	4 of 4	1 of 1
Medication Reconciliation At Admission (Rehabilitation Services)	Met	4 of 4	1 of 1
Medication Reconciliation At Admission (Substance Abuse and Problem Gambling Services)	Met	4 of 4	1 of 1
Medication Reconciliation At Admission (Surgical Care Services)	Met	4 of 4	1 of 1

Required Organizational Practice	Overall rating	Test of Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication Reconciliation at Transfer or Discharge (Ambulatory Care Services)	Met	4 of 4	1 of 1
Medication Reconciliation at Transfer or Discharge (Community-Based Mental Health Services and Supports Standards)	Unmet	2 of 3	1 of 2
Medication Reconciliation at Transfer or Discharge (Critical Care)	Met	4 of 4	1 of 1
Medication Reconciliation at Transfer or Discharge (Emergency Department)	Met	4 of 4	1 of 1
Medication Reconciliation at Transfer or Discharge (Medicine Services)	Met	4 of 4	1 of 1
Medication Reconciliation at Transfer or Discharge (Mental Health Services)	Unmet	1 of 4	0 of 1
Medication Reconciliation at Transfer or Discharge (Obstetrics Services)	Met	4 of 4	1 of 1
Medication Reconciliation at Transfer or Discharge (Rehabilitation Services)	Met	4 of 4	1 of 1
Medication Reconciliation at Transfer or Discharge (Substance Abuse and Problem Gambling Services)	Met	4 of 4	1 of 1
Medication Reconciliation at Transfer or Discharge (Surgical Care Services)	Met	4 of 4	1 of 1

Required Organizational Practice	Overall rating	Test of Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Surgical Checklist (Obstetrics Services)	Unmet	2 of 3	0 of 2
Surgical Checklist (Operating Rooms)	Met	3 of 3	2 of 2
Two Client Identifiers (Ambulatory Care 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 (Managing Medications)	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
Two Client Identifiers (Operating Rooms)	Met	1 of 1	0 of 0
Two Client Identifiers (Rehabilitation Services)	Unmet	0 of 1	0 of 0
Two Client Identifiers (Substance Abuse and Problem Gambling Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Surgical Care Services)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test of Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Verification Processes For High-Risk Activities (Ambulatory Care Services)	Met	2 of 2	1 of 1
Verification Processes For High-Risk Activities (Community-Based Mental Health Services and Supports Standards)	Met	2 of 2	1 of 1
Verification Processes For High-Risk Activities (Critical Care)	Met	2 of 2	1 of 1
Verification Processes For High-Risk Activities (Diagnostic Imaging Services)	Met	2 of 2	1 of 1
Verification Processes For High-Risk Activities (Medicine Services)	Met	2 of 2	1 of 1
Verification Processes For High-Risk Activities (Mental Health Services)	Met	2 of 2	1 of 1
Verification Processes For High-Risk Activities (Obstetrics Services)	Met	2 of 2	1 of 1
Verification Processes For High-Risk Activities (Rehabilitation Services)	Met	2 of 2	1 of 1
Verification Processes For High-Risk Activities (Surgical Care Services)	Met	2 of 2	1 of 1
Patient Safety Goal Area: Medication Use			
Concentrated Electrolytes (Managing Medications)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test of Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Heparin Safety (Managing Medications)	Met	4 of 4	0 of 0
Infusion Pumps Training (Ambulatory Care Services)	Met	1 of 1	0 of 0
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 (Managing Medications)	Met	1 of 1	0 of 0
Infusion Pumps Training (Medicine Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Mental Health Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Obstetrics Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Operating Rooms)	Met	1 of 1	0 of 0
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
Medication Concentrations (Managing Medications)	Met	1 of 1	0 of 0
Narcotics Safety (Managing Medications)	Met	3 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Client Safety Plan (Leadership)	Met	0 of 0	2 of 2

Required Organizational Practice	Overall rating	Test of Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Worklife/Workforce			
Client Safety: Education And Training (Leadership)	Met	1 of 1	0 of 0
Client Safety: Roles And Responsibilities (Leadership)	Met	1 of 1	2 of 2
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 Audit (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 Control Guidelines (Infection Prevention and Control)	Met	1 of 1	0 of 0
Infection Rates (Infection Prevention and Control)	Met	1 of 1	3 of 3
Influenza Vaccine (Infection Prevention and Control)	Met	3 of 3	0 of 0
Sterilization Processes (Infection Prevention and Control)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Falls Prevention			
Falls Prevention Strategy (Ambulatory Care Services)	Met	3 of 3	2 of 2
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 of 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			
Suicide Prevention (Community-Based Mental Health Services and Supports Standards)	Met	5 of 5	0 of 0
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

During the on-site survey, the surveyor team made the following observations about the organization's overall strengths, opportunities for improvement, and challenges.

North Bay Regional Health Centre is a newly merged organization operating on several sites in two communities, with the main site located in a very new building.

The board has overseen the successful merger of two organizations and construction of a new facility, and is ensuring mental health and related issues have the same prominence as those of acute care. In preparation for accreditation, the board has reviewed and updated its structure, process and policies. The board has confirmed an operational review and strategic planning initiative to achieve financial stability and establish the hospital's strategic direction for the next several years.

The board should consistently apply the organization's ethics framework to its own decisions and assume greater awareness and some degree of oversight for the overall Human Resources and Communication plans. The board is urged to secure First Nations representation to ensure the perspective of this significant portion of its service population is present at the governance table.

Seventeen community partners were interviewed. All indicated they have very constructive relationships with the hospital. Partnership initiatives include visiting specialists and surge capacity with other hospitals, sponsoring the initiating of and then sharing services with the Children's Treatment Centre, providing secure access by long-term care homes to relevant patient information, and representation at regional tables for planning and shared lean initiatives. The hospital is investing capital funds in mental health initiatives and partners in other mental health operations. There is a strong partnership with the overall North Bay community stemming from the development of the new hospital. Community partnerships have led to the development of clear roles and responsibilities for each community agency, ensuring alignment and collaboration along the continuum. There was evidence of many regional meetings to plan for the best possible patient care along the continuum. This is particularly important for mental health in this northern community.

For twelve years, the hospital has participated in the Interim Strategy group that includes twenty community partners (e.g. other hospitals, long-term care facilities, mental health agencies, CCAC, community agencies). This is one source of current information on the community, where collaborative initiatives often begin, serves as a forum for joint strategic planning and is also a formal advisory group to the LHIN.

There are many new people in leadership roles (including the CEO) and a new director structure has been implemented. These new roles have been embraced by the organization and leadership team, and are making significant contributions to the hospital. Many staff indicted how responsive and attentive their managers are to any issues raised with them. Staff speak positively about the organization and comment about the access to resources, education and orientation. Staff at some locations other than the main site felt somewhat disconnected from recognition, communication and development opportunities.

There are a large number of physicians who are very engaged in the organization as members of teams and in key hospital roles. The WINGS leadership skills development and mentoring program is available to all staff. Recruitment of staff and physicians can be a challenge due to location of the community. As a result of a focussed initiative, the number of volunteers have increased from 137 to 400, including a very successful 'ambassador' program.

There was evidence of many best-practices in the delivery of care and services. Interdisciplinary teamwork was demonstrated in many areas, with clinical teams reporting satisfaction with their new facilities and resources to care for patients. Medication reconciliation on admission was thorough, consistent and best practice throughout the organization. "My Meds" was a visible strategy with the community including a medication bag for patients, newspaper advertising and staff engagement. Volunteers participate in the HELP Program, where they support frail seniors through visitation and intervention to prevent delirium.

Transfer of care from the ED to the inpatient bed has been facilitated by an "admission nurse". This practice is noteworthy. Antibiotic stewardship and patient safety brochures have both been developed as a "draft" for patients. The organization is encouraged to complete the process so that patients have this information available in written format. The Infection Control Practitioner monitors all admissions from the emergency department, enabling a rapid identification of potential outbreaks within the facility.

The organization's efforts on integrating mental health and acute care are important for this merger. "Stamp out Stigma" is a strategy from the board to the front-line. The mental health continuum available for patients has been well developed over time. The hospital makes impressive use of telemedicine to link mental health patients to their home communities and to continue to care for those patients when they return to their home communities.

Critical incident notification, review and disclosure has been well established within the organization. Front-line staff, physicians were aware and engaged in potential risks for patients. MAC makes critical incident review the top of their agenda. Quality improvement is embedded in the organization. One physician was quoted as saying "this is a hospital that works". He explained that a hospital that works, is one that constantly improves their performance over time.

Consistent application of two client identifiers prior to medication administration was not evident. As this was identified in the previous Accreditation Canada survey, the organization is encouraged to focus on a strategy to improve adoption of this ROP.

The organization is to be commended for its commitment to advancing its quality improvement efforts through the More Time to Care strategy, using Theda Care as a model and enhancing the hospital's implementation of lean to improve quality, safety and efficiency. This will be further enabled through the development of a performance dashboard and business intelligence system to facilitate the communication of performance metrics throughout the organization. The high number of pre-printed orders reflect the organization's commitment to providing a consistent level of reliable care.

All patients interviewed throughout the hospital indicated satisfaction with their care and with the hospital overall.

