ACCREDITATION AGRÉMENT CANADA
Qmentum

Accreditation Report

Deep River & District Hospital/Four Seasons Lodge

Deep River, ON

On-site survey dates: November 17, 2019 - November 20, 2019

Report issued: December 9, 2019

About the Accreditation Report

Deep River & District Hospital/Four Seasons Lodge (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 2019. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

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

Confidentiality

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

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

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

A Message from Accreditation Canada

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

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

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

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

We look forward to our continued partnership.

Sincerely,

Leslee Thompson
Chief Executive Officer

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Executive Summary

Deep River & District Hospital/Four Seasons Lodge (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. Accreditation Canada is an independent, not-for-profit organization that sets standards for quality and safety in health care and accredits health organizations in Canada and around the world.

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

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

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

Accreditation Decision

Deep River & District Hospital/Four Seasons Lodge's accreditation decision is:

Accredited with Exemplary Standing

The organization has attained the highest level of performance, achieving excellence in meeting the requirements of the accreditation program.

About the On-site Survey

- **On-site survey dates: November 17, 2019 to November 20, 2019**

- **Location**

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

  1. Deep River & District Hospital

- **Standards**

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

  System-Wide Standards

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

  Service Excellence Standards

  5. Biomedical Laboratory Services - Service Excellence Standards
  6. Diagnostic Imaging Services - Service Excellence Standards
  7. Emergency Department - Service Excellence Standards
  8. Inpatient Services - Service Excellence Standards
  9. Long-Term Care Services - Service Excellence Standards
  10. Point-of-Care Testing - Service Excellence Standards
  11. Primary Care Services - Service Excellence Standards
  12. Reprocessing of Reusable Medical Devices - Service Excellence Standards
  13. Transfusion Services - Service Excellence Standards

- **Instruments**

  The organization administered:

  1. Worklife Pulse
  2. Canadian Patient Safety Culture Survey Tool
  3. Governance Functioning Tool (2016)
  4. Client Experience Tool

Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
 Population Focus (Work with my community to anticipate and meet our needs)	41	0	0	41
 Accessibility (Give me timely and equitable services)	62	0	2	64
 Safety (Keep me safe)	428	1	47	476
 Worklife (Take care of those who take care of me)	92	7	3	102
 Client-centred Services (Partner with me and my family in our care)	213	1	6	220
 Continuity (Coordinate my care across the continuum)	44	0	2	46
 Appropriateness (Do the right thing to achieve the best results)	754	1	41	796
 Efficiency (Make the best use of resources)	44	0	5	49
Total	**1678**	**10**	**106**	**1794**

Overview by Standards

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

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

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

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

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	50 (100.0%)	0 (0.0%)	0	36 (100.0%)	0 (0.0%)	0	86 (100.0%)	0 (0.0%)	0
Leadership	50 (100.0%)	0 (0.0%)	0	96 (100.0%)	0 (0.0%)	0	146 (100.0%)	0 (0.0%)	0
Infection Prevention and Control Standards	40 (100.0%)	0 (0.0%)	0	29 (100.0%)	0 (0.0%)	2	69 (100.0%)	0 (0.0%)	2
Medication Management Standards	61 (100.0%)	0 (0.0%)	17	56 (100.0%)	0 (0.0%)	8	117 (100.0%)	0 (0.0%)	25
Biomedical Laboratory Services **	72 (100.0%)	0 (0.0%)	0	105 (100.0%)	0 (0.0%)	0	177 (100.0%)	0 (0.0%)	0
Diagnostic Imaging Services	59 (100.0%)	0 (0.0%)	9	64 (97.0%)	2 (3.0%)	3	123 (98.4%)	2 (1.6%)	12
Emergency Department	69 (95.8%)	3 (4.2%)	0	98 (100.0%)	0 (0.0%)	9	167 (98.2%)	3 (1.8%)	9
Inpatient Services	58 (98.3%)	1 (1.7%)	1	81 (100.0%)	0 (0.0%)	4	139 (99.3%)	1 (0.7%)	5

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Long-Term Care Services	54 (96.4%)	2 (3.6%)	0	98 (100.0%)	0 (0.0%)	1	152 (98.7%)	2 (1.3%)	1
Point-of-Care Testing **	38 (100.0%)	0 (0.0%)	0	45 (97.8%)	1 (2.2%)	2	83 (98.8%)	1 (1.2%)	2
Primary Care Services	59 (100.0%)	0 (0.0%)	0	90 (100.0%)	0 (0.0%)	1	149 (100.0%)	0 (0.0%)	1
Reprocessing of Reusable Medical Devices	53 (98.1%)	1 (1.9%)	34	31 (100.0%)	0 (0.0%)	9	84 (98.8%)	1 (1.2%)	43
Transfusion Services **	76 (100.0%)	0 (0.0%)	5	68 (100.0%)	0 (0.0%)	1	144 (100.0%)	0 (0.0%)	6
Total	**739 (99.1%)**	7 (0.9%)	66	897 (99.7%)	3 (0.3%)	40	1636 (99.4%)	10 (0.6%)	106

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

Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client Identification (Point-of-Care Testing)	Met	1 of 1	0 of 0
Client Identification (Transfusion Services)	Met	1 of 1	0 of 0
Information transfer at care transitions (Emergency Department)	Met	4 of 4	1 of 1
Information transfer at care transitions (Inpatient Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Long-Term Care Services)	Met	4 of 4	1 of 1
Medication reconciliation as a strategic priority (Leadership)	Met	3 of 3	2 of 2
Medication reconciliation at care transitions (Emergency Department)	Met	1 of 1	0 of 0
Medication reconciliation at care transitions (Inpatient Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Long-Term Care Services)	Met	4 of 4	0 of 0
The “Do Not Use” list of abbreviations (Medication Management Standards)	Met	4 of 4	3 of 3
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management Standards)	Met	4 of 4	1 of 1

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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Compliance (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Hand-Hygiene Education and Training (Infection Prevention and Control Standards)	Met	1 of 1	0 of 0
Infection Rates (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Inpatient Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Long-Term Care Services)	Met	5 of 5	1 of 1
Pressure Ulcer Prevention (Inpatient Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Long-Term Care Services)	Met	3 of 3	2 of 2
Suicide Prevention (Emergency Department)	Met	5 of 5	0 of 0
Suicide Prevention (Long-Term Care Services)	Met	5 of 5	0 of 0
Venous Thromboembolism Prophylaxis (Inpatient Services)	Met	3 of 3	2 of 2

Summary of Surveyor Team Observations

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

Deep River and District Hospital, Four Seasons Lodge Long-Term Care, and North Renfrew Family Health Team have a strong board whose members are well educated about their roles and responsibilities and are eager to see the organization advance. The bylaws and policies have been reviewed and meet the needs of the organization and comply with legislation. Board members receive a thorough orientation to their role.