Section 2 Detailed Required Organizational Practices Results

This section gives more information about unmet ROPs. It shows the patient safety goal area into which the ROP falls, the requirements of the ROP, and the set of standards where it can be found.

The patient safety goal areas are safety culture, communication, medication use, worklife/workforce, infection control, and risk assessment.

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Communication	
Client And Family Role In Safety The team informs and educates individuals and families in writing and verbally about the individual and family's role in promoting safety.	· Diagnostic Imaging Services 15.7 · Medicine Services 15.4 · Rehabilitation Services 15.4 · Substance Abuse and Problem Gambling Services 15.4 · Mental Health Services 15.5 · Critical Care 16.3 · Community-Based Mental Health Services and Supports Standards 17.7
Medication Reconciliation at Transfer or Discharge The team reconciles the client's medications at interfaces of care where the client is at risk for medication discrepancies (circle of care, discharge) with the involvement of the client and family or caregiver when medication management is a component of care, or as deemed appropriate through clinician assessment.	· Mental Health Services 11.3 · Community-Based Mental Health Services and Supports Standards 14.3
Two Client Identifiers The team uses at least two client identifiers before providing any service or procedure.	· Rehabilitation Services 9.8
Surgical Checklist The team uses a safe surgery checklist to confirm safety steps are completed for a surgical procedure.	· Obstetrics Services 9.9

Section 3 Detailed On-site Survey Results

This section shows detailed on-site results. When reviewing these results, it is important to review the service excellence and the system-wide results together, as they are complementary.

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

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

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

See Appendix B for a list of priority processes.

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

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

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

3.1 Priority Process Results for System-wide Standards

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

Some priority processes in this section also apply to the service excellence standards. Where there are unmet criteria that also relate to services, those results should be shared with the relevant team.

3.1.1 Priority Process: Planning and Service Design

Developing and implementing the infrastructure, programs and service to meet the needs of the community and populations served.

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
4.6	The organization's strategic plan includes goals and objectives that have measurable outcomes that are consistent with the mission and values.	
4.9	The organization's leaders communicate the strategic goals and objectives to leaders throughout the organization, staff, and service providers and verify that goals at the team, unit, or program level align with the strategic plan.	
4.10	The organization's leaders report on the organization's progress toward achieving the strategic goals and objectives to internal and external stakeholders and the governing body where applicable.	
4.11	The organization's policies and procedures for all key functions, operations, and systems in the organization are documented, authorized, implemented, and up to date.	
6.2	When developing the operational plans, the organization's leaders seek input from staff, service providers, volunteers, and other stakeholders, and communicate the plans throughout the organization.	
6.3	The operational plans identify the resources, systems, and infrastructure needed to deliver services and achieve the strategic plan, goals and objectives.	

Surveyor comments on the priority process(es)

Many staff interviewed were aware of the general themes of the organizational values. All mental health staff were aware of a documented patient bill of rights. There is quarterly staff recognition related to organization values. Prior to moving into the new building, there was a substantial initiative to familiarize staff with the organization's mission, vision and values. There is reference to patient care and values in senior decision-making.

An inclusive, participatory strategic planning is underway. Operational planning is completed in many departments, to varying levels of detail. When there is a new strategic plan, a more consistent approach, all in alignment with the overall strategy, will benefit the organization.

For twelve years, the hospital has participated in the Interim Strategy group that includes twenty community partners. This is one source of current information on the community, where collaborative initiatives often begin, serves as a forum for joint strategic planning and is also a formal advisory group to the LHIN.

Examples of programs that have been adjusted to provide better service are:
- the consolidation of Native Services and Aboriginal Outreach into a single service
- the redesign of Vocational Rehabilitation Services.

3.1.2 Priority Process: Governance

Unmet Criteria		High Priority Criteria
Standards Set: Governance		
1.3	The governing body approves, adopts, and follows the ethics framework used by the organization.	!
6.2	The governing body, in consultation with the CEO, identifies timeframes and responsibility for achieving the strategic goals and objectives.	!
7.9	The governing body oversees the development of the organization's talent management plan.	!
10.3	The governing body works with the CEO to establish, implement, and evaluate a communication plan for the organization.	
13.3	The governing body shares the records of its activities and decisions with the organization.	!

Surveyor comments on the priority process(es)

The board has adapted to the new merged organization and building by:
- Developing new policies and procedures
- Ensuring integration of mental health and acute care issues at the board level
- Helping to remove the stigma of mental health in this hospital
- Approaching quality as an entire organization, rather than a silo approach

The Board's Quality Committee has a work plan and brings the report to the entire board, including a report of critical incidents. All adverse events and near misses go to the Quality Committee (monthly). The entire board is invited to review and ask questions about indicator results. The board receives progress reports on the implementation of ROPs.

Board decisions are driven by patient care and organizational values.

All briefing notes include the identification of risks.

Workplace issues are monitored through NRC Picker results, management updates, human resources indicator reports, informal contact with staff at social events (such as barbecues) and board participation in mock tracers.

Internal updates on board proceedings are through monthly management forums and through CEO blogs.

Board members are recruited using:
- Matrix of skills
- Nomination Committee
- Advertisements

- A thorough interview process that includes a review of expected contribution and time commitments plus awareness of strategic plan, mission and vision, and then reference checks.

New board member orientation includes:
- Orientation to the Public Hospitals Act and to the portal
- New members are given a mentor
- Educational programs are provided prior to each board meeting

Board evaluation includes annual peer evaluation, full board evaluation, Chair evaluation and a survey after each meeting. A comprehensive governance review was just completed, prompted by the results of the Accreditation Canada Governance Function tool.

The relationship with CEO is managed through:
- Performance objectives reviewed monthly
- Performance targets tied to executive compensation
- Board chair meetings on a regular basis

Significant differences of opinion between management and the board are addressed through:
- Concerns brought directly to the CEO
- Regular meeting between chair and CEO
- In-camera sessions after each board meetings provide an opportunity to bring back issues to the CEO
- Chair keeps the operational/governance issues in-line

Community diversity is reflected through invitations to First Nations representatives and recruitment outside of North Bay (e.g. Sudbury and Timmins). The board should confirm a First Nations representative to ensure that perspective is present at the board table.

To facilitate the relationship with government, there is regular communication with the MP, MPP and LHIN.

3.1.3 Priority Process: Resource Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

A participatory process is used to develop annual capital and operating budgets.

The hospital's financial performance is thoroughly reviewed, analyzed and reported to management and the board. This is done monthly and on an ad hoc basis when required. Analysts are available to support managers in the management of their area's financial performance.

The hospital is experiencing financial challenges. This is being addressed through internal initiatives and an operational review that will be completed by calendar year-end.

3.1.4 Priority Process: Human Capital

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

There is a Wellness Committee that sponsors social activities as well as initiatives such as a Weight Watchers and stress management education. Managers' spans of control were recently reduced, as a result of analysis and review.

The Occupational Health and Safety Committee is active in addressing risks and hzards and providing related education, and includes representatives from across the organization. All staff interviewed acknowledged that workplace safety is a priority for this organization. All confirmed that they had received training regarding preventing workplace violence. Recently, there was also a very popular and well-attended seminar on workplace bullying.

All clinical and non-clinical staff interviewed spoke of a broad range of opportunities for in-house professional development opportunities. There is also organizational support to attend external educational activities.

The hospital has well-defined and well thought-out immunization policies that balances individual rights with the interests of patients and the hospital workforce.

There is regular reporting of human resources indicators to management, senior management and the board of directors.

The hospital is acting on the results of a recent staff satisfaction survey.

There is a WINGS leadership skills development program that is available to all staff.

All updated job descriptions include responsibility for safety.

The hospital has acknowledged the need to ensure staff performance appraisals are done regularly. This is tracked and reported on and the rate of compliance has recently shown improvement.

Although there is low participation, there is an established mechanism for exit interviews. There is staff dedicated to attendance management.

There are a variety of recognition initiatives, including quarterly staff awards for examplifying organizational values.

All clinical and non-clinical staff interviewed at the main site spoke positively of their quality of work life, professional development responsibilities, and the responsiveness and attentiveness of their manager. Staff interviewed at other locations felt disconnected, not as included in infromation sharing and did not feel they had access to the same quality of worklife and professional development opportunities.

There is an overall Human Resources Plan, work plan and regular reporting of human resources data to management and the board of directors. The do not, as yet, completely align with each other or with the strategic plan of the organization.

3.1.5 Priority Process: Integrated Quality Management

Continuous, proactive and systematic process to understand, manage and communicate quality from a system-wide perspective to achieve goals and objectives.

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
12.2	The organization's leaders implement an integrated risk management approach to mitigate and manage risk.	!
12.3	As part of the integrated risk management approach, the organization's leaders develop contingency plans.	!
12.4	The organization's leaders disseminate the risk management approach and contingency plans throughout the organization.	!
12.5	The organization's leaders evaluate the effectiveness of the integrated risk management approach and make improvements as necessary.	
16.3	The organization's leaders require, monitor, and support service, unit, or program areas to monitor their own process and outcome measures that align with the broader organizational strategic goals and objectives.	!
16.7	The organization's leaders communicate the results of quality improvement activities broadly, as appropriate.	!

Surveyor comments on the priority process(es)

There is evidence of many quality improvement initiatives underway across the organization. Providing staff with access to performance measures (data) would help to further engage all staff in driving improvements as well as support decision making at the unit level (e.g. hand hygiene compliance rates posted by unit).

The organization should be applauded for their recognition of employees. The organization may want to consider a recognition event specific to quality improvement to sustain enthusiasm in the organization for quality improvement.

Clearly the organization has been focused on quality and safety for years. This program has matured over time due to strong leadership. With Bonnie's pending retirement, we hope the organization continues to strengthen its momentum on improving quality and safety.

The organization has a well developed clinical risk management program. Response to critical incidents are prioritized and completed within 4 days. This may be a leading practice. There is an enabling team that supports a positive patient safety culture.

The incident report shared with governance demonstrates transparency and adoption of legislative requirements. A more detailed report could help the organization advance their efforts on patient safety which may influence decisions on quality improvement projects in the future.

3.1.6 Priority Process: Principle-based Care and Decision Making

Identifying and decision making regarding ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

There is a well-developed ethics resolution process that is well known throughout the orgfanization to first attempt to resolve ethical issues within multi-disciplinary teams. Trained staff can and or an external ethicist can also be available to assist. The hospital's Ethics Committee is also available to provide support. Mental health staff have access to an online toolbox of supports to assist with resolution of ethhical situations.

An external ethicist is available to assist staff and teams. Ethics Committee minutes are shared with the board and key issues are highlighted.

There is a plan to further educate the organization on the role and function of the Erhics Committee and ethical issues, and to build capacity through Lunch and Learns, discussion of examples and learning forums. The Ethics Committee provides reports through the Vice President of Quality to senior management and the Quality Committee of the Board.

Some staff are aware of the "patient bill of rights" and/or the hospital's organizational values.

All clinical staff consulted felt there is adequate organizational support to resolve ethical issues and could not suggest any improvements.

The ethical implications of research projects are reviewed by a separate board that operates in accord with national standards.

3.1.7 Priority Process: Communication

Communication among various layers 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)

Strengths:
The organization has an engaged, proactive Board that provides clear oversight to the organization. All Board meetings are concluded with an in camera session without the CEO and Sr. Staff in attendance.

A Communications and Marketing portfolio exists to oversee communications and media relations. Materials shared with the survey team were proactive and well presented. There is a good mix of tools used to ensure that the right information is in the right hands at the right time. Newsletters, brochures, inter and intranet are examples of these. An innovative communication tool involves the bi-weekly (or more) blogs penned by the CEO. Discussions throughout the organization confirmed that staff accessed the tools available to them and were aware of corporate, program and service communications.

The process of ensuring legacy policies are updated, revised and re-titled to reflect "North Bay Regional Health Centre" are underway. All Corporate polices are available electronically via "Go Live" and a plan is in place to input the Departmental policies. There are clear protocols for updating and systems are in place to ensure that updates are reviewed as required. A Policy Coordinator has been in place for the past year to ensure that education/resources are available to the end-users. The organization is to be commended for its approach to policy management.

The Community Stakeholders's meeting confirmed that the organization is very open with its communication, with all feeling that they can access information as required.
Communication initiatives between the management structures at Kirkwood Place and Health Sciences North occur at least quarterly to discuss the myriad of issues that occur as a result of their reliance on each other's services.

A plan for moving towards an electronic documentation system is underway. One area is currently piloting the system.

The electronic incident management system "Reds" is user friendly, and an effective means for moving the incident forward towards resolution.

There is progressive initiative to provide CCAC and long-term care facilities with on-line access to patient test results.

There was a significant internal breach of confidentiality that was dealt with seriously and used as a learning opportunity. One result was increased compliance with privacy protocols. Privacy is enhanced by insisting on specific confidentiality language in vendor contracts, data sharing agreements and remote access agreements for physicians and their staffs.

Hospital staff do more than 50 presentations per year in the community to share information and foster relationships.
Internally, the blog has become an effective means of communication. Monitored 'readership' has increased from 500 to 2,000. Several public relations initiatives have been recognized nationally and internationally.

In-hospital screens will soon allow broadcasting of messages and provide opportunities for direct stakeholder input. Social media initiatives are just beginning.

Opportunities for Improvement:

At the current time, the communication plan has been developed and implemented without input from the Board of Directors. Due to the nature of the Board's advocacy role, it should be the Board that oversees the development of the communication plan and the organization's leaders implement the plan.

The Information Management System at the King Street Mental Health Clinics has not kept pace with the growth of the programs. Many of the Community Mental Health Clinics are now District and Regional in scope, and having a paper-based medical record precludes timely access to information. The organization is encouraged to address the need for an electronic record for Community Mental Health.

For sites/programs that are not on the NBRHC main campus, many front-line staff articulated that they feel "forgotten" by the Main campus at times. Several examples were cited when staff had to remind the Main campus that they were also on the video conference, or what about there input in a issue etc. The organization is encouraged to seek out remedies to address these concerns.

3.1.8 Priority Process: Physical Environment

Providing appropriate and safe structures and facilities to successfully carry out the mission, vision, and goals.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Two main sties were visited, North Bay Regional Health centre and Kirwood place. Both sites are kept very clean and are well maintained. The renovation done at Kirkwood place meets the needs of the population it serves. There is a strong element of client and staff safety in the design and the maintenance of these facilities. There is a strong investigative process in place to assess . The organisation has optimized to use of cameras to detect both security and safety risk. For example, video recordings will be reviewed to see if the carpet in an entrance increase the risk of tripping patients by assessing the near misses.

At the Kirkwood site there is room to improve patient safety by locking of classrooms when not in use to prevent patients from wondering. It was noted that an iron and a paper cutter where accessible. The use of metal surrogated knifes in kitchen should be assessed to decrease the risk of patient self harm.

The infection control process during renovations should be reviewed to ensure these are in line with Standard for patient care and related areas during construction, maintenance and renovation. http://www.chica.org/cjic/vol23no1A.pdf as it was unclear what infection control procedures are needed to be in place in working on ceiling tiles.

3.1.9 Priority Process: Emergency Preparedness

Dealing with emergencies and other aspects of public safety.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

A multi-disciplinary Emergency Response Committee meets regularly, as do a series of subcommittees corresponding to specific codes. This function is accountable to senior management through the Vice-President of Corporate Services. Emergency Planning is done within the hospital, in conjunction with community partners and as part of the community emergency management plan.

All staff were educated on emergency preparedness before moving to the new building. New staff are trained as part of orientation and through e-learning. Volunteers are made aware of emergency planning during their orientation. Physicians would receive information on emergency preparedness appropriate the area they work in. Other examples of preparation include recent med-sled training.

All clinical and non-clinical staff who were interviewed were aware of their role in common emergencies and knew where to find the information for less common situations.

There is a schedule for regular mock codes. When the mock code is implemented, it is observed by designated representatives. The exercise is then reviewed by the corresponding committee and recommendations are made for modifications as appropriate.

For ongoing events, an incident management system is used. This has also been practiced under mock situations.

The pandemic plan is in the process of being updated. The Health Unit/Medical Officer of Health has a close partnership with the hospital, including planning and infection control activities.

At Kirkwood Place, there is excellent collaboration with Health Sciences North for emergency preparation.

3.1.10 Priority Process: Patient Flow

Smooth and timely movement of clients and their families through appropriate service and care settings.

Unmet Criteria		High Priority Criteria
Standards Set: Emergency Department		
2.3	The team has strategies in place to effectively manage overcrowding and surges in the Emergency Department.	!
6.3	The team quickly recognizes overcrowding in the Emergency Department and follows protocols to move clients elsewhere within the organization.	!
Standards Set: Operating Rooms		
11.5	The operating room team contacts clients or follow-up service providers to help evaluate the effectiveness of the procedure and the post-surgical transition, and makes improvements to its services as appropriate.	!

Surveyor comments on the priority process(es)

The organization is currently challenged to improve the flow of patients who are waiting bed placement following an admission in the emergency department. Wait times from physician order to admit to in-patient beds are often lengthy. Some of the challenges sited are compliance with the 1100 hour discharge on the units, lack of resources in the community to support the Home First initiatives resulting in a high number of Alternate Level of Care patients in the hospital, as well as a commitment on the in-patient units to developing and following guidelines for Expected Date of Discharge as well as benchmarking/receiving data regarding Length of Stay and other pertinent matrix measures.
There are many innovative and creative initiatives in place to improve patient flow and the community partnerships and collaboration to address the challenges are to be commended. The team is very proud of their relationship with the community agencies, area hospitals and the social work/discharge planning team who are making every effort to avoid patient admissions to the emergency department and hospital.

3.1.11 Priority Process: Medical Devices and Equipment

Machinery and technologies designed to aid in the diagnosis and treatment of healthcare problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The CSR department demonstrated strong leadership, and a commitment to quality management of its reprocessing and sterilization system. The development and installation of a computerized tracking system for instruments and equipment would enhance and simplify quality reporting. One would encourage the surgical program to look at utilizing a single orthopaedic joint system. This would significantly simplify the sterilization and processing of equipment and hence significantly decrease the possibility of error occurring.