The community is supportive of the health campus and strong community partnerships are in place.

The leadership team is very cohesive and functions well. The leaders support the CEO and each other and are eager to work to bring the organization to the next level. They have worked very hard in the past two to three years to reach the minimum standards for the organization.

Staff feel well cared for and supported by the leadership team. They appreciate the education they receive to enhance care and service. They comment favourably on the leadership team and feel that vast operational improvements have been made. All are quite knowledgeable regarding quality improvement and believe they can work together to further improve the organization.

Patients, residents, and families have positive comments about their care and service. They note that communication is open and transparent, and that they truly feel part of the decision-making process and listened to by the leadership team. Participants in the people-centred care focus group expressed concern that their input is not always considered important.

Patient and resident satisfaction is positive and survey results reflect a positive attitude. People who were interviewed report feeling comfortable, cared for, and listened to.

Detailed On-site Survey Results

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

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

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

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

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

See Appendix B for a list of priority processes.

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

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

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

Priority Process Results for System-wide Standards

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

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

Priority Process: Governance

Meeting the demands for excellence in governance practice.

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

Board members are well educated about their roles, responsibilities, and accountabilities. There is a documented orientation process for each member. The members very much appreciate the education that is provided at every meeting. It is a skills-based board and recruitment is based on the skill mix needed at the time.

The board finds that communication from the organization to the board is timely and transparent. Board members report that the CEO does a wonderful job of keeping the organization accountable and has built a strong and cohesive management team that is focused on growth and improvement. Policies and bylaws are reviewed and revised annually. The board receives balanced scorecard results monthly, approximately one week ahead of the meeting to give them time for review prior to the meeting.

The board recognizes the strong partnerships that the organization has with the town of Deep River and surrounding area.

The board uses the ethics framework to work through situations and make decisions. The members feel it is very effective and fosters problem solving.

The board has 11 members. Succession planning is done each cycle to ensure the board has a strong healthy mix to maintain the board's direction.

The board evaluates the CEO annually using a 360-degree tool and goals and objectives related to the strategic plan. The board also evaluates its own performance, individually and collectively.

The Chief of Staff is positive about physician relationships with the campus, although recruitment is an issue. The board, the surrounding area, and the community have developed a recruitment strategy.

Priority Process: Planning and Service Design

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization has developed a strong relationship with the community and receives input from a variety of sources in the community as well as from the Ministry of Health and Long-Term Care. This provides baseline information for analysis of future needs and potential solutions. The organization is encouraged to pursue ongoing dialogue with potential community partners to move forward with sustainability initiatives. The leadership team has brought the organization to a minimum level of recognition but further development in this area is needed.

The campus approach helps provide a proactive approach to wellness in the community, but ongoing development is required to move it to the next level for the community. The desire to construct a larger Family Health Team facility is positive but continued research is necessary to determine the best use for the existing structure to enhance the campus and the community.

Priority Process: Resource Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The leadership team is refining the database to improve the resource management process. All equipment is now inventoried and this improves control with regard to repair and/or replacement as well as ongoing planning for future expenditures.

Finance has a process to build operating and capital budgets, and to bring the drafts to the leadership team for review before they are forwarded to the board for review and acceptance. The board and managers monitor the budget regularly to maintain the organization's financial stability.

Resource allocation is conducted in a fair and equitable manner based on the need of any given area.

The organization's financial practices meet all legal requirements.

Priority Process: Human Capital

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

An effective human resource plan is in place. The plan is reviewed annually and revised as necessary. It includes strategies for retention and development. It is difficult to recruit and retain casual staff.

Workplace health policies have been developed.

The organization has a variety of professional development initiatives that are available to staff and managers.

The health and safety program complies with all legislation. There is an active Health and Safety Committee.

Immunization rates for flu vaccination are very good, running on average at 70 to 75 percent. This year's total has not yet been tabulated.

Workplace violence prevention is handled well. Assessments have been completed in all units and there are policies in place for reporting and education.

The Worklife Pulse Tool was administered in 2019 as a measurement tool.

Position profiles are reviewed and revised annually and as necessary. Safety training has been completed using Surge and is an annual educational initiative.

A cross-section of short- and long-term management and staff files were reviewed. Except for a few performance evaluations from 2006 and 2009, evaluations were not present and this can be a risk. An initiative is being launched to make this a priority in 2020.

Human resources has developed checklists of quick reference needs for staff files and these are very effective.

Priority Process: Integrated Quality Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Quality improvement is identified in the strategic plan. The organization had to use additional financial resources to bring it to the minimum level, but the leadership team is eager to bring this organization to the best it can be level of function.

Policies and processes are clear, concise, and well documented. They are shared with staff and managers throughout the organization. Quality boards are used on every unit and staff understand what the boards represent. Staff have received approximately one hour per week of education on quality improvement to bring them to their current level of understanding.

A policy about how to file a complaint are in place for acute and long-term care. The policy is posted on bulletin boards as well. The process is available to staff, patients, residents, and families.

The leadership team supports the staff of each unit to grow and develop their quality improvement skill level as it relates to integrated quality improvement.

Risk management is practiced throughout the organization and a clear policy and process is in place. The indicators are reported to the board quarterly and as necessary.

The new management team has worked hard to develop and educate staff to their current level with regard to quality improvement.