3.2 Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Clinical Leadership

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

Competency

- Developing a highly competent interdisciplinary team with the knowledge, skills and abilities to develop, manage, and deliver effective and efficient programs, services, and care.

Episode of Care

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

Decision Support

- Information, research and evidence, data, and technologies that support and facilitate management and clinical decision-making.

Impact on Outcomes

- The identification and monitoring of process and outcome measures to evaluate and improve the quality of services to clients and the impact on client outcomes.

Medication Management

- Interdisciplinary provision of medication to clients.

Organ Donation

- Donation services provided from identification of a potential donor to donor management and organ recovery.

Infection Prevention and Control

- Measures practiced by healthcare personnel in healthcare facilities to decrease transmission and acquisition of infectious agents.

Surgical Procedures

- Delivery of safe surgical care to clients, from preparation and the actual procedure in the operating room, to the post-recovery area and discharge.

Diagnostic Services: Imaging

- Availability of diagnostic imaging to provide health care practitioners with information about the presence, severity, and causes of health problems, and the procedures and processes used by these services.

Diagnostic Services: Laboratory

- Availability of laboratory services to provide health care practitioners with information about the presence, severity, and causes of health problems, and the procedures and processes used by these services.

Blood Services

- Safe processes to handle blood and blood components, from donor selection and blood collection through to providing transfusions.

3.2.1 Standards Set: Ambulatory Care Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.1	The team works together to develop goals and objectives.	
2.2	The team's goals and objectives for ambulatory care services are measurable and specific.	
Priority Process: Competency		
4.9	Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	
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		
18.5	The team shares evaluation results with staff, clients, and families.	
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		
The ambulatory services are well organized and resourced. The managers, clinicians and staff are proud of their services for patients and the teamwork they provide. Staff receive orientation and ongoing education. There is an e-learning module for staff. The organization is commended in the proactive work they have done on enhancing workplace teamwork by reducing bullying in the workplace. The ambulatory services are a magnet for recruitment.		
Priority Process: Competency		
The interdisciplinary team are supported in keeping their education up to date. Many team members have been in their clinical areas for years and are very competent in their roles. Teamwork within and beyond the clinic is evident to benefit patients across the continuum.		

Priority Process: Episode of Care

The Ambulatory Care Services are well organized and patient-centred. The patients have a positive experience with their providers. One physician states "this is a hospital that works" due to its commitment to continuous improvement. The decentralized registration areas promote a positive patient experience.

The Wound Clinic may benefit from a regional vision for standardized patient care across the continuum.

Priority Process: Decision Support

There are many sources of information for ambulatory services. The Ontario Renal Network requires specific information to measure and monitor outcomes for patients. The VTE clinic provides a unique service to this community, enhancing the safety for orphaned patients on coumadin. This program would benefit from a improved monitoring report on outcome indicators. The VTE prophylaxis will be spreading from the surgical population to the medical population.

Priority Process: Impact on Outcomes

Although there is evidence of process and outcome measures in ambulatory services, there are opportunities to strengthen these reports and to standardize both content and frequency of reporting. Huddle boards, once implemented, will improve the visibility of results for both staff and patients.

3.2.2 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 lab has recently been certified and assessed by OLA. All specimens are safely labelled and identified. A process is in place for handling after hour specimens.

3.2.3 Standards Set: Blood Bank and Transfusion Services

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

Surveyor comments on the priority process(es)
Priority Process: Blood Services
The blood bank underwent a recent OLA survey and assessment. No deficiencies were found in this department. Coverage is provided by a trained technician for 24 hrs. All blood products are readily available and replenished daily.

3.2.4 Standards Set: Community-Based Mental Health Services and Supports Standards

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
The organization has met all criteria for this priority process.			
Priority Process: Competency			
6.2	Each team member has a position profile that defines his or her role, responsibility, and scope of practice.		
Priority Process: Episode of Care			
7.11	The team follows a process to identify, address, and record all ethics-related issues.		!
14.3	The team reconciles the client's medications at interfaces of care where the client is at risk for medication discrepancies (circle of care, discharge) with the involvement of the client and family or caregiver when medication management is a component of care, or as deemed appropriate through clinician assessment.		ROP
	14.3.1	There is a demonstrated, formal process to reconcile client medications at interfaces of care where the client is at risk of medication discrepancies (circle of care, discharge).	**MAJOR**
	14.3.3	The team provides the client with a copy of the up-to-date medication list, clear information about the changes, and educates the client to share the list when encountering providers in the client's circle of care.	**MINOR**
Priority Process: Decision Support			
The organization has met all criteria for this priority process.			
Priority Process: Impact on Outcomes			
17.7	The team informs and educates individuals and families in writing and verbally about the individual and family's role in promoting safety.		ROP
	17.7.2	The team provides written and verbal information to individuals and families about their role in promoting safety.	**MAJOR**
18.5	The organization shares benchmark and leading practice information with its partners and other organizations.		
19.1	The team has processes in place to regularly monitor the quality of its services and supports.		

19.2	The team regularly monitors process and outcome measures.	
19.4	The team compares its results with other similar interventions, programs, or organizations.	
19.5	The team uses the information it collects to identify successes and make ongoing improvements.	
19.6	The team shares evaluation results with staff, individuals, and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Nipissing Assertive Community Treatment Team demonstrates passionate commitment to understanding and responding to the complex care needs of their clients, using a person-centred, strength-based, individual directed approach. The team should be commended for the quality of care they provide to support clients across the continuum of health services, as required. For example, when a client experiences a mental health crisis requiring hospitalization, the ACT team provides the organization's emergency department with well informed, relevant current and historical medical information, actively participates in the inpatient care conferences and actively participates in the development of the client's discharge plan.

The Regional Forensic Program and the Regional Specialized Mental Health Program are commended for their comprehensive strategic plans; well-informed by and responsive to the needs of the community.

Priority Process: Competency

The organization has an extensive workplace violence prevention program to support a safe and healthy workplace.

The organization has a well developed and well disseminated program to prevent and manage harassment and bullying in the workplace.

The organization has developed and implemented a program to recognize staff each quarter who exemplify the organization's values.

Priority Process: Episode of Care

The Word Play Program should be commended for the well developed collaborative relationships they have built with community partners to ensure seamless access to services for their clients and families. This program provides an excellent example of client and family centred care. The team is compassionate, passionate, and committed to doing the best for patients.

The Mental Health Client Care Centre (120 King Street) houses several high functioning, district and regional programs and services, including regional and district outreach services for Early Episode in Psychosis, Concurrent Disorders and Eating Disorders. The team is compassionate, passionate, and committed to doing the best for patients.

The multidisciplinary teams provide patient centred care and develop comprehensive goals with their patients.

Patients described staff as professional and skilled at what they do.

There is support for ongoing education, the use of e-learning and best practices. The multidisciplinary teams are very supportive of each other and work together to resolve conflict.

The multidisciplinary teams complete a comprehensive review when near misses or adverse events occur and they identify areas for improvement and make the changes to improve patient safety.

Services and programs are planned and implemented bearing in mind the work done at other organizations.

There is evidence that clinical practice guidelines are in use in some of the service areas and the organization is encouraged to continue to support the implementation of best practices.

Passionate and caring staff are the key strengths of the community mental health programs and services.

Priority Process: Decision Support

There is good evidence of use of technology to support timely access to care and services (e.g. video conference).

Priority Process: Impact on Outcomes

The community mental health programs demonstrated actions that support workplace safety.

3.2.5 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			
4.6	Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.		
Priority Process: Episode of Care			
9.8	The team schedules one or more interdisciplinary meetings with clients and their family members in a private setting.		
Priority Process: Decision Support			
The organization has met all criteria for this priority process.			
Priority Process: Impact on Outcomes			
16.3	The team informs and educates clients and families in writing and verbally about the client and family's role in promoting safety.		ROP
	16.3.1	The team develops written and verbal information for clients and families about their role in promoting safety.	**MAJOR**
	16.3.2	The team provides written and verbal information to clients and families about their role in promoting safety.	**MAJOR**
Priority Process: Organ Donation			
The organization has met all criteria for this priority process.			

Surveyor comments on the priority process(es)
Priority Process: Clinical Leadership
Objectives are clearly identified.
Priority Process: Competency
Annual performance evaluations have not been completed for all staff. The unit is adequately staffed and continuing education is encouraged and supported. The unit is a teaching facility for both nursing and medical students.

Priority Process: Episode of Care

A rapld response team is in place with clear goals and objectives.This provides rapid access and care for patients. The patients other care givers are quickly informed of patient status.
The unit is well organized and the objective and move forward strategy
Excellent support and help exists for staff to handle and work through stressful encounters.

Priority Process: Decision Support

3.5 Although there is an anaesthetist available for care for ventilated patients daily, the anaesthetist rotates every 24 hours - which creates a concern for continuity of care. Further, this ICU is an open unit. It may be a good recommendation to consider closing the "vented 6 bed" portion of the ICU, which would enable an intensivist model of care.

Priority Process: Impact on Outcomes

Sentinel events are recognized and reported . Corrective action is implemented.

Priority Process: Organ Donation

The organization is well versed and informed in identifying potential donors. Staff act in a dignified and professional manner to identify potential donors. The results are significant and the staff is to be congratulated.

3.2.6 Standards Set: Diagnostic Imaging Services

Unmet Criteria		High Priority Criteria
Priority Process: Diagnostic Services: Imaging		
6.5	Diagnostic imaging providers have a Policy and Procedure Manual that includes detailed procedures for positioning the client for diagnostic imaging examinations that is signed by the medical director or designate.	
6.7	The team annually reviews and updates the Policy and Procedure Manual.	
11.3	The team follows a specific procedure for people who assist in diagnostic imaging examinations.	
15.7	The team informs and educates clients and families in writing and verbally about the client and family's role in promoting safety.	ROP
15.7.2	The team provides written and verbal information to clients and families about their role in promoting safety.	**MAJOR**
Surveyor comments on the priority process(es)		
Priority Process: Diagnostic Services: Imaging		

The department is regularly keeping track of department performance indictors to assess and improve their performance. The department has a culture of patient safety. Patient are treated with respect. The departemne aims at optimizing the use of diagnostic imaging within the region.

The department has state of the art equipments. The proximity with the emergency department and the use of the emergency trained nurses increase the responsiveness in case of patient reaction and ensures optimal patient recovery after procedures requiring sedations.. The department could benefit for updating all it policies and procedures to ensure they are up to date. it would be important to define high risk procedures to put in place extra safety process in place.

3.2.7 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 Donation	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The department is well staffed and resourced. Monitoring and assessing paediatric patients is in place. A separate waiting and quiet area for psychiatric patients is available. Isolation rooms are available and removed from the main patient area. The staff will be undergoing
Privacy was a concern when patients were seeing the triage nurse. The department is aware of this and modifications are planned.

Priority Process: Competency

Staff in the department receive appropriate training. Extra training is encouraged and supported. Ongoing training occurs in the department.

Priority Process: Episode of Care

The department was well resourced. Patients are assessed and managed in a timely fashion.The major difficulty is achieving transfers in a timely fashion to admitting units..CTAS and Paediatric CTAS are done

appropriately with a formal process for re-evaluation for patients waiting.The department has a process for identifying exceptional care and service.

Priority Process: Decision Support

The department is well equipped and resourced. They provide training for many medical,health and allied health professionals.

Priority Process: Impact on Outcomes

Daily statistics are collected and recorded about activities in the department.

Priority Process: Organ Donation

The department identifies potential donors. The established policy is put in action and the ICU informed. The ICU then takes over the process.

3.2.8 Standards Set: Infection Prevention and Control

Unmet Criteria	High Priority Criteria
Priority Process: Infection Prevention and Control	

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)
Priority Process: Infection Prevention and Control

The ICP department is very proud of the leading edge Antimicrobial Handbook developed by the Antimicrobial Subcommittee of the Infection Control Committee.This handbook was derived from the Sunny Brook Health Sciences Centre guidelines with adaptations to tailor to local ecology and practice at NBRHC. It is currently in draft format and will be circulated to appropriate users for review. The ICP coordinator is a member of the Provincial Antimicrobial Advisory Committee which she sees as a valuable asset to the work of the team.
The ICP staff monitor all infections that are diagnosed through an ER visit. This process has shown success in identifying an outbreak of Strep A which was linked back to a community group home. The ICP communicated with staff at the group home and the situation was addressed. The ICP staff are encouraged to continue their communication and partnerships with community, off site locations, regional agencies and their LHIN.
The handwashnig compliance is a challenge for the organization and it is hoped that each department will take ownership of their audits and compliance rates.
It was noted at Kirkwood Place in Sudbury that hand washing compliance on some of the units was a challenge due to the nature of the patient population. Housekeeping have carts that can be locked and hand sanitizer solution could be secured, however, there are no keys for the locks. The organization may want to investigate resourcing services with portable hand sanitizer containers.
The Kirkwood site has a high staff compliance for influenza vaccination.
The Kirkwood staff are to be complimented for the cleanliness of the facilities,uncluttered hallways and patient care areas.

3.2.9 Standards Set: Laboratory and Blood 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
There are outside labs available to provide certain services, however they're capped with respect to the number of tests they can perform. This causes increased strain and increased use of resources to manage the outpatient lab at the hospital. The department is currently trying to develop a process to better manage this increased demand from both the public and ordering physicians. Recruitment of qualified staff continues to be a challenge.The department is spacious, well equipped with well trained individuals. There are some staff who are cross trained to work in more than one area in the lab. The hospital does lab work for outlying facilities and has a process in place for safe delivery and processing of specimens. OLA accreditation was done in 2011. Some deficiencies were identified mainly related to urinalysis point of testing.These deficiencies have been addressed.

3.2.10 Standards Set: Managing Medications

Unmet Criteria		High Priority Criteria
Priority Process: Medication Management		
2.4	Staff and service providers have access to the formulary, and are made aware of which medications are included and excluded from the list.	
2.5	The organization defines and lists available high-risk/high-alert medications.	!
3.3	The organization examines the packages and labels of drugs being considered for selection to identify any potential for confusion.	!
3.10	The organization's procurement processes include assessing the potential for risk associated with each medication received in the organization.	!
7.5	Unit dose oral medications remain in the manufacturer's or pharmacy's packaging until they are administered.	!
8.1	The pharmacy establishes and follows a policy and process to monitor bulk chemicals which includes eliminating those that are not regularly used or that are considered dangerous.	!
11.4	The pharmacy computer system is used to perform dose range checks and to warn staff and service providers about low and high doses for high alert medications.	!
13.3	The pharmacy dispenses medications in unit dose packaging.	!
15.2	The organization has medication delivery turn-around times for emergency, urgent, and routine medications.	
18.5	Service providers seek an independent double check before administering high-alert/high-risk medications.	!
18.6	Staff and service providers adhere to medication administration schedules.	!
18.9	The organization tracks lot numbers to identify and inform providers when a client has received a recalled vaccine.	
22.1	The organization selects and monitors process and outcome indicators for medication use and medication management.	
22.2	The organization monitors medication use with an ongoing medication utilization review.	
22.4	Based on the data collected and analyzed, the organization identifies and addresses areas for improvement.	

Surveyor comments on the priority process(es)

Priority Process: Medication Management

The pharmacy has up to date equipments and facilities.

The organisation has an excellent medication reconciliation process on admission throughout in patient units. There is still some work required to optimize the process for medication reconciliation on transfer and on discharge in acute care section of the hospital.

The pharmacy should work on building stronger communication with physicians to minimize using nursing staff to convey their questions.

The organisation should enforce the practice of dating multi dose punctured vials in order to reduce waste and risk of contamination.

The organisation is encouraged to continue the implementation of pharmacy generated MAR throughout the hospital and point of care bar coded EMAR.

The hospital is doing do not use abbreviations audits, however, there is a significant numbers of these still in use. the hospital should reassess an optimal process to provide targeted direct provider feedback in order to speed up practice change.

The organization should encourage pharmacists to get more involved in patient care areas, by partaking more regularly in medical rounds in key clinical care areas.

The organization does not have any concentrated potassium on the units. However, the calcium, magensiun and concentrated sodium chloride are available . there are safety features in place to prevent medication errors. The current practice is in line with the new proposed 2014 ROP stating:
The organization evaluates and limits the availability of concentrated electrolytes and removes parenteral formats with the potential to cause harmful medication incidents from client service areas.
Guidelines:
There are also reports of accidental death from the inadvertent administration of concentrated sodium chloride solution. Removal of concentrated electrolytes from client service areas is a valuable use of resources to minimize the risk of death or disabling injury associated with these agents. Concentrated electrolytes to be the focus of audit and removal from client service areas include:

- Calcium (all salts): concentrations greater than or equal to 10%
- Magnesium sulfate: concentrations greater than 20%
- Potassium (all salts): concentrations greater than or equal to 2 mmol/mL (2 mEq/mL)
- Sodium acetate and sodium phosphate: concentrations greater than or equal to 4 mmol/mL
- Sodium bicarbonate: concentrations greater than or equal to 4.2%
- Sodium chloride: concentrations greater than 0.9%

Exceptions: When the following concentrated electrolytes must be available in selected client service areas, the specified safeguards are required (at minimum):

- Calcium: pre-filled syringes (1 g in 10 mL) in emergency carts or boxes only
- Sodium bicarbonate: pre-filled syringes (4.2% and 8.4%) in emergency carts or boxes only
- Sodium chloride: 3% bags are segregated from non-medicated intravenous solutions in

selected areas (e.g. Neurology, Emergency Departments, Critical Care) Additional strategies to ensure the safe use of high-alert medications such as concentrated electrolytes may be found in Accreditation Canada's High-Alert Medications ROP.