The leadership team has developed a comprehensive patient safety plan that is monitored regularly by the management team. Results are shared with the board.

Sustainability is an ongoing challenge for the organization. It has reached the minimum standard but is encouraged to pursue education and development for the maturity of the organization and staff.

Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization has developed an effective ethics framework in consultation with the Champlain LHIN Ethics Committee. Staff, managers, and board have all received extensive education about the use of the framework.

Staff appear to understand the concepts in the ethics framework and readily seek out managers for assistance.

The senior management team is aware of ethical scenarios. It regularly monitors and would be aware if trends were appearing; however, no trends are apparent to date. Research has not been done recently but the framework can be used to evaluate research proposals that may arise.

Staff review and sign the organizational code of conduct at time of hire, as part of their orientation.

Priority Process: Communication

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

There is a comprehensive communication plan for 2017 – 2019, and a new plan is being developed. Internal and external communication tools have been developed. Various methods of communication are used to provide partners, staff, and community with the most up-to-date information available regarding health care in the community.

Processes have ben developed to allow residents and patients to easily communicate with the administration. Quality initiatives are also posted on dashboards for all to view. The organization is also heavily involved in health promotion in the community.

Leadership staff do weekly interactive rounds with staff in the clinical areas to address any concerns they may have.

Priority Process: Physical Environment

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The facility is well kept and maintained. There is not much clutter and there appears to be adequate space to move equipment and patients. Backup systems are regularly tested and serviced by outside providers. A central monitoring station is in place where all the activity regarding heat and cooling for the facility can be viewed. Maintenance staff are available 24/7 to deal with physical plant issues. Each day a list of maintenance requests that have been submitted is reviewed in the department and appropriate action is taken.

Plans are being developed for the construction of a new and expanded family health team facility.

Space in the facility is provided to community organizations such as the Food Bank. Laundry services are also provided to external partners.

Bilingual signs are being installed.

The organization installed solar panels; however, this is not providing the expected savings. An extensive energy audit has been completed and steps taken to improve the efficiency of the facility.

Physiotherapy services are provided in the facilities, under a separate corporate structure. The hope is to attract other therapeutic and diagnostic groups to the organization to establish an integrated health hub for the area.

Priority Process: Emergency Preparedness

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization is very active in preparing for emergencies. The town has developed and implemented an all-hazard disaster and emergency response plan. Emergency preparedness policies have been brought up to date. Annual updates have been done for code silver and code blue.

The number of mock codes has been increased. Code red is now done monthly. Code blue was done twice a year but, at the request of staff, this will be changed to every two months or quarterly in the new year. A mock code white was done earlier in the year. A mock code orange was done with the Department of National Defence in 2018.

Plans are in place to do a mock code with the local police department.

An incident management system was developed and implemented during the mock code done with the Department of National Defence. The debrief included discussions on how the process could have been done better.

Code white was updated in 2019.

Priority Process: People-Centred Care

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The Patient and Family Advisory Council has been very active for several years. The members do not remember undergoing a formal orientation but do remember signing a confidentiality agreement. The committee usually meets every two months. An agenda is provided and topics related to patient concerns are discussed.

The council functions as a subcommittee of the board. A board member is an active member. The council reviews relevant policies and procedures and discusses concerns about safety and patient care.

The committee is committed to providing input into the overall functioning of the facility.

Priority Process: Patient Flow

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

A policy and procedure have been developed to manage patient flow during times of overcrowding in the emergency department (ED). On a daily basis all the hospitals in the Local Health Integration Network (LHIN) provide a list of the number of beds available to accept patients. On occasion, if overcrowding does occur, patients may be transferred to facilities where beds are available.

Physicians are encouraged to round on their patients early in the morning so a clear picture of the number of available beds for the day is known. The organization has twelve funded beds on the inpatient unit and four additional unfunded beds that are usually occupied. A nurse manager does rounds on a daily basis to get an overview of potential discharges and the number of beds that may become available.

When overcrowding occurs emergency medical services (EMS) is notified and the ED goes on bypass. Recently, the policy and procedure related to overcrowding were tested and several limitations were identified during the debrief. Alterations were then made to the policy.

ED patients are evaluated by an interdisciplinary team to avoid admission and provide care and support through external partners. Community services including an assisted living facility, a community paramedic program, and the Match program for seniors help keep patients out of hospital. Every Monday, a discharge planning protocol is put in place. Weekly teleconferences occur within the LHIN to discuss barriers that may be impeding the flow and care of patients.

Patient flow is well managed and controlled. However, with the increasing pressures on hospitals for beds and increasing numbers of alternate level of care patients, this may become a more permanent problem.

Priority Process: Medical Devices and Equipment

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

Unmet Criteria	High Priority Criteria
Standards Set: Reprocessing of Reusable Medical Devices	
5.11 Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!

Surveyor comments on the priority process(es)

There are no reprocessing services available at the organization. Medical equipment is disposable and does not require reprocessing. Procedures requiring reprocessing services are not performed.

Disinfection is done in the x-ray department. Ultrasound endo probes and laryngeal blades are disinfected. The area where disinfection occurs is very cramped. Clean and dirty areas are separated by a low-lying barrier with the sterilizing solution located behind the dirty cleaning area. Working surfaces are made of porous material. In January 2020 the area is slated to be renovated and the area for disinfection will be moved and enlarged to meet standards.

All medical equipment is serviced and maintained by biomedical engineering. A contract is in place with Children's Hospital of Eastern Ontario to provide this service. There is process to identify which equipment requires routine maintenance. The technician is in Pembroke and is usually available the same day if required for emergency repairs.

Departments such as radiology and the physical plant have maintenance contracts with the appropriate providers to perform routine maintenance services.

Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Point-of-care Testing Services

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

Clinical Leadership

- Providing leadership and direction to teams providing services.

Competency

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

Episode of Care

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

Decision Support

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

Impact on Outcomes

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

Medication Management

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

Organ and Tissue Donation

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

Infection Prevention and Control

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

Diagnostic Services: Imaging

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

Diagnostic Services: Laboratory

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

Transfusion Services

- Transfusion Services

Standards Set: Biomedical Laboratory Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Episode of Care

A policy and procedure are in place to identify patients who are at risk of falls. Appropriate action is taken to protect these individuals in the laboratory setting.