3.2.11 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			
11.6	Following transition or end of service, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning.		
Priority Process: Decision Support			
The organization has met all criteria for this priority process.			
Priority Process: Impact on Outcomes			
15.3	Staff and service providers participate in regular safety briefings to share information about potential safety problems, reduce the risk of error, and improve the quality of service.		!
15.4	The team informs and educates clients and families in writing and verbally about the client and family's role in promoting safety.		ROP
	15.4.1	The team develops written and verbal information for clients and families about their role in promoting safety.	**MAJOR**
	15.4.2	The team provides written and verbal information to clients and families about their role in promoting safety.	**MAJOR**

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The team members report a high level of satisfaction in their work life. They state that the voicera communication system allows them to connect to their peers and patients in a timely fashion. They commend their department leaders for involving them in the design of services, ongoing evaluation, and review.
The student nurses were very excited about their patient assignments on the unit and the support they received from all staff.
Volunteers have been engaged in the "Hospital Elder Life Program" (HELP). The Volunteer Coordinator attends morning bullet rounds and reviews all seniors on the unit. Volunteers are assigned appropriately and provide interventions that enhance the patient experience. This program is well supported by unit staff.

Priority Process: Competency

The team complimented the new space, brightness, cleanliness and spacious patient care areas. Concern was expressed regarding the difficulty patients, families and visitors have navigating the unit. The organization may want to consider additional signage. staff expressed concern that the central nursing station was overcrowded and very noisy most of the time.
The staff reported that they are pleased with the designated funding to support their ongoing education and training.

Priority Process: Episode of Care

The team reports that they have a "buddy" system which provides backup and support to each other. They are proud of their multidisciplinary team approach to patient centred care.

Priority Process: Decision Support

The medical services have a well integrated electronic medical record and is well resourced with space and electronic equipment for staff access.

Priority Process: Impact on Outcomes

The team indicates that they are in the process of implementing the "huddle" boards. The organization is encouraged to continue moving this initiative forward.

3.2.12 Standards Set: Mental Health Services

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
The organization has met all criteria for this priority process.			
Priority Process: Competency			
3.2	Team members have position profiles that define roles, responsibilities, and scope of practice.		
4.10	Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.		
Priority Process: Episode of Care			
8.10	The team follows the organization's process to identify, address, and record all ethics-related issues.		!
11.3	The team reconciles the client's medications with the involvement of the client, family or caregiver at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).		ROP
	11.3.1	There is a demonstrated, formal process to reconcile client medications at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).	**MAJOR**
	11.3.2	Depending on the model, the prescriber uses the Best Possible Medication History (BPMH) and the active medication orders to generate transfer or discharge medication orders (proactive), OR, the team makes a timely comparison of the BPMH, the active medication orders, and the transfer or discharge medication orders (retroactive).	**MAJOR**
	11.3.3	The team documents that the BPMH, the active medication orders, and the transfer or discharge medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.	**MAJOR**
	11.3.5	The process is a shared responsibility involving the client or family, and one or more health care practitioner(s), such as nursing staff, medical staff, and pharmacy staff, as appropriate.	**MINOR**
Priority Process: Decision Support			
The organization has met all criteria for this priority process.			
Priority Process: Impact on Outcomes			

14.5	The team shares benchmark and best practice information against its partners and other organizations.	
15.4	Staff and service providers participate in regular safety briefings to share information about potential safety problems, reduce the risk of error, and improve the quality of service.	!
15.5	The team informs and educates clients and families in writing and verbally about the client and family's role in promoting safety.	ROP
15.5.2	The team provides written and verbal information to clients and families about their role in promoting safety.	MAJOR
16.1	The team identifies and monitors process and outcome measures for its mental health services.	
16.4	The team uses the information it collects about the quality of its services to identify successes and opportunities for improvement, and makes improvements in a timely way.	
16.5	The team shares evaluation results with staff, clients, and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Clinical leaders across all areas of the organization's Mental Health programs and services demonstrate a passionate commitment to provide safe, quality care to patients.

Priority Process: Competency

The organization demonstrates value for learning and development of staff as evidenced by the clinical education support present in many of the mental health service areas.

Priority Process: Episode of Care

The organization is encouraged to implement medication reconciliation at transition points across, all mental health programs, where medication orders are changed or rewritten (internal transfer and/or discharge).

The multidisciplinary team provides patient centred care and develops comprehensive goals with the patient.

Kirkwood Place should be commended for their education program supporting children and youth.

Passionate and caring staff are the key strengths of the mental health programs.

Priority Process: Decision Support

There is good evidence of use of technology to support timely access to care and services (e.g. video conference).

Priority Process: Impact on Outcomes

The Regional Forensic Program is commended for their comprehensive high risk verification process for the management of changes to patient's level of privilege in the interest of ensuring a safe community.

3.2.13 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			
9.9	The team uses a safe surgery checklist to confirm safety steps are completed for a surgical procedure.		ROP
	9.9.3	The team has developed a process for ongoing monitoring of compliance with the checklist.	**MAJOR**
	9.9.4	The team evaluates the use of the checklist and shares results with staff and service providers.	**MINOR**
	9.9.5	The team uses results of the evaluation to improve the implementation of and expand the use of the checklist.	**MINOR**
Priority Process: Decision Support			
The organization has met all criteria for this priority process.			
Priority Process: Impact on Outcomes			
The organization has met all criteria for this priority process.			

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The unit serves as the regional obstetrical unit. C-section availability is present in the unit for both elective and emergency procedures.The neonatal unit is able to care for newborns from 30 weeks gestational age with ventilatory support. Physicians have good rapport with major teaching centres regarding patient care for both obstetrical and neonatal units.Appropriate transfers are easily arranged.

Priority Process: Competency

Several nurses,physicians and midwives recently took the ALARM course and are very enthusiastic in implementing what was learned. Sessions will be organised to ensure that all staff will take the course.A reporting system is being implemented to track outcomes. The team has done several mock code pinks.

Priority Process: Episode of Care

All patients are assessed several weeks prior to due date or C-section date. Information about the unit is provided. Appropriate consultation is obtained ie. medical,social worker, children's aid etc. This is to facilitate safe pre and post natal care. Medications require a double check and signature from two staff members.

Priority Process: Decision Support

The department is well equipped. A system is being developed to monitor clinical indicators.

Priority Process: Impact on Outcomes

The department recently had an adverse event. All the staff has become aware of this and education, support and change in process has been implemented.

3.2.14 Standards Set: Rehabilitation Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.1	The team collects information about its clients and the community.	
1.2	The team uses the information it collects about clients and the community to define the scope of its services and set priorities when multiple service needs are identified.	
2.1	The team works together to develop goals and objectives.	
Priority Process: Competency		
3.5	The organization provides sufficient workspace to support interdisciplinary team functioning and interaction.	
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		
	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		
9.8	The team uses at least two client identifiers before providing any service or procedure.	ROP
9.8.1	The team uses at least two client identifiers before providing any service or procedure.	**MAJOR**
14.5	The team shares benchmark and best practice information with its partners and other organizations.	
15.4	The team informs and educates clients and families in writing and verbally about the client and family's role in promoting safety.	ROP
15.4.1	The team develops written and verbal information for clients and families about their role in promoting safety.	**MAJOR**
16.1	The team identifies and monitors process and outcome measures for its rehabilitation services.	

16.4	The team uses the information it collects about the quality of its services to identify successes and opportunities for improvement, and makes improvements in a timely way.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

NBRHC:
Strengths:
The physical layout of the NBRHC Complex Continuing Care, B1, and Rehab Units are neat, orderly, and functional. The environment is inviting and promotes a calming effect.

At the NBRHC: Complex Continuing Care and B1 are well organized with strong leadership (despite the manager being new to the area) that is committed to involving patients and staff in changes. Rehabilitation Unit is currently under the Medicine portfolio

Comprehensive orientation is provided and staff feel that their learning needs are met with on-going educational opportunities that are made available to them.

Patients/families feel that they are supported by the team and would recommend these units.

There is a multidisciplinary Quality Improvement/Risk Management Committee that meets monthly. Terms of Reference (still in draft) for this committee identifies developing and monitoring of performance indicators. This remains a work in progress.

Opportunities for Improvement
Since the last Accreditation Survey, there does not appear to be sufficient progress made in the areas of data collection, and goals and objectives setting that are monitored for achievement. When asked specifically as to whether the units had goals and objectives that they were working towards, the general response was "we are not there yet". The units are encouraged to gather feedback from internal and external stakeholders and formulate measurable goals and objectives that can be monitored for achievement on an annual basis.

The Quaility/Risk Committee needs to continue their work in developing strategies to enhance overall performance by creating and monitoring performance indicators. Several front-line/educators/clinical leads were asked as to what performance measures they were monitoring and the general response was "don't know". Perhaps when the Corporate Strategic Plan is rolled out, individual unit metrics that are aligned with the Strategic Plan can be implemented.

Kirkwood Site
Strengths:
The key strength of this team is the dedicated, interdisciplinary staff, and leadership team. The current Director is in an interim role, leaving her post in NBRHC as Director of HR.
When asked of the team as to what they were most proud of, several of the nursing staff reported that is was "The Team" despite only being together as a for just less than 2 years.

The Team should be commended for their success in achieving great improvement in their over time and absenteeism.

Opportunities for Improvement

Similarly to the NBRHC comments, when inquiry was made as to the goals/objectives that the Unit was working towards, the response was generally "we are not there yet".

The team identified that the current patient population is an array of different types of patients, all requiring a very different approach to care: developmentally delayed, organic brain injuries, behavioural issues etc. It is recommended that the team set priorities on an annual basis to help prioritize the service needs that will be required to continue to care for patients to the level that they have identified.

Priority Process: Competency

Strengths:
At the Kirkwood site, and NBRHC Complex Continuing Care, B1 and Rehab Teams are high functioning interprofessional teams that are committed to doing the best for patients. The teams provide patient centred care and develops comprehensive goals with the patients.

Patients described staff as professional and skilled at what they do.

There is support for ongoing education, the use of e-learning and best practices.
Staff is very supportive of each other and work together to resolve conflict.

Weekly case conferencing is done on all of the patients at the Kirkwood Site. All members of the multidisciplinary team are in attendance. Peer Support have been fully integrated within the team. They provide excellent feedback that has resulted in positive outcomes for patients.

Opportunities for Improvement:

The "Nurse"s Desk" area at the Kirkwood site does not meet the needs of the day-day workings of the Rehab unit. In addition, there are a large number of allied health professionals that are needed to care for the complex needs of these clients, and they must resort to various other areas of the units to document/discuss/review particular needs of the clients that they serve. The organization is encouraged to devote their attention to remedy this situation.

Priority Process: Episode of Care

Strengths:
Patients commented that the team develops a respectful professional relationship with them that promotes their well-being.

An Ethicist committee is available for consult as required.

At the B1 unit, a number of more high low beds have been purchased which has made a difference in the management of patients at risk for falls.

Since the last Accreditation survey, the falls prevention program has been re-instituted.

Staff appear well supported and able to advocate for their patients. They find they have a receptive ear in management. Collectively this supports a good working environment.

Complex client situations involve focused interdisciplinary discussions with the intent of having the patient discharged to the right continuum of care as quickly and safely as possible.

Having spoken with a number of staff that included physicians, nurses, students, housekeeping, as well as patients, there is evidence that all were well informed about hand washing best practices. Surveyors observed numerous examples of compliance on the part of staff.

Areas for Improvement

The organization uses ISMP "Do Not Use List." However, staff still accept written orders that use unacceptable abbreviations. The organization is encouraged to implement a process that does not accept these abbreviations for written orders. Suggest that a list be placed in the paper charts adjacent to the medication orders for easy reference.

It was identified that access to vocational services at the Kirkwood site is problematic as the vocational therapists are not readily available. The organization is encouraged to explore options to improve access.

Priority Process: Decision Support

Strengths:

All members of the Interdisciplinary team document their assessment in a comprehensive medical record. Patient centred goals are developed with patients and reviewed during rounds on a regular basis. There is evidence that there is good sharing of information amongst the team.

Coordination of care, although not without its challenges in specific case situations by and large is seamless.

Complex patient situations involve focused interdisciplinary discussions with the intent of having the patient discharged to the right continuum of care as quickly and safely as possible.

Priority Process: Impact on Outcomes

Strengths:

The team has re implemented a falls prevention strategy. The clinical educator has done audits on the process to ensure effectiveness of the program.

At the Kirkwood site, despite the limitations in the physical space, the actual care delivered to patients is solid.

At both sites, patients/families articulated that they were satisfied with the customer service they receive.

The teams have a good focus on safety.

Opportunities for Improvement:

Although staff have cared for some of their patients for "months", and knew who the patients were very well, Accreditation Canada does not create an exception for teams that care for patients on an extended basis. It was observed at NBRHC that using 2 client identifiers were not always done prior to delivering medication/services.

As a general observation, staff from both campuses, in all units, know very little information about metrics, strategies, and indicators that the organization as a whole is monitoring, other than hand hygiene rate. At the unit level, performance monitoring is very much in its infancy at the current time. Staff members from all Rehab units that were visited were not aware of any key performance indicators that were regularly reviewed and monitored.

At the NBRHC site, there was little to no written information for clients and families about their role in promoting safety. The only item given to patients/families on admission is the "Stay on Your Feet" brochure, prepared by an outside agency.

3.2.15 Standards Set: Substance Abuse and Problem Gambling 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	
14.5 The team shares benchmark and best practice information with its partners and other organizations.	
15.4 The team informs and educates clients and families in writing and verbally about the client and family's role in promoting safety.	ROP
15.4.1 The team develops written and verbal information for clients and families about their role in promoting safety.	**MAJOR**
16.3 The team compares its results with other similar interventions, programs, or organizations.	
Surveyor comments on the priority process(es)	
Priority Process: Clinical Leadership	

Strengths:
The Nipissing Detoxification and Substance Abuse Program [NDSAP] is recognized as a provincial service receiving referral for treatment from across Ontario. It's services include withdrawal management, crisis intervention and 21-day Residential treatment centre.

This is a high functioning, multidisciplinary team that is dedicated to providing the best patient care possible. It is well organized and all members work together to ensure that the patients/staff are safe.

Under new management, the program manager has set goals and objectives for the team/services.

As of particular importance, in collaboration with the Acute Inpatient Psychiatric Unit and the Mental Health Clinic, the 3 units have embarked on a Division Level Strategic Plan "founded on the values of the NBRHC as a result of the need for the stabilization of services during a time of seeming instability, perceived negative change and opportunity for potential growth". The strategic plan will be able to be aligned with the strategic priorities of the corporate Strategic Plan, once completed.

Opportunities for Improvement:
Goals/objectives and performance monitoring is being done at the management level. However all of this information is relatively unknown to the majority of staff. The organization is encouraged to continue on their path to posting their dashboard results/patient surveys in a visible area.

Collecting data is a very good start, but for the data to be useful, the team is encouraged to drill down and make improvements to their processes based on trends in the data.

Priority Process: Competency

Strengths:
Since the last Accreditation Survey, several hand washing and alcohol hand wash stations have been installed throughout the various units.

In addition, the QI committee (now termed the Quality and Risk Management Committee) does meet monthly and performance/patient satisfaction indicators are reviewed.

A good orientation program and buddy system is available to staff.

There is a plan to complete all Performance appraisals over the next several months, as it had been noted that this had not been priority until recently.

Services and programs are planned and implemented bearing in mind the work done at other orgs.

Credentials and licenses are reviewed annually by the director.

Priority Process: Episode of Care

Strengths:

Good solid work is being done by the Team.

Patient satisfaction with the care providers and the care processes delivered is high across all sites.

Med. Rec. is done for every patient.

Information transfer is managed well by the team.

Priority Process: Decision Support

Strengths:

Team seeks clients' perspectives through surveys, focus groups, interviews and meetings.

Opportunites for Improvement:
It is suggested that planning and benchmarking at the service level is an area of improvement.

Priority Process: Impact on Outcomes

Strengths:
The NDSAP undertook the Patient Safety Culture Tool survey and has reviewed the results closely. 2 red flags resulted from the survey and the Team has made recommendations to address the flags.

The team has a good focus on safety.

Patient satisfaction is monitored via NCR Picker and is reviewed on a regular basis.

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

Opportunities for Improvement:
It is suggested that planning and benchmarking at the service level is an opportunity for improvement.

There are many pamplets/brochures/educational material for the clients that they serve, but few, if any, discuss their role in safety. In addition, the team has not developed there own written information for client and families about their role in promoting safety.

The team needs to work on more clearly identifying what metrics it is monitoring that is aligned to the corporate scorecard but is relevant at the program/service level for Addictions.

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

3.2.16 Priority Process: Surgical Procedures

Delivery of safe surgical care to clients, from preparation and the actual procedure in the operating room, to the post-recovery area and discharge.

Unmet Criteria		High Priority Criteria
Standards Set: Operating Rooms		
2.8	The team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	
14.4	The team sets performance goals and objectives and measures their achievement.	
Standards Set: Surgical Care Services		
2.1	The team works together to develop goals and objectives.	
2.2	The team's goals and objectives for its surgical care services are measurable and specific.	
4.8	Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	
8.9	The team follows the organization's process to identify, address, and record all ethics-related issues.	!
11.6	Following transition or end of service, the team contacts clients, families, or referral organizations or teams to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning.	

Surveyor comments on the priority process(es)

Humidity and temperature within the operating theatres and patient areas are controlled from a central location. Medical and unit staff complained that both temperature and humidity were not locally monitored or controlled thus raising safety concerns and comfort for staff and patients.
Concern was expressed by one of the surgeons in the OR that the PACS system is very often slow to activate.
The physical layout of the units lends to a continuum of flow from admission to discharge of the patients as well as observing evidence based practice for sterile/clean and soiled equipment.
The new manager is making a concerted effort to recognize the good work of the employees on the unit and communicating this recognition through various media.
The staff stated that they are most proud of their team and the new facility and equipment.

Section 4 Instrument Results

As part of Qmentum, client organizations administer instruments. Instruments (or tools) are surveys related to areas such as governance, patient safety culture, and quality of worklife. They are completed by a representative sample of clients, staff, senior leaders, board members, and other stakeholders.

4.1 Governance Functioning Tool

The Governance Functioning Tool enables members of the governing body to assess board structures and processes, provide their perceptions and opinions, and identify priorities for action. The four aspects of the governing body that it is designed to measure are:

- 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 Quality Performance Roadmap on the client organization portal. The organization then had the opportunity to address challenging areas.