Priority Process: Diagnostic Services: Laboratory

Laboratory services at the organization are provided through a partnership with the Eastern Ontario Regional Laboratory Association (EORLA) which manages the services provided. The individuals providing services are all EORLA staff, with the organization only providing the space.

EORLA is responsible for maintaining and providing new equipment as required. Services are provided to inpatients, the ED, and outpatients as required. A list of 21 chemistries has been developed in consultation with stakeholders. These are done on-site and are considered as stat tests. All other specialty testing is referred to The Ottawa Hospital. Laboratory services are available 24/7.

Regular surveys are performed to evaluate patient and stakeholder satisfaction with the services, and adjustments or improvements are made. Information about service use is provided monthly and serves as a baseline as to which additional laboratory services may be required.

EORLA has successfully completed the transition from on-site testing of outpatients to Dynacare.

Laboratory staff have undergone specific education to perform required tests. Annual required continuing

education is verified by the manager as is staff licensure.

A medical director overseas all laboratory activities and is available for consultation as required. EORLA members are not interconnected, which would allow an uninterrupted flow of information. EORLA is developing one integrated document management system that would allow information to be shared among all partners to improve patient care and eliminate duplicate testing.

Standards Set: Diagnostic Imaging Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Diagnostic Services: Imaging		
3.10	The team evaluates and documents each team member's performance in an objective, interactive, and constructive way.	
17.6	The team reviews its diagnostic reference levels at least annually as part of its quality improvement program.	
Surveyor comments on the priority process(es)		
Priority Process: Diagnostic Services: Imaging		

Services provided include ultrasound investigations, mammography, bone density testing, radiography, and electrocardiography. Patients can present at the department with their requisition and have the investigation done almost immediately. An appointment is usually required for ultrasound investigations.

Fluoroscopy exams are not performed. There is no C-arm available. With ultrasound various injections and biopsies can be performed by the radiologist. Because of the previous high demand for ultrasound services a second full-time ultrasound technologist was hired to increase the availability of ultrasound investigations and decrease wait times. Endocavity ultrasound is the only invasive procedure performed.

The x-ray department is under the direction of a medical director who is stationed in Ottawa but who visits the hospital several times a month. The radiologist has access to a PACS system at home and uses this to interpret x-rays. The radiologist is notified when x-rays require immediate interpretation. Usually written reports are available within 24 hours. When the radiologist is not available arrangements are made with Pembroke Hospital to provide backup services. X-rays are stored in the PACS system locally and with the Northeastern Ontario Diagnostic Imaging Network (NEODIN). These are then available to 17 participating hospitals, with the 10 most recent images done on the patient available for viewing. A centralized MRI ordering system is being developed through The Ottawa Hospital.

The Ontario breast screening program is stationed at the organization for routine mammograms.

Quality indicators are monitored. They are available on the dashboard for all to see and follow.

A new x-ray machine and portable machine have been purchased. Renovations will be starting in January 2020 with a timeframe of approximately twelve weeks for installation of the new machine. The machine will greatly improve the quality of imaging and will have the most up-to-date software.

Standards Set: Emergency Department - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.6	Seclusion rooms and/or private and secure areas are available for clients.	!
Priority Process: Competency		
4.14	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
4.16	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		
Priority Process: Organ and Tissue Donation		
The organization has met all criteria for this priority process.		
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

Specific goals and objectives have been developed for the ED. Data are regularly collected and available on dashboards for all to see.

There are eight beds in the ED. The department sees approximately 16,000 visits per year. It is staffed 24/7 with backup from diagnostic imaging and the laboratory. Overnight there is one nurse available who can call for help if required. Equipment to manage adult and paediatric patients is available.

There is no safe room or a negative pressure room to isolate patients with infectious diseases. The leadership is aware of this and there are discussions about how to proceed.

Priority Process: Competency

Staff in the ED are expected to have advanced cardiovascular life support training, and experience working in critical care areas or other EDs is preferred. All staff undergo a comprehensive orientation that covers policies and procedures, and ethical dilemmas. Team members receive additional training and education to manage mental health patients and those with addictions.

All staff have completed initial training and evaluation in the use of pumps. The organization uses two different pumps. One is a newer version of the older one, and use and operating procedures are similar.

Staff complete a self-education module annually.

Priority Process: Episode of Care

The entrances to the ED are clearly marked and accessible to all. EMS patients come through a separate entrance. All patients presenting to the ED are assigned a Canadian Triage and Acuity Scale score and assigned to an appropriate area based on their presentation and score.

Patients at risk of suicide are assessed at the initial evaluation.

In cooperation with EMS a list of the type of patient for whom appropriate care can be provided has been established. Not all services are provided at the organization. As a result, patients with certain medical conditions (e.g., stroke, fractures) bypass this ED and are transported to facilities providing the necessary level of care. This eliminates significant delay and helps get the patient quickly to a facility where appropriate care can be provided.

A process is in place to forward information about a patient's care in the ED to the primary care provider. This maintains continuity of care.

Priority Process: Decision Support

Most of the nursing documentation is recorded electronically. Much of the physician documentation is done manually and then scanned into the chart. Physician orders are not done electronically. An integrated electronic medical record is being developed with The Ottawa Hospital as the lead.

Evidence-based protocols have been developed for conditions that are seen frequently in the ED. These have been reviewed by the physicians involved, the Pharmacy and Therapeutics Committee, and finally by the Medical Advisory Committee. This has improved the standard of care for common conditions.

Priority Process: Impact on Outcomes

Quality improvement initiatives have been developed and are available for all to see, and processes are changed based on the results. Indicator data are regularly analyzed to determine the effectiveness of the

quality improvement activities.

The ED does not conduct research projects, although the department does have nursing and medical students come through periodically as part of their clinical experience.

A pamphlet is available to all patients presenting to the ED, with information as to what to expect during their visit.

Standardized protocols and procedures have been developed. Evidence-based guidelines are used when possible.

The ED participates in and carries out mock codes on a regular basis. The department participated with the Department of National Defence in managing a mock plane disaster.

Priority Process: Organ and Tissue Donation

Because of the acuity of patients seen in the ED, the organization does not participate in organ and tissue donation.

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

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

The organization has met all criteria for this priority process.

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

The Infection Prevention and Control Committee meets quarterly. Terms of references have been established. Members include the Renfrew District Health Unit; a family physician from the Family Health Team; a microbiologist contracted through EORLA; local staff; and members from long-term care, housekeeping, laundry, and dietary. Audits are done periodically but the goal is to do these more frequently.

Glow powder is used to monitor the effectiveness of cleaning.

The organization has not experienced outbreaks that require isolation of a unit. The organization acts proactively to isolate any patients who may potentially initiate an outbreak. Great effort has been made to update the policies and procedures and review and update the pandemic plan.

Outbreaks in the community or region are reported through the Health Unit. This allows the organization to be aware of potential problems.

The staff immunization rate for influenza is commendably high.

The organization is challenged to improve hand-hygiene compliance for staff and visitors. Even after a comprehensive education program, audits show that compliance rates remain low.

There is no formal isolation room with negative pressure. The administration and board are encouraged to look at having a room built.

Standards Set: Inpatient Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
3.11 Team member performance is regularly evaluated and documented in an objective, interactive, and constructive 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	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The inpatient medical service has implemented goals and objectives for patient care. Families are encouraged to participate in all aspects of providing care for the patient. A comprehensive information booklet is provided to patients at admission and these are reviewed by the nurse.

Only adult patients are admitted for care. Paediatric patients are referred to outlying institutions that provide paediatric care.

Priority Process: Competency

All registered nurses on the inpatient units are expected to have advanced cardiovascular life support training or obtain it within the first six months of employment. The organization provides financial support for those undergoing recertification.

During orientation, all staff receive instruction on the organization's ethical decision-making framework. There are several examples of ethical dilemmas that have been encountered in the care of patients.

Performance evaluations are not performed, although this is expected to begin in January 2020.

The organization encourages and supports ongoing professional development. Education and training are provided on infusion pumps, established clinical care pathways, appropriate use of restraints, identifying and reducing risks to patients and team members, and awareness of the organization's policy on reporting workplace violence.

Palliative care champions have been identified to care and provide support to staff who may be involved in caring for palliative patients.

Priority Process: Episode of Care

Nursing evaluation of admitted patients is standardized. All information is obtained from the patient or their caregiver. Standardized admission order sets have been developed, and standardized care plans are implemented for the most common medical conditions seen on the ward. This has improved patient care and provides consistency in the management of these patients.

If needed, a comprehensive geriatric needs assessment is performed. Also if required, an assessment of the patient's palliative and end-of-life care needs is completed. The family is strongly encouraged to participate in all decision making about patient care.

Interdisciplinary rounds are done weekly to evaluate the patient care and progress. If needed, family meetings are arranged to change the care plan or provide other options for care.

Several departmental quality improvement activities have been developed. The results are posted on dashboards for staff, patients, and family to see.

Standardized transfer of information forms have been developed to facilitate the transfer of patient information from one area to another. These are routinely audited for completeness.

Priority Process: Decision Support

Patient information is documented electronically and manually. The ANZER health electronic software is being used. The organization will be changing to the EPIC electronic health record which will eventually provide seamless documentation of patient information to all EPIC end users in the Champlain LHIN.

Priority Process: Impact on Outcomes

Evidence-based information guidelines are used to provide standardized care for patients. These are developed by the physicians involved in the care of patients and are initially reviewed by the Pharmacy and Therapeutics Committee and the Medical Advisory Committee. Guidelines and protocols are regularly reviewed so they remain current and continue to show best care pathways. Standardized patient care pathways have been developed.

Interdisciplinary rounds are done weekly for all patients. If necessary, family meetings are held to outline

anticipated care requirements.

At discharge patients are provided with information about follow-up and any medication that may be required. A copy of the discharge prescription is faxed to the pharmacy and given to the patient. A discharge summary of patient care is forwarded to the family physician. Any community services required are arranged prior to discharge.

Nursing documentation is done electronically. The nurses use computers located at the main desk. It is suggested that the workstation on wheels be moved to an area outside the room where nurses can document and at the same time observe the patient.

Regular huddles occur at transfer of care.

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

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
3.15 Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
3.17 Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

At admission, the resident and family provide information about the resident.

Priority Process: Competency

Staff in long-term care also work in acute care, although the full-time registered practical nurses remain in the long-term care area. A thorough and complete orientation is available to all new staff and Surge learning is completed annually. All mandatory education is online.

IV therapy is traditionally not conducted in the long-term care unit. As the need arises and to avoid admission to acute care, a hydration intravenous will be run in consultation with the charge registered nurse who works in both areas.

There is a small chapel in the unit were residents and families may attend as desired. Residents and families have input into decorating the unit to promote a home-like environment. The redecorating program will start in 2020 with rooms and halls being repainted in colours selected by the residents and

furniture for common spaces being selected by residents. Staff and residents are consulting on different ways to further create a home-like atmosphere, such as murals and decals for the walls.

All team members receive education and training about initiating a complaint, bullying, or other similar issues.

Having the organization and long-term care under one corporate structure has been beneficial. Multiple benefits are identified, including that competencies can be maintained easily and shared leadership, education, housekeeping, laundry, IT, and maintenance can be provided.

Priority Process: Episode of Care

The team provides care and service around the clock to residents and families, and attempts to remove any barriers that they identify. Residents and families are involved in the admission process and care services by providing input during the assessment, and this is truly a joint effort. Residents and families indicate that communication is open and transparent.

The team assesses the capabilities and capacity of each resident in consultation with the family. Residents' wishes are identified and adhered to. Staff speak to the residents and families in a very respectful and courteous manner. Interpretation services are used when needed but most residents speak English. Informed consent is obtained at admission and clearly documented in the medical record.

Although residents are not involved in research activities, the ethics framework would be used should a research proposal be submitted to the organization.

Education is provided to staff regarding abuse, reporting of abuse, and investigative processes. Families are provided with information regarding reporting any type of abuse or neglect and instructions are posted for them to view as well.

The pharmacy monitors and, in partnership with nursing staff, conducts medication reconciliation at admission, transfer, and discharge.

The organization has an established falls prevention program, wound and skin program, and suicide prevention program. Residents are assessed at admission and quarterly as needed.

Two person-specific identifiers are used. It is suggested that the process be refined to include photos and a secondary tool that new staff can use.

The organization follows a least-restraint policy but some family members request the use of restraints. Staff provide education to families about the use of restraints and alternatives.

Priority Process: Decision Support

The organization is using a hybrid documentation system and is moving toward a complete electronic system in 2020. Policies for record retention, storage, and destruction meet legislative requirements.

Standardized assessment tools are used and staff are well educated on the proper use of all tools.

Staff are aware of the ethics framework and have received ongoing education to deal with ethical issues. Residents and families have been consulted and have input into ethical decisions.

Priority Process: Impact on Outcomes

Care and service is provided based on evidence-based guidelines and staff evaluate and document all outcomes. Staff are provided with annual education on the ethics framework to them understand and use this tool.

Staff and families identify risks and the team uses strategies to mitigate risk and produce positive and safe outcomes for residents and staff.

There is a policy on disclosure of negative outcomes to residents and families. Disclosure is conducted according to processes outlined in the policy.

The team tracks indicators and uses the data to establish quality improvement initiatives. It is encouraged to continue to sustain this program and refine and further develop it to the next level of maturity.

Standards Set: Medication Management Standards - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Medication Management	

The organization has met all criteria for this priority process.

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

Medication management is contracted to North West Pharmacy for acute care and to Rexall Pharmacy for long-term care.

Policies and processes are in place for both contracts. Long-term care has medication carts supplied and access to a pharmacist 24 hours a day. On-site auditing and education are provided. Access to all medication is timely.

The acute ward has an on-site dispensing room and a pharmacy technician dispenses to the automated dispensing units on the floors, under the direction of a pharmacist.

Both systems work effectively. Contracts are in place and Pharmacy and Therapeutic Committee meetings are conducted according to standards.

Chemotherapy medication and paediatric dosing are not part of the services provided.

The organization evaluates this process regularly and has found that meet its needs in a timely manner.

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

Unmet Criteria	High Priority Criteria
Priority Process: Point-of-care Testing Services	
9.3 Health care professionals reporting POCT results carefully explain the results to clients.	
Surveyor comments on the priority process(es)	
Priority Process: Point-of-care Testing Services	

Point-of-care testing is carried out in the medical unit and in the ED. All staff involved in performing the tests have received appropriate training and are monitored. Policies and procedures have been developed on how to perform and interpret the results.

During the annual skills day, all staff involved are required to complete the educational module.

Maintenance of the equipment is under the direction of the laboratory staff. Staff who do not complete the required educational modules can be locked out of performing the tasks to ensure quality and patient safety.

Standards Set: Primary Care Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Information collected from patients and families is used to inform decisions about strategies and plans. The Family Health Team has created community partnerships and benefits from being part of the organization (e.g., infrastructure, information technology, housekeeping, maintenance). The executive director is part of a group in the Champlain LHIN that meets regularly to discuss issues and strategies.

The team sees approximately 4,000 patients from the area, with three to four physicians and two nurse practitioners. The recently added part-time mental health worker will be an asset. Approximately 30 percent of the case load is paediatric and obstetrical and approximately 12 percent are senior citizens.

The executive director works with the administration and the Ministry of Health and Long-Term Care to determine staffing needs for the team. Human resources conducts recruitment. The organization provides a comprehensive onboarding program for all staff.

The team uses a modern information technology program that is very user friendly and meets staff needs.

The team operates in very limited space. A proposal has been made to the Ministry for expansion, in alignment with the organization, and this will provide space to grow. The team is extremely creative in making use of the limited space.

The team is familiar with community resources available to patients and uses all the resources that it can access.

Priority Process: Competency

All staff have mandatory annual education to complete which helps maintain competency. Qualifications are checked at time of hire and for credentialled staff each year at renewal.

Team members are provided with training on equipment and directions are readily available for them to review.

Team members are educated about how to escalate complaints and how to direct patients to address discrimination. Patients and families have input into many aspects of the team in a consultative manner.

Priority Process: Episode of Care

Patients have access to the team by phone, internet, or through the kiosk and they are satisfied with this access. Hours of operation are 8:30 a.m. to 4:30 p.m., Monday to Friday.

Standardized assessment tools are used during intake. Group sessions are conducted at specific times and days and the clinic notifies patients about them. The clinic uses the organization's diagnostic imaging department and laboratory services and this expedites care and service. Patients may be referred to subspecialists to provide the best health care possible.

Consent and capacity are identified, and treatment is provided as needed. The organization's ethics framework is used to address ethical situations.

Patients are very much part of the care routine and have many opportunities to discuss their care pathway.

Priority Process: Decision Support

Information technology is maintained by the organization which truly demonstrates the value of this corporate structure. Policies and procedures, as well as the mission, vision, values, and strategic direction are organization-wide, and these have a health team focus as needed.

Confidentiality and privacy are maintained in accordance with legislation and organizational policy.

Priority Process: Impact on Outcomes

Evidence-based guidelines are the basis for procedures in the clinic and these are effective. The Family Health Team offers a variety of clinics (e.g., lumps and bumps, hypertension, pap clinics, smoking cessation, pre-natal, Depo-Medral). Patient and family input shows they are satisfied with the services.

The team has a truly preventive focus.

The team has identified a growth factor in the past two to three years with recruitment, expansion, and standardization. The team recognizes that there are still opportunities for ongoing growth and development.

Standards Set: Transfusion Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Episode of Care

A policy and procedure are in place to identify patients who are at risk for falls. They are appropriately identified using the organization's standard identification procedures.

Priority Process: Transfusion Services

EORLA supervises blood transfusion services. Policies and procedures for blood administration have been developed and the inventory amount has been established. The number of units used on a monthly basis is regularly communicated. Blood inventories are regularly checked and any units that may expire in the next two weeks are returned to institutions where they may be used. As a result of this system there is little waste of blood products.

Blood products can be easily requested from Canadian Blood Services as required. Usually transfusion and cross-matching will occur within an hour. An interdisciplinary Transfusion Committee meets regularly to oversee audits and quality improvement activities, which are reported to the Medical Advisory Committee.

Instrument Results

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

Governance Functioning Tool (2016)

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

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

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

- **Data collection period: April 12, 2018 to April 30, 2018**
- **Number of responses: 6**

Governance Functioning Tool Results

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1. We regularly review and ensure compliance with applicable laws, legislation, and regulations.	17	0	83	95
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	17	0	83	97
3. Subcommittees need better defined roles and responsibilities.	100	0	0	74
4. As a governing body, we do not become directly involved in management issues.	0	0	100	86
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	93

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
6. Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	96
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	0	100	95
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	17	0	83	95
9. Our governance processes need to better ensure that everyone participates in decision making.	83	0	17	65
10. The composition of our governing body contributes to strong governance and leadership performance.	17	17	67	93
11. Individual members ask for and listen to one another's ideas and input.	0	0	100	96
12. Our ongoing education and professional development is encouraged.	17	33	50	86
13. Working relationships among individual members are positive.	0	0	100	96
14. We have a process to set bylaws and corporate policies.	0	17	83	96
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	98
16. We benchmark our performance against other similar organizations and/or national standards.	17	17	67	79
17. Contributions of individual members are reviewed regularly.	17	67	17	65
18. As a team, we regularly review how we function together and how our governance processes could be improved.	17	17	67	83
19. There is a process for improving individual effectiveness when non-performance is an issue.	17	33	50	62
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	0	17	83	84

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
21. As individual members, we need better feedback about our contribution to the governing body.	50	33	17	47
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	17	17	67	81
23. As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	96
24. As a governing body, we hear stories about clients who experienced harm during care.	40	20	40	84
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	0	17	83	91
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	17	0	83	89
27. We lack explicit criteria to recruit and select new members.	83	0	17	81
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	0	0	100	89
29. The composition of our governing body allows us to meet stakeholder and community needs.	0	0	100	93
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	94
31. We review our own structure, including size and subcommittee structure.	17	0	83	89
32. We have a process to elect or appoint our chair.	0	0	100	91

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

Overall, what is your assessment of the governing body's impact over the past 12 months, in terms of driving improvements to:	% Poor / Fair	% Good	% Very Good / Excellent	%Agree * Canadian Average
	Organization	Organization	Organization	
33. Patient safety	0	33	67	83
34. Quality of care	0	33	67	85

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

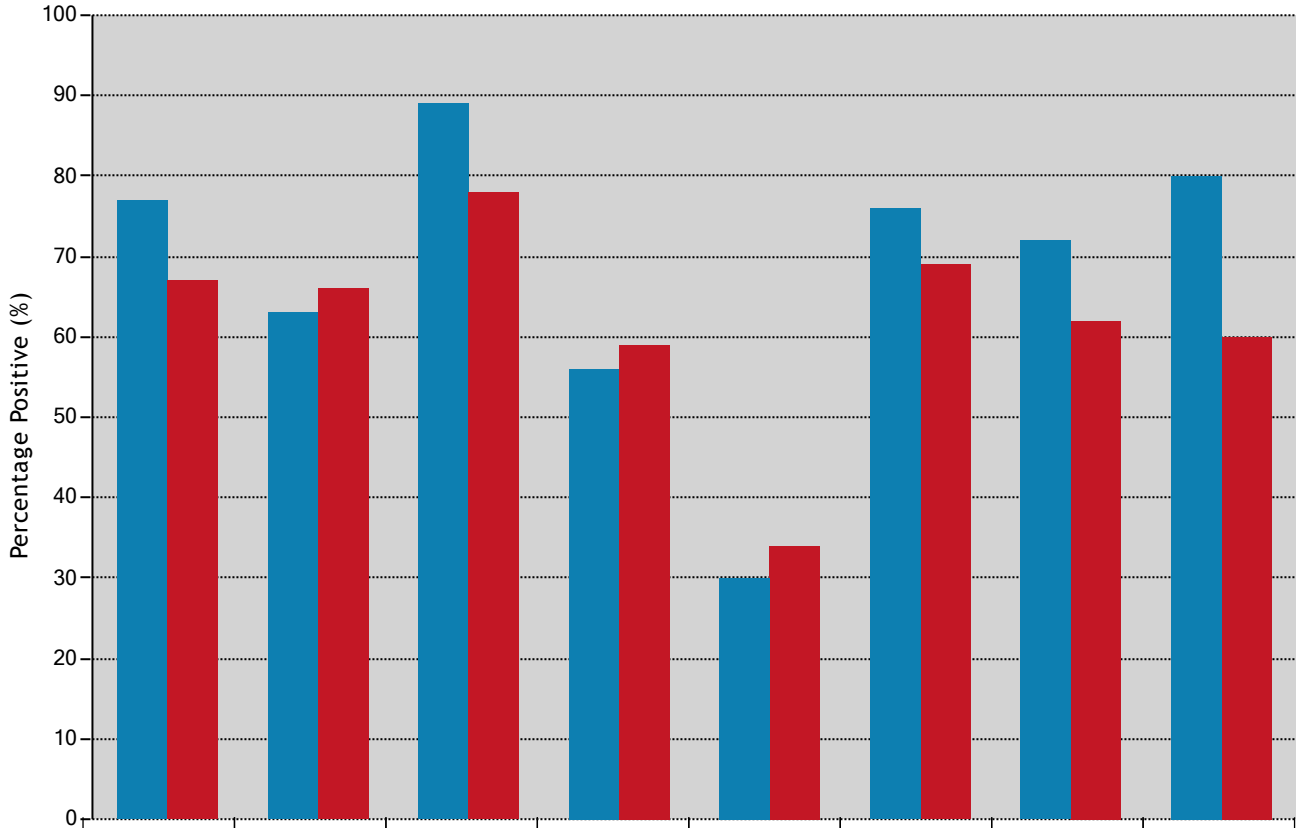
Canadian Patient Safety Culture Survey Tool

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

Results from the Patient Safety Culture Tool allow the organization to identify strengths and areas for improvement in a number of areas related to patient safety and worklife. Accreditation Canada provided the organization with detailed results from its Patient Safety Culture Tool prior to the on-site survey through the client organization portal. The organization then had the opportunity to address areas for improvement. During the on-site survey, surveyors reviewed progress made in those areas.

- **Data collection period: June 3, 2019 to November 28, 2019**
- **Minimum responses rate (based on the number of eligible employees): 42**
- **Number of responses: 44**

Canadian Patient Safety Culture Survey Tool: Results by Patient Safety Culture Dimension



	Organizational (senior) leadership support for safety	Supervisory leadership for safety	Unit learning culture	Enabling Open Communication I: judgment-free environment	Enabling Open Communication II: job repercussions of error	Incident follow up	Stand-alone items	Overall Perceptions of Client Safety
	77%	63%	89%	56%	30%	76%	72%	80%
	67%	66%	78%	59%	34%	69%	62%	60%

Legend

Deep River & District Hospital/Four Seasons Lodge

* Canadian Average

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

Worklife Pulse

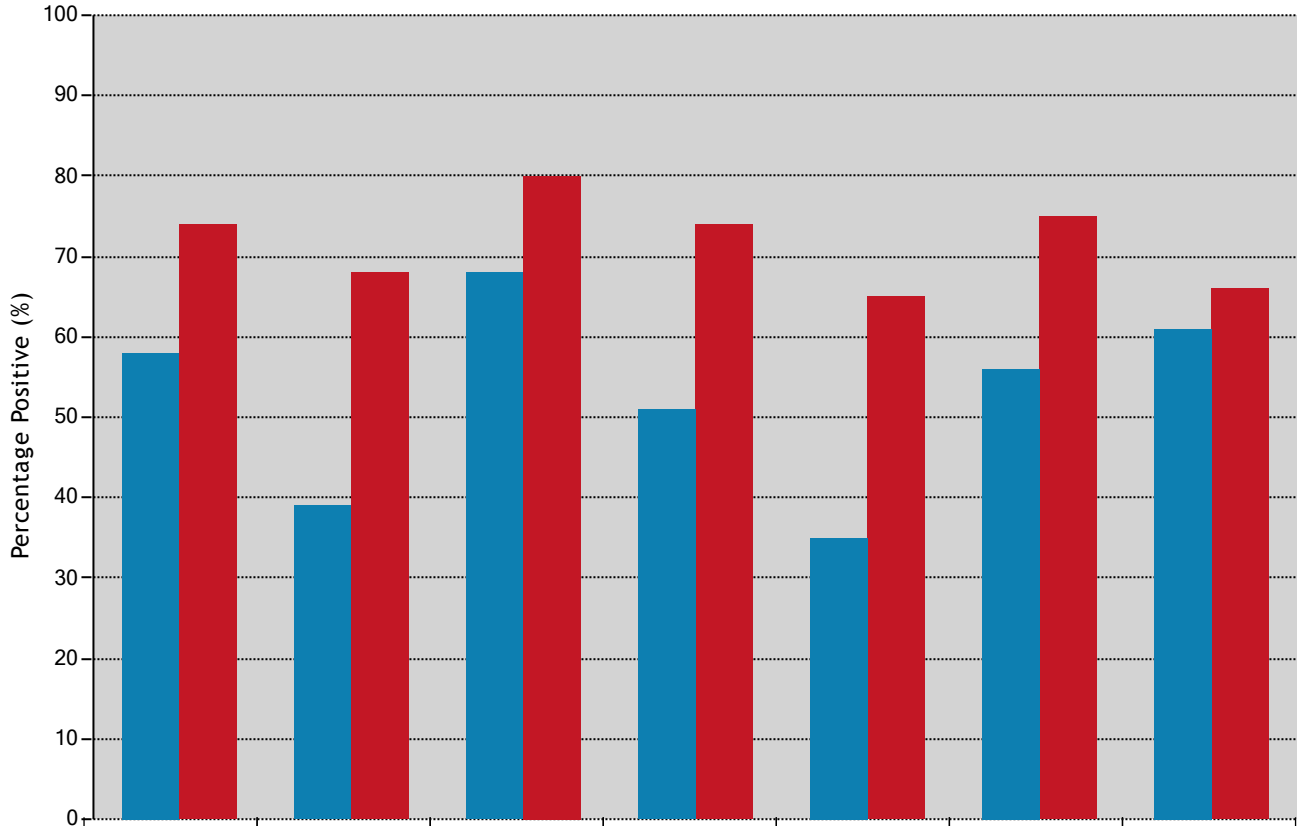
Accreditation Canada helps organizations create high quality workplaces that support workforce wellbeing and performance. This is why Accreditation Canada provides organizations with the Worklife Pulse Tool, an evidence-informed questionnaire that takes a snapshot of the quality of worklife.

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

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

- **Data collection period: November 1, 2018 to November 30, 2018**
- **Minimum responses rate (based on the number of eligible employees): 87**
- **Number of responses: 89**

Worklife Pulse: Results of Work Environment



	Job	Training and Development	Coworkers	Immediate Supervisor	Senior Management	Safety and Health	Overall Experience
	58%	39%	68%	51%	35%	56%	61%
	74%	68%	80%	74%	65%	75%	66%

Legend

Deep River & District Hospital/Four Seasons Lodge

* Canadian Average

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

Client Experience Tool

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

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

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

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

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

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

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

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

Appendix A - Qmentum

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

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

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

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

Action Planning

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

Appendix B - Priority Processes

Priority processes associated with system-wide standards

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