- **Data collection period: September 19, 2011 to October 21, 2011**
- **Number of respondents: 11**

Governance Functioning Tool: Results by Aspect of Governing Body

		% Disagree	% Neutral	% Agree	%Agree * Canadian Average
		Organization	Organization	Organization	
1	We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations.	18	9	73	94
2	Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	0	0	100	95
3	We have sub-committees that have clearly-defined roles and responsibilities.	0	0	100	97
4	Our roles and responsibilities are clearly identified and distinguished from those delegated to the CEO and/or senior management. We do not become overly involved in management issues.	0	0	100	95
5	We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decision-making.	9	9	82	91

		% Disagree	% Neutral	% Agree	%Agree * Canadian Average
		Organization	Organization	Organization	
6	Disagreements are viewed as a search for solutions rather than a “win/lose”.	18	0	82	95
7	Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	98
8	Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	9	0	91	97
9	Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	0	0	100	96
10	Our governance processes make sure that everyone participates in decision-making.	0	0	100	93
11	Individual members are actively involved in policy-making and strategic planning.	9	9	82	90
12	The composition of our governing body contributes to high governance and leadership performance.	0	9	91	94
13	Our governing body’s dynamics enable group dialogue and discussion. Individual members ask for and listen to one another’s ideas and input.	0	0	100	97
14	Our ongoing education and professional development is encouraged.	9	9	82	88
15	Working relationships among individual members and committees are positive.	0	0	100	98
16	We have a process to set bylaws and corporate policies.	0	18	82	96
17	Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	98
18	We formally evaluate our own performance on a regular basis.	0	9	91	78
19	We benchmark our performance against other similar organizations and/or national standards.	18	18	64	72

		% Disagree	% Neutral	% Agree	%Agree * Canadian Average
		Organization	Organization	Organization	
20	Contributions of individual members are reviewed regularly.	27	27	45	60
21	As a team, we regularly review how we function together and how our governance processes could be improved.	27	0	73	78
22	There is a process for improving individual effectiveness when nonperformance is an issue.	0	45	55	53
23	We regularly identify areas for improvement and engage in our own quality improvement activities.	0	18	82	80
24	As a governing body, we annually release a formal statement of our achievements that is shared with the organization's staff as well as external partners and the community.	9	18	73	83
25	As individual members, we receive adequate feedback about our contribution to the governing body.	27	27	45	63
26	Our chair has clear roles and responsibilities and runs the governing body effectively.	0	0	100	96
27	We receive ongoing education on how to interpret information on quality and patient safety performance.	9	0	91	84
28	As a governing body, we oversee the development of the organization's strategic plan.	9	18	73	97
29	As a governing body, we hear stories about clients that experienced harm during care.	9	0	91	79
30	The performance measures we track as a governing body give us a good understanding of organizational performance.	9	9	82	90
31	We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	0	0	100	90

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
32 We have explicit criteria to recruit and select new members.	0	0	100	86
33 Our renewal cycle is appropriately managed to ensure continuity on the governing body.	0	0	100	93
34 The composition of our governing body allows us to meet stakeholder and community needs.	0	9	91	94
35 Clear written policies define term lengths and limits for individual members, as well as compensation.	0	9	91	95
36 We review our own structure, including size and sub-committee structure.	0	0	100	90
37 We have a process to elect or appoint our chair.	0	0	100	93

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2012 and agreed with the instrument items.

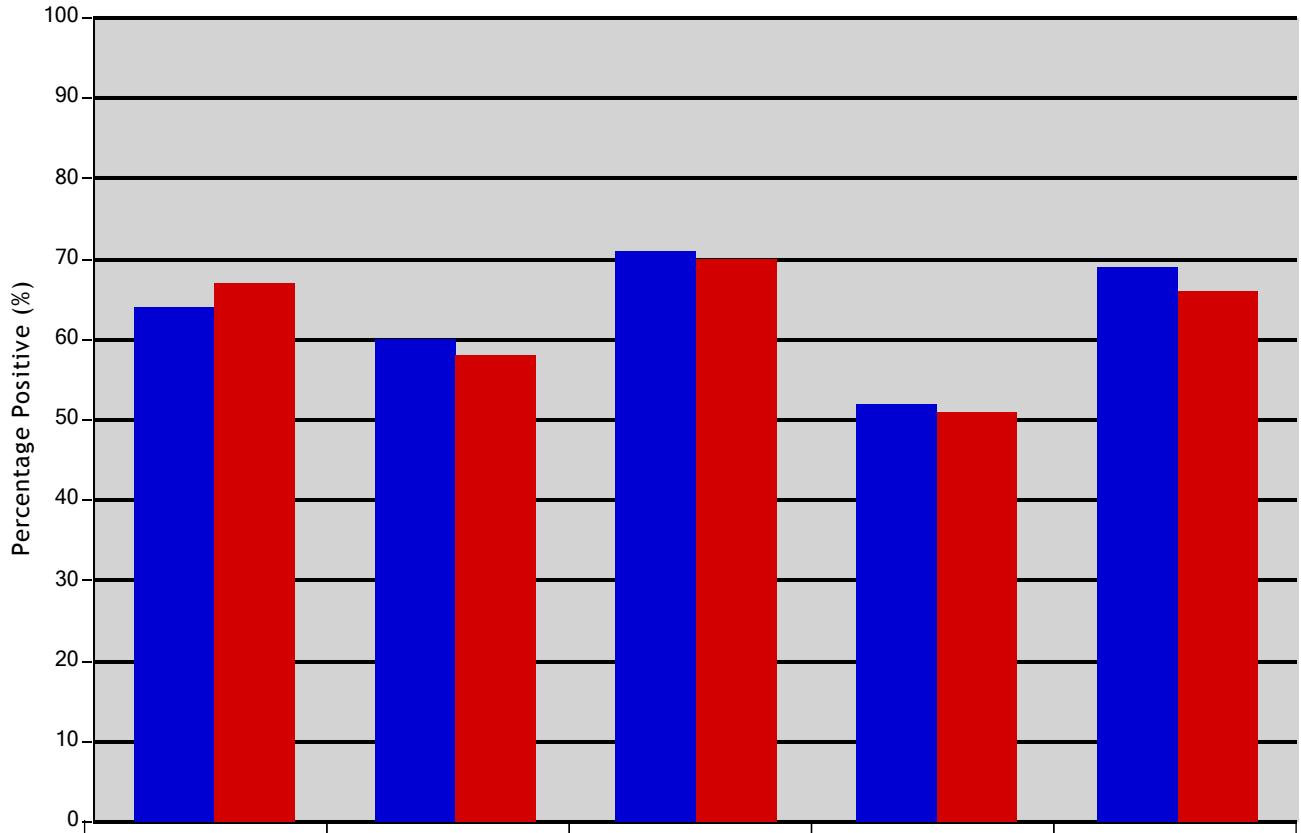
4.2 Patient Safety Culture Tool

The Patient Safety Culture Tool provides insight into staff perceptions of patient safety, allowing 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 Quality Performance Roadmap on the client organization portal. The organization then had the opportunity to address areas for improvement. During the on-site survey, surveyors reviewed progress made in those areas.

- **Data collection period: September 14, 2011 to October 16, 2011**
- **Minimum response rate (based on the number of employees): 329**
- **Number of respondents: 1012**

Patient Safety Culture: 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
	64%	60%	71%	52%	69%
	67%	58%	70%	51%	66%

Legend

North Bay Regional Health Centre

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2011 and agreed with the instrument items.

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 three-year cycle, Accreditation Canada provides ongoing liaison and support to help the organization address issues, action plan, 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 conditions.

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
Human Capital	Developing the human resource capacity to deliver safe, high quality services
Integrated Quality Management	Using a proactive, systematic, and ongoing process to manage and integrate quality and achieve organizational goals and objectives
Medical Devices and Equipment	Obtaining and maintaining machinery and technologies used to diagnose and treat health problems
Patient Flow	Assessing the smooth and timely movement of clients and families through service settings
Physical Environment	Providing appropriate and safe structures and facilities to achieve the organization's mission, vision, and goals
Planning and Service Design	Developing and implementing infrastructure, programs, and services to meet the needs of the populations and communities served
Principle-based Care and Decision Making	Identifying and making decisions about ethical dilemmas and problems
Resource Management	Monitoring, administering, and integrating activities related to the allocation and use of resources

Priority processes associated with population-specific standards

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

Priority processes associated with service excellence standards

Priority Process	Description
Blood Services	Handling blood and blood components safely, including donor selection, blood collection, and transfusions
Clinical Leadership	Providing leadership and direction to teams providing services
Competency	Developing a skilled, knowledgeable, interdisciplinary team that can manage and deliver effective programs and services
Decision Support	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
Episode of Care - Primary Care	Providing primary care in the clinical setting, including making primary care services accessible, completing the encounter, and coordinating services
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 Donation	Providing organ donation services for deceased donors and their families, including identifying potential donors, approaching families, and recovering organs
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
Organ Transplant	Providing organ transplant services, from initial assessment of transplant candidates to providing follow-up care to recipients
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
Surgical Procedures	Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge