ACCREDITATION AGRÉMENT CANADA Qmentum

Accreditation Report

Almonte General Hospital / Fairview Manor

Almonte, ON

On-site survey dates: May 7, 2023 - May 10, 2023

Report issued: June 7, 2023

About the Accreditation Report

Almonte General Hospital / Fairview Manor (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 May 2023. 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 will be treated in confidence by Accreditation Canada in accordance with the terms and conditions as agreed between your organization and Accreditation Canada for the Assessment Program.

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

Table of Contents

Executive Summary

Almonte General Hospital / Fairview Manor (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

Almonte General Hospital / Fairview Manor's accreditation decision is:

Accredited with Commendation (Report)

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

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)	36	0	0	36
 Accessibility (Give me timely and equitable services)	53	8	1	62
 Safety (Keep me safe)	426	20	32	478
 Worklife (Take care of those who take care of me)	100	6	1	107
 Client-centred Services (Partner with me and my family in our care)	206	26	1	233
 Continuity (Coordinate my care across the continuum)	43	0	0	43
 Appropriateness (Do the right thing to achieve the best results)	568	51	11	630
 Efficiency (Make the best use of resources)	43	3	0	46
Total	**1475**	**114**	**46**	**1635**

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	93 (96.9%)	3 (3.1%)	0	143 (97.9%)	3 (2.1%)	0
Infection Prevention and Control Standards	39 (100.0%)	0 (0.0%)	1	27 (93.1%)	2 (6.9%)	2	66 (97.1%)	2 (2.9%)	3
Medication Management (For Surveys in 2021)	87 (96.7%)	3 (3.3%)	10	47 (97.9%)	1 (2.1%)	2	134 (97.1%)	4 (2.9%)	12
Diagnostic Imaging Services	58 (100.0%)	0 (0.0%)	10	67 (100.0%)	0 (0.0%)	2	125 (100.0%)	0 (0.0%)	12
Emergency Department	61 (84.7%)	11 (15.3%)	0	92 (86.0%)	15 (14.0%)	0	153 (85.5%)	26 (14.5%)	0
Inpatient Services	54 (91.5%)	5 (8.5%)	1	73 (89.0%)	9 (11.0%)	3	127 (90.1%)	14 (9.9%)	4
Long-Term Care Services	46 (83.6%)	9 (16.4%)	1	86 (87.8%)	12 (12.2%)	1	132 (86.3%)	21 (13.7%)	2

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Obstetrics Services	59 (83.1%)	12 (16.9%)	2	77 (88.5%)	10 (11.5%)	1	136 (86.1%)	22 (13.9%)	3
Perioperative Services and Invasive Procedures	102 (91.1%)	10 (8.9%)	3	97 (89.0%)	12 (11.0%)	0	199 (90.0%)	22 (10.0%)	3
Reprocessing of Reusable Medical Devices	82 (100.0%)	0 (0.0%)	6	40 (100.0%)	0 (0.0%)	0	122 (100.0%)	0 (0.0%)	6
Total	**688 (93.2%)**	50 (6.8%)	34	735 (92.0%)	64 (8.0%)	11	1423 (92.6%)	114 (7.4%)	45

* Does not includes ROP (Required Organizational Practices)

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 (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
Client Identification (Obstetrics Services)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client Identification (Perioperative Services and Invasive Procedures)	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
Information transfer at care transitions (Obstetrics Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Perioperative Services and Invasive Procedures)	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
Medication reconciliation at care transitions (Obstetrics Services)	Met	4 of 4	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures)	Met	4 of 4	0 of 0
Safe Surgery Checklist (Obstetrics Services)	Met	3 of 3	2 of 2
Safe Surgery Checklist (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
The “Do Not Use” list of abbreviations (Medication Management (For Surveys in 2021))	Met	4 of 4	3 of 3
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management (For Surveys in 2021))	Met	4 of 4	1 of 1
Concentrated Electrolytes (Medication Management (For Surveys in 2021))	Met	3 of 3	0 of 0
Heparin Safety (Medication Management (For Surveys in 2021))	Met	4 of 4	0 of 0
High-Alert Medications (Medication Management (For Surveys in 2021))	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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Infusion Pumps Training (Obstetrics Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Perioperative Services and Invasive Procedures)	Met	4 of 4	2 of 2
Narcotics Safety (Medication Management (For Surveys in 2021))	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
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Compliance (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Hand-Hygiene Education and Training (Infection Prevention and Control Standards)	Met	1 of 1	0 of 0

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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Venous Thromboembolism Prophylaxis (Perioperative Services and Invasive Procedures)	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.

The Almonte General Hospital (AGH) and Carleton Place and District Memorial Hospital (CPDMH) formed the Mississippi River Health Alliance (MRHA) in 2017 with the goal of providing the best possible care to their communities through their combined efforts. Together the hospitals serve a population of over 30,000 and provide a wide range of services including 24/7 emergency services, diagnostics (DI and Lab), medical/surgical beds, level one obstetrical beds, perioperative services, ambulatory care, complex continuing care and outpatient clinics. In addition, AGH operates Almonte Fairview Manor, a 112 bed Long-Term Care home located on the AGH site, as well as Lanark County Paramedic Services. Over the last three years, the organizations have demonstrated their efforts on managing the COVID-19 pandemic. There is recognition for their proactive and flexible approaches to keeping patients, residents and team members safe, and supporting where needed in other areas of their community.

The Almonte General Hospital and Carleton Place and District Memorial Hospital are separate corporations which formed the Mississippi River Health Alliance (MRHA) in 2017. Each hospital has a Board of Directors (board) which is composed of seven elected members and seven ex-officio voting members from the other corporation. Over the past six years the members of the respective boards have worked closely together to identify and support the best possible integrated care close to home for all the communities served by the two hospitals. Through working together members of the boards recognized common goals and have now moved to have Allied Boards. The Allied Boards hold a single set of meetings and review data and make decisions for both corporations. Members of the Allied Boards are very knowledgeable and strongly committed to the integration of the organizations with the goal of being 'better together'. The Allied Boards are commended for leadership they have demonstrated to their communities in working together to ensure the quality care is available to those living in smaller, rural communities.

The Mississippi River Health Alliance (MRHA) enjoys the support of a number of partners within their communities and regionally. Working relationships were described as very collaborative, with an ability to readily communicate with leadership. Partners described MRHA and their relationship with MRHA as supportive, like family, respectful, unwavering, innovative, interested in the community and progressive. Partners also commented that the hospitals enjoy a long history of providing good care and are held with affection by many.

The leadership team of MRHA is very engaged and committed. All the senior leaders as well as directors for several other services including finance, pharmacy, and human resources are integrated across the two hospitals. The integrated leaders divide their time across the two sites and work to maintain visibility at both. Leadership has adopted the Studer model of management to support increased alignment and accountability as well as improving employee engagement and patient experience. The organization is commended for the efforts that have been taken using the Studer model to ensure alignment of managers' goals and objectives with the corporate plan. MRHA is encouraged to ensure that staff, physicians, patients

and family members are included in the development and monitoring of program or department specific goals and objectives.

The health human resource challenges facing MRHA is not different than found in other hospitals or in small rural healthcare environments. The market is highly competitive for all classifications including the support service area, and ongoing efforts are in place related to recruitment and retention. To support these efforts, MRHA has developed a three-year Human Resources Plan (2023 – 2026) focused on encouraging existing staff to stay and grow within the organization, as well as on being more competitive to attract new staff and physicians.

To support retention of staff, a number of actions to promote a positive work life culture have been implemented including engaging staff in the review of schedules and implementing job sharing opportunities.

Staff and physicians are highly committed to the organizations and to their communities. They appear genuine, caring and compassionate and work well together as a team to support patients and their families.

Over the past several years, a significant focus has been on the development of an integrated clinical services plan (MRHA 2030) which was approved in 2021. This plan was developed through the work of six advisory panels (the composition of which included staff, physicians and patient and family advisors) which focused on key areas of service delivery across the two organizations. For each of the existing areas of service (emergency, inpatient, surgical, obstetrics, outpatient, diagnostic and long-term care) future growth and change were identified as well as the enablers to make these a reality. The enablers identified included the move to a common electronic medical record platform across the two sites, further integration of human resources, and facility renewal at both sites starting with the redevelopment of the CPDMH emergency department which is currently underway.

The organizations support a culture of quality and patient safety with standardized practices and have a keen desire to provide quality care to their communities. The MRHA is encouraged to build upon this culture and enhance the structures and processes to support the identification and implementation of quality improvement initiatives at the department level with the inclusion of staff, physicians, patients and families.

Fairview Manor provides a village approach to living. Connecting and involving community partners, they support residents in a homelike environment that meets their unique needs while providing a sense of purpose and community connection daily. A focused restorative care approach defines living goals unique to each resident that will help them achieve the greatest independence possible. The physical space is incredibly clean and welcoming, providing an atmosphere of 'We have pride in our home'. This, along with the robust recreational therapy offerings, makes the manor a delightful place to live and work.

Patients interviewed were very appreciative of the care they had received. The ability to receive quality care close to home was deeply valued. The MRHA has had a long history of engaging patients and families in their care and using the voice of patient advisors to provide input on various operational documents and draft plans. The organizations are encouraged to build upon the good work that has been done to date by

the Patient and Family Advisory Committee (PFAC) and consider embedding advisors into the various programs and departments across the organizations.

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)

The Almonte General Hospital and Carleton Place and District Memorial Hospital are separate corporations which formed the Mississippi River Health Alliance (MRHA) in 2017. Over the past six years the members of the respective boards have worked closely together to identify and support the best possible integrated care close to home for all the communities served by the two hospitals. Through working together members of the boards recognized common goals and have now moved to have Allied Boards. Each hospital has a Board which is composed of seven elected members and seven ex-officio voting members from the other corporation. The Allied Boards hold a single set of meetings and review data and make decisions for both corporations. One nominating committee reviews and recommends candidates when an opening occurs on either of the Allied Boards. Members for each board are elected through an open and transparent process and are selected in keeping with a skills matrix as well as the goal of maintaining diversity in culture, gender, ethnicity and geographical locations within the areas served by the organizations. One Chair, Vice Chair and Treasurer are elected and serve both Allied Boards. New members to the Allied Boards received a thorough orientation and all members receive ongoing education on a regular basis.

Members of the Allied Boards are very knowledgeable and strongly committed to the integration of the organizations with the goal of being 'better together'. The Allied Boards are commended for the leadership they have demonstrated to their communities in working together to ensure that quality care is available to those living in smaller, rural communities.

The Allied Boards maintain five standing committees, each of which has a comprehensive workplan directing activities throughout the year. A patient and family advisor is a member of the Board Quality Committee and written patient stories/comments/concerns are brought forward to the committee on a regular basis. The organizations are encouraged to explore the potential of, where possible, having patient stories presented directly by the patient or family member.

Monitoring patient safety, quality indicators and potential risks to the organizations are seen as critical

work by the members of the Allied Boards. Members are knowledgeable about patient safety and quality improvement and spoke to the rigor with which reports are reviewed and enquiries made of senior staff.

Members of the Allied Boards are highly committed to reviewing their own functioning as an evaluation of committee functioning is completed after each committee meeting, a full board evaluation is completed on an annual basis, and member peer evaluations are conducted every two years.

Priority Process: Planning and Service Design

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
4.12 Policies and procedures for all of the organization's primary functions, operations, and systems are documented, authorized, implemented, and up to date.	

Surveyor comments on the priority process(es)

The two organizations developed a common strategic plan in 2017 and this plan has been under review in the past year. At the time of this survey, a new five-year plan (2023- 2028) has been approved by the Allied Boards but had not yet been rolled out to the organizations. In addition to the review of the strategic plan, the organizations reviewed their respective missions and visions and created one mission and vision for the MRHA. Internal and external stakeholders have been engaged in the work of developing the new strategic plan, mission and vision. Work is to be done in the coming months to gather input from staff and physicians on the current values.

Corporate goals for the current year have been developed and are grouped under five key pillars: care, access, people, alliance and resources. Implementation of the corporate goals and objectives across the organizations is supported through the use of a leadership effectiveness measures tool or LEM. Each leader has their own LEM which includes the goals and objectives they have set in keeping with the overall corporate goals. Leaders are expected to develop a 90-day action plan describing work to be done to achieve their goals. MRHA is commended for the efforts that have been taken to ensure alignment of goals and objectives with the corporate plan. As well, the organization is encouraged to ensure that staff, physicians, patients and family members are included in the development and monitoring of program or department specific goals and objectives.

Over the past several years, a significant focus has been on the development of an integrated clinical services plan (MRHA 2030) which was approved in 2021. This plan was developed through the work of six advisory panels (the composition of which included staff, physicians, and patient and family advisors) which focused on key areas of service delivery across the two organizations. The MRHA 2030 plan recommends the further service profile and priorities, clinical service enablers, partnerships and infrastructure required to best meet the needs of areas served by the MRHA. The MRHA has also joined the local Ontario Health Team with the goal of being an active participant in the provision of acute and long-term care services in the area.

A key focus within the clinical services plan is to redesign care delivery models to create true

interprofessional care teams with the introduction of new roles, and to ensure staff can work to their full scope of practice. Enablers were also identified and include the move to a common electronic medical record platform across the two sites, further integration of human resources, and facility renewal at both sites starting with the redevelopment of the CPDMH emergency department which is currently underway.

The organizations are in the process of reviewing and revising policies and procedures to create consistency across MRHA. There are several policies that have not yet been reviewed and are out of date. The organizations are commended for working toward this consistency and are encouraged to move forward and complete the work to update all policies and procedures.

The MRHA enjoys the support of a number of partners within their community and regionally. Working relationships were described as very collaborative, with an ability to readily communicate with hospital leadership. Partners described MRHA and their relationship with MRHA as supportive, like family, respectful, unwavering, innovative, interested in the community and progressive. Partners also commented that the hospitals enjoy a long history of providing good care and are held with affection by many.

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 MRHA has recently integrated the finance department staff across the two hospitals. This has resulted in improved workflow and efficiency. However, the two organizations do continue to have separate budgets and financial reporting. There is a consistent and comprehensive process in place to create annual operating and capital budgets in the two organizations. Managers are engaged in zero based budgeting with the support of the finance team. Monthly variance reports are available to the managers who in turn provide an analysis of potential variances to their director/vice president. Capital budgeting is a very open and collaborative process, including managers, physicians, and the foundation staff in the review of what is required to support patient care and the prioritization of these needs in terms of funds available.

The Allied Boards approve both the annual operating and capital budgets and receive regular reports throughout the year on how spending is tracking to budget. Annual audits are conducted on the two organizations by external audit firms and the findings are presented to the Finance Committee of the Allied Boards as well as the full membership of the Allied Boards.

The Almonte General Hospital has recently been successful in having the Ministry of Health recognize the organization's long standing structural deficit and with this funding has been able to move out of a deficit position.

The MRHA is commended for the focus on cost reduction and the engagement of staff, physicians, and managers in identifying potential cost saving opportunities in their areas of work. The organizations are encouraged to explore the implementation of a formal impact analysis prior to onboarding new physician specialties and/or programs.

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)

The MRHA has implemented a number of actions to promote a positive work life culture including engaging staff in the review of schedules and implementing job sharing opportunities. As well, staff are encouraged to take their vacation and to disconnect from work and not feel the need to respond to emails when not at work. A peer support program has been implemented to assist staff who may be experiencing a challenging situation in their home life or post an unusual event at MRHA.

The organizations have drafted a three-year Human Resources Plan (2023 – 2026) focused on recruitment and retention of health human resources. The challenges facing MRHA are not different from those found in other hospitals or in small rural healthcare environments. The market is highly competitive for all classifications including the support service areas. The three-year plan is focused on becoming more competitive and attractive to candidates; to support the health and well-being of staff as well as build leadership capacity with the goal of retaining current staff, and to also create a culture of inclusivity and respect for the populations served. The organizations are encouraged to move forward with implementing this plan and to also enhance the talent management plan to include steps to support staff growth and development such that the organization is growing their own leaders.

Currently both hospitals have a significant number of novice staff, many with less than two years of experience. The MRHA is encouraged to ensure that adequate resources are made available to support both novice staff and leaders.

The organization is commended for the consistent approach to the completion of performance reviews and staff rounding which provides an opportunity for the manager to provide positive and constructive feedback as well as career goals.

Formal role descriptions defining reporting relationships are available for all roles; however, the hospitals are encouraged to review the various different titles of leaders, and to bring further clarity to the organizational reporting structures.

A key goal for MRHA is to implement an inter-professional model of care and to maximize the scopes of practices for all regulated health professionals. To date work has been done to support registered practical nurses (RPN) to practice to their full scope of practice.

The organizations are encouraged to move forward with their plan to implement an Equity, Diversity and Inclusion (EDI) Committee and to also address some relatively quick changes such as non-gender washrooms.

Priority Process: Integrated Quality Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organizations support a culture of quality and patient safety with standardized practices and a keen desire to provide quality care to their communities. Opportunities for quality improvement are identified through formal and informal methods including incident reports, inspection reports, patient and staff satisfaction reports, post discharge phone calls, and performance indicators. Committees throughout MRHA have a responsibility for quality improvement within their particular mandate. Overall quality of patient care and services is monitored by organization-wide committees who in turn report quality results to the Quality Committee of the Allied Boards.

In some of the departments visited, corporate goals were posted along with a Stoplight document which describes the work being done in that department to achieve actions which align with the corporate goals. However, in some the areas staff were not able to identify quality initiatives being worked on in their department and quality boards were not consistently found across the organizations. The MRHA is encouraged to review and enhance the structures and processes in keeping with the identification, implementation, and monitoring of quality improvement initiatives at the department level. As well, it is recommended that the organizations include patient and family advisors in the identification, implementation and monitoring of department or unit quality improvement work, and that education be provided to staff and patient and family advisors to increase their knowledge on quality improvement.

Both hospitals hold the same quality indicators for the current year with a focus on discharge information to patients, medication reconciliation, and ensuring alignment with the Choosing Wisely best-practice guidelines for blood transfusions and inpatient blood draws. The Long-Term Care home, Fairview Manor, is focused on reducing falls and implementing individualized palliative care plans for patients when needed.

Incident reporting is facilitated through a paper form in Carleton Place and electronic forms in Almonte. There is a plan to move to electronic reporting at CPDMH. Every incident is reviewed by the appropriate manager and cumulative reports are reviewed at the monthly patient care and quality committee meetings. Reports are also summitted to the Allied Boards Quality Committee. The organizations review near misses and have recently re-branded this work as Good Catch to provide opportunities for education regarding best practice and ensure an actual event does not occur.

MRHA is commended for the work on ensuring the consistent use of bedside shift reporting and on the post discharge follow-up phone calls being made to the patients, well as for having welcomed family members or close friends of the patient or resident to act as essential care partners to provide consistent

support for the patient/resident throughout their care journey.

There is no dedicated individual who supports quality improvement activities. This responsibility is carried by several leaders. MRHA is encouraged to review the potential of having a dedicated resource for quality.

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 Mississippi River Health Alliance (MRHA) has an active Ethics Committee engaged in elevating the practice of ethical decision making. They are actively involved in educating the organization through online education, lunch and learns and promotional material to ensure staff understand practice expectations and resources available to support decision making. The committee has representation from all sites made up of frontline, leadership, a board member, clergy, physicians, PFAC, and an ethicist from Champlain Center for Health Care Ethics. The partnership with Champlain provides a regional approach to the provision of health care ethics services. There is the ability to access an ethicist for challenging clinical and organizational issues as well as to partner for education. The PFAC member of this committee also sits on the regional Ethics Committee and is very engaged in providing input to the team.

MRHA is committed to an ethical framework to guide and support ethical behaviour and decision making by all staff, medical staff, volunteers and students. They have implemented two decision making tools. The IDEA framework and the Accountability for Reasonableness (A4R) framework. The IDEA framework provides a fair, step-by step process to help guide healthcare providers and administrators in working through clinical ethical issues encountered in the delivery of healthcare. The A4R framework is used for more organizational ethical issues or at a governance level. The team uses these frameworks to guide decision-making and actions about ethical issues that arise from the bedside to the boardroom.

The team reviews all research proposals to understand the impact and risk to the organization is discussed and has a policy to guide decision making. As the organization roles out the new strategic plan, mission, vision and values, it is encouraged to ensure that any research undertaken at MRHA is aligned with the mission, vision and values. Another opportunity to continue to maintain awareness of principal-based care and ethical decision making is to continue with the ongoing educational opportunities using different modalities as well as, at a minimum, to ensure appropriate education is delivered during the orientation process.

Priority Process: Communication

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
11.1 Information management systems selected for the organization meet the organization's current needs and take into consideration its future needs.	

Surveyor comments on the priority process(es)

The MRHA currently has two communication plans; one that speaks to general communication activities to internal and external audiences, and a second plan that has focused on building awareness of the alliance between the Almonte General Hospital and the Carleton Place and District Memorial Hospital. The goal in the near future is to blend these two plans into one, with actions that speak to both areas of focus. The two corporations have separate websites and work is also underway to implement a new, common website. A number of different social media platforms are used to communicate externally and use of these is monitored and evaluated.

Communication with the community and external stakeholders is supported through various actions including the publishing of board meeting minutes, media releases, semi-annual publication of a newsletter, and periodic town halls and open forums. Patient and resident information handbooks are available to all new admissions to provide information such as patient's rights and responsibilities and how to raise concerns or compliments. Digital communication monitors are also used internally to support sharing of information with staff, physicians, patients, and visitors.

The two corporations currently have different electronic information systems and although these systems are supporting some of the organizations' needs, there is an urgent need to enhance the degree of electronic documentation, including the implementation of Computer Physician Order Entry (CPOE) in both organizations, as well as to address the barriers to information flow that having two different systems has created.

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)

Almonte General Hospital is exceptionally clean and well-appointed in decor. It was a great pleasure to walk through the building and the many areas of care. Staff were amazing and positive about the site and their contributions, taking great pride in their environment as they should. The maintenance team is well aware of the SOPs and needs regarding preventative maintenance, as well as emergency preparedness, and their response accountabilities.

The flow through the ORs and sterile process is very smooth for movement of patients and supplies. MDRD's new space is very efficient and works extremely well. There is great quality control and SOPs are in play appropriately. Priority processes are all met.

Housekeeping and laundry are well engaged in the team’s work on each of the areas and very responsive to site needs in a timely manner.

Suggestions for improvement are: 1. Implement an automated OR readout for ventilation cycles of the HVAC system, temperature in the theatre, and humidity. 2. Reduce and move to eliminate overhead paging as it is disruptive to patients and staff. 3. Continue to work towards involving patients, residents, and families at the onset of changes so their advice is coordinated and implemented in the decisions.

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 development of a Joint Emergency Preparedness Committee across the Almonte and Carlton Place hospitals and Fairview LTC has been successful in ensuring consistent processes, while at the same time looking at unique ways of meeting emergency preparedness standards for the LTC site.

There is evidence of a passionate and genuine commitment to emergency preparedness planning and MRHA is encouraged to continue defining their annual workplan to reflect the proactive work they want to achieve.

It is clear they use information from actual and mock code situations to make improvements to their processes.

Working in collaboration with external stakeholders (EMS, OPP, Municipalities and others) is important to them and they are encouraged to continue with those efforts. The organizations are encouraged to continue to look at table-top code exercises as a simplified way of doing mock codes.

Over the last three years, the organizations have demonstrated their efforts on managing the COVID-19 pandemic. There is recognition of their proactive and flexible approaches to keeping patients, residents, and team members safe. They are also recognized for supporting where needed in other areas of their community.

Priority Process: People-Centred Care

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

Unmet Criteria		High Priority Criteria
Standards Set: Emergency Department		
1.1	Services are co-designed with clients and families, partners, and the community.	!
2.5	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
4.15	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
18.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Inpatient Services		
1.1	Services are co-designed with clients and families, partners, and the community.	!
2.5	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
3.12	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
Standards Set: Leadership		
3.3	Teams, clients, and families are supported to develop the knowledge and skills necessary to be involved in quality improvement activities.	
Standards Set: Long-Term Care Services		
1.1	Services are co-designed with residents and families, partners, and the community.	!
1.7	Barriers that may limit residents, families, service providers, and referring organizations from accessing services are identified and removed where possible, with input from residents and families.	

Patient and Family Advisors and Patient and Family Advisory Committees (PFAC) have also been in place for a number of years. Each of the corporations has had their own PFAC until last year with the two committees agreed to form a joint Patient and Family Advisory Committee for MRHA. The Joint PFAC consists of Patient and Family Advisors as well as staff that provide coordination and leadership as needed. Throughout the past few years PFAC has been engaged in several activities including wayfinding, providing input on various operational documents, initiating a presentation about PFAC at general orientation, pet therapy, and providing input to the plan for a new ER in Carleton Place. As well a member of PFAC now sits on several of the hospital wide committees including the Board Quality Committee, the Ethics Committee and the Records Management Committee.

Fairview Manor has an engaged Resident and Family Council which meets monthly and has been involved the residents' feedback form, falls prevention and a walking program that has been initiated to further residents' mobility.

There has however been an ongoing challenge with recruitment of additional members to the PFAC and this was further hindered during the pandemic. MRHA is encouraged to renew their efforts to bring on more members and consider embedding the advisors into the various programs and department across the organizations. Members of the PFAC interviewed during the survey supported the suggestion of being associated with a particular department and becoming more engaged in the work of that area. Patient advisors being part of programs or departments also provides the opportunity to engage these voices in the co-design of services, the identification and monitoring of quality initiatives, and in many of the service planning activities which at this point do not have patient and family input.

The MRHA is also encouraged to review the criteria for becoming a patient advisor and the length of term to be served by the advisor. Currently volunteers can also serve as an advisor and this has the potential to create difficulty in separating the roles as a volunteer and acting as a patient advocate, versus a patient advisor who is to provide input to the organization through a patient's eyes.

Priority Process: Patient Flow

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

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

The ED team and leadership are innovative and collaborative in finding opportunities to improve patient flow, including working across all three sites of MRHA.

The organization is encouraged to continue to work on efforts for meeting the 48-hour repatriation target.

Priority Process: Medical Devices and Equipment

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Teams are very knowledgeable about medical devices, storage requirements, preventative maintenance needs, and reprocessing. Staff are educated and familiarized with all new equipment.

With larger, more expensive purchases, vendors contract for education, and preventive maintenance to ensure appropriate use and best life for equipment. A sound and consistent approach to preventative maintenance and equipment repair and return are in place through community partner CHEO, which also supports biomedical services.

Safe handling of equipment and reprocessing occurs at every point of the chain. Repairs are noted and tracked, and the site uses a ROI approach to determine repair versus purchase new. There is great support from the procurement manager.

MDRD has had a recent renovation and has a streamlined, efficient, state-of-the-art space that provides for decontamination with full application of IPAC and OH&S policy compliance. Very knowledgeable and dedicated staff follow strong controls and documentation of MDRD processes and reporting.

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:

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

Standards Set: Diagnostic Imaging Services - Direct Service Provision

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

The organization has met all criteria for this priority process.

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

This team has managed for a couple of years with no formal leadership and did incredibly well. They are a very small but knowledgeable, competent team with great connections into the community for radiologist support and planning, as well as the family medicine clinic as external partners in care. The physical space is very small and patient flow is poor.

Currently private conversation can only occur in the procedure rooms, and it does, but this could delay the next person's procedure.

Development of the physical space renovation for the CT scanner will present an opportunity to redesign a better flow for patients, a better seating space, and a room for private consultation/conversation.

Standards Set: Emergency Department - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.3	Specific goals and objectives regarding wait times, length of stay (LOS) in the emergency department, client diversion to other facilities, and number of clients who leave without being seen are established, with input from clients and families.	
1.4	Services are reviewed and monitored for appropriateness, with input from clients and families.	
2.4	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.	
2.11	A universally-accessible environment is created with input from clients and families.	
6.2	Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from clients and families where appropriate.	
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
9.16	A process to investigate and respond to claims that clients' rights have been violated is developed and implemented with input from clients and families.	!
10.2	The assessment process is designed with input from clients and families.	
13.9	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support		
14.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
15.2	Policies on the use of electronic communications and technologies are developed and followed, with input from clients and families.	

Priority Process: Impact on Outcomes		
16.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
16.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
16.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
16.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
17.1	A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families.	!
17.2	Strategies are developed and implemented to address identified safety risks, with input from clients and families.	!
17.3	Verification processes are used to mitigate high-risk activities, with input from clients and families.	!
17.4	Safety improvement strategies are evaluated with input from clients and families.	!
18.1	Information and feedback is collected about the quality of services to guide quality improvement initiatives, with input from clients and families, team members, and partners.	
18.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
18.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
18.13	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	
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

There is evidence that the ED clinical leadership uses information to inform service design and address the recruitment/retention of ED staff. The leadership team is encouraged to continue with skill mix opportunities. The ED physician team is acknowledged for revisiting their scheduling approach for vacant shifts to ensure consistent coverage.

Priority Process: Competency

The ED team and leadership is committed to ensuring all team members are provided with ongoing education and training. The opportunity to provide cross training between ED and other units is excellent for growth and development of staff in ED and other areas.

The team leader role is providing exceptional support for education, mentorship of new staff and leading changes for the department.

Priority Process: Episode of Care

The ED team has well established processes and procedures to ensure the delivery of safe, quality care to their patients and families.

Through discussion with patients and families it was highlighted that the team members take time to explain and involve them in care and they feel feel safe and informed. There was also the recognition of the caring approach of the team members.

There are strong collaborative partnerships with EMS and the OPP that has been beneficial to achieve safe care.

It is recommended that a patient and family advisor be engaged on the ED program team meetings to provide input on a regular basis.

Priority Process: Decision Support

The ED team provides good documentation given that are using both electronic and paper-based systems. To ensure quality and safety, the organization needs to continue with their efforts towards a fully electronic medical record.

The team is encouraged to move towards a formal patient and family representative role on the ED program meeting.

Priority Process: Impact on Outcomes

The ED team is committed to using evidence-based and best-practice guidelines to develop policy and procedures, medical directives, patient information, and other tools to guide their practice.

Quality and safe care is a priority for all members of the team and the passion for quality improvement is clearly evident.

The adoption of the Stoplight report demonstrates how their input is turned into action.

The leadership team is strongly encouraged to evolve the patient and family advisory role formally on the ED program meetings to ensure there is regular input into planning and evaluating of ED services.

Priority Process: Organ and Tissue Donation

The ED team is commended for their work on establishing their organ and tissue donation process for the hospital since the last survey!

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

Unmet Criteria		High Priority Criteria
Priority Process: Infection Prevention and Control		
5.2	Team members, clients and families, and volunteers are engaged when developing the multi-faceted approach for IPC.	
14.3	Input is gathered from team members, volunteers, and clients and families on components of the IPC program.	
Surveyor comments on the priority process(es)		
Priority Process: Infection Prevention and Control		

The Infection Prevention and Control (IPAC) interdisciplinary committee sets direction and goals for the IPAC team.

This team is very collaborative and connected with community partners and resources, including the family MDs, Public Health and Infectious Disease specialists.

The very creative team ensures organizational knowledge is high and aligned with best practices, as well as directing several programs to ensure patient and staff safety is upheld.

They were at the lead in their region during COVID-19 and planned accordingly with major support from colleagues and community partners. They set up opportunities to test and track cases as well as provide an option for immunizations to the community, patients/residents and staff.

IPAC is to be celebrated for their outcomes and mitigating outbreaks, along with all the staff who participated and supported measures to keep the community and those they serve as safe as possible. Lessons learned continue to shape the future of the program and opportunities to improve site responses to microbial stewardship, surgical site prevalence and many more.

Standards Set: Inpatient Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.5	Service-specific goals and objectives are developed, with input from clients and families.	
1.6	Services are reviewed and monitored for appropriateness, with input from clients and families.	
2.4	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.	
2.6	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
2.8	A universally-accessible environment is created with input from clients and families.	
6.2	Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from clients and families where appropriate.	
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		
12.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
Priority Process: Impact on Outcomes		
14.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
14.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
14.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!

14.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The in-patient unit provides care for both surgical and medical patients and does not include care for the paediatric population. There are 18 acute medical/surge beds and 26 complex continuing care beds included on the unit with a multidisciplinary team providing care. They have a high occupancy rate and like many organizations have challenges placing ALC (alternative level of care) patients. Recent opening of additional community facilities in the area has eased some of the backlog of patients waiting for placement.

The team solicits feedback from patients and families using post discharge phone calls. The manager completes these calls allowing an opportunity to validate patient safety initiatives currently practiced on the unit. The leader asks for feedback on bedside shift reports, rounding, and staff compliance with introducing themselves when caring for patients. Questions are altered according to the quality improvement projects underway on the unit. Additional open-ended questions allow for feedback to identify opportunities for improvement. The team is encouraged to look for other ways to involve patients and families in the development of team goals and objectives as well as program design and operations through participation in care team committees.

Priority Process: Competency

There is a strong leadership presence on the in-patient unit to help support staff and guide practice. There are challenges with recruitment and retention with a plan to continue efforts to ensure appropriate staffing can be achieved. The team has built relationships with local universities and colleges to provide clinical placements as a strategy to recruit new graduates. They have also created clinical extern positions to be able to hire students into these positions to facilitate future employment opportunities. The team has unfilled vacancies as well as 50 percent of their current staff with less than two years' experience. This creates challenges with skill mix. They share staffing resources between CCC and the acute area to help mitigate risk and balance workload pressures.

Staff report feeling well prepared and supported to work on these units through educational offerings and learning available to them. The interdisciplinary team works collaboratively to provide care working closely with patients and families. There are interdisciplinary rounds weekly and family meetings as needed to help coordinate care. The team is commended for their work on hard wiring the bedside shift report and hourly rounding to improve delivery of safe patient care. White boards in patient rooms were noted to be filled out with all relevant information and consistently used as a communication tool.

Priority Process: Episode of Care

The team uses the Morse Fall Scale scoring which provides an indication of the likelihood that a patient

will fall. Universal fall precautions are then implemented where appropriate to ensure a safe environment that prevents falls and reduces the risk of injuries from falling. Information and education are given to the patient as to how they can help prevent a fall. If a fall occurs the incident is recorded in the safety management system allowing the team to review processes to make improvements when needed. The unit leader reviews the fall with the team caring for the patient however, there was no information posted that would allow staff to understand how many falls are occurring and any improvements underway. Consider posting the number of falls, and falls with injuries, to engage staff in problem solving.

Upon admission a Best Possible Medication History (BPMH) is generated and documented into Cerner on the Medication History Power Form by a member of the team using and indicating at least two, whenever possible, other sources and involving the patient and family in the process. The admitting physician reviews each medication and orders the appropriate therapy for the patient by circling C (continue) DC (discontinue) or 'see new order'. The BPMH medication reconciliation report for admission is then reviewed within 24 hours by the physician and appropriate changes are made to the patient's medication treatment. The team has been working with pharmacy towards improving the accuracy and quality of the BPMH on admission through auditing and education.

The Braden Assessment Scale for predicting pressure sore risk is completed upon admission and every week. Documented protocols and procedures based on best practice guidelines are then implemented to prevent the development of pressure ulcers. This is another quality metric that could be regularly shared with staff to assess the effectiveness of the interventions in place and look for opportunities.

VTE prophylaxis is included in admission order sets with reminders built into the Cerner system. There is a VTE policy in place to guide practice and pharmacy plays an important role in ensuring patients are on the appropriate thromboprophylaxis.

The team uses a PACE transfer tool to ensure that information shared at care transitions between units is defined and standardized. At shift change the team is commended for is hard-wiring bedside shift report into the practice on the unit making the patient a part of the process in the delivery of their care. This important initiative allows the nurse to visualize and assess the patient and environment, as well as communicate with and involve the patient in the plan of care.

In addition to the bedside shift report, the team uses hourly rounding to proactively address a patient's needs. Some of the benefits of hourly rounding include increased patient satisfaction and decreased call bells for assistance. Consider tracking and sharing these metrics to understand the impact hourly rounding is having.

Priority Process: Decision Support

An accurate, up-to-date, and complete record is maintained for each patient. The team uses Cerner as their documentation platform. This electronic health record helps to standardize documentation and provide cues to complete necessary assessments, and tools for falls risk assessments, Braden Scores, and VTE prophylaxis to name a few. The team finds Cerner to be user friendly, providing them them with

ability to capture care delivered.

The organization has policies and procedures for securely storing, retaining, and destroying patient records. in accordance with legislations.

Priority Process: Impact on Outcomes

There is no patient representation on the Quality Improvement and Risk Management (QIRM) Committee. The purpose of this committee is to improve quality and safety of patient/resident care and services through the effective use of clinical and operational information, supported by available scientific evidence and best-practice information. By including patients on this committee, the voice of the patient could be imbedded in the program more effectively.

The team has started to collect and post quality indicators but there are opportunities to expand these unit specific indicators to reflect the quality improvement initiatives that are undertaken. Stoplight reports on the unit help staff see what improvements are being worked on and which ones have been completed. Linking data to show the improvement made or the need to improve would help staff understand the magnitude of the problem and further engage frontline staff in problem solving. Initiatives underway such as bedside shift report, AIDET (Acknowledge, Introduce, Duration, Explanation, and Thank You). or rounding are validated by patients during post discharge phone calls. The leader also uses the discharge phone calls to identify any safety risks patients may have encountered during their stay to help drive improvement opportunities on the unit.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.3	Service-specific goals and objectives are developed, with input from residents and families.	
2.4	The physical space is designed with input from residents and families and is safe, comfortable, and reflects a home-like environment.	
2.8	A universally-accessible environment is created with input from residents and families.	
5.2	Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from residents and families where appropriate.	
Priority Process: Competency		
3.1	Required training and education are defined for all team members with input from residents and families.	!
3.4	Education and training are provided to team members on how to work respectfully and effectively with residents and families with diverse cultural backgrounds, religious beliefs, and care needs.	
3.16	Resident and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
Priority Process: Episode of Care		
8.2	The assessment process is designed with input from residents and families.	
11.1	Policies and procedures for POCT are developed with input from residents and families.	
Priority Process: Decision Support		
13.8	There is a process to monitor and evaluate record-keeping practices, designed with input from residents and families, and the information is used to make improvements.	!
14.2	Policies on the use of electronic communications and technologies are developed and followed, with input from residents and families.	

14.3	Policies and procedures for disclosing health information for secondary use are developed and followed.	
Priority Process: Impact on Outcomes		
15.2	The procedure to select evidence-informed guidelines is reviewed, with input from residents and families, teams, and partners.	
15.3	There is a standardized process, developed with input from residents and families, to decide among conflicting evidence-informed guidelines.	!
15.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from residents and families.	!
15.5	Guidelines and protocols are regularly reviewed, with input from residents and families.	!
16.3	Verification processes are used to mitigate high-risk activities, with input from residents and families.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

A wonderful team of professionals are truly committed to the people they are supporting in this village. They have not had family or resident input to design of the site or the work.

Priority Process: Competency

Integrated teamwork is evident. New opportunities have been identified for palliative care, followed with education to underpin the next phases of implementing this change in the model of care.

Restorative care is a goal for every resident and is individualized and reviewed monthly for each resident to monitor progress.

Education and training are ongoing for multiple areas - the newest one being around behavior optimization for residents with memory care issues.

Priority Process: Episode of Care

There is very strong support to keep residents as independent as possible for as long as possible through a restorative care approach. Formalized palliative end-of-life care is at early stages.

Families and residents are involved in determining care and daily living options. The team has a strong sense of advocacy for the people they serve and are united in their efforts to give people a sense of purpose and value daily.

Priority Process: Decision Support

Families and residents could be more involved in providing input in decision support policy development as well as maintenance of records.

Priority Process: Impact on Outcomes

Informal discussions with residents and families provide some input.

A suggestion for improvement is to put in place a process for seeking families' and residents' feedback in several identified areas using a very formalized process to enable validation of evidence.

Staff and managers are very open to hallway conversations which they use in development of standardized approaches and evaluation of programs and interventions.

Provision of education on their role for people-centered care would provide better understanding of this formalization.

Standards Set: Medication Management (For Surveys in 2021) - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Medication Management		
13.1	Access to medication storage areas is limited to authorized team members.	!
13.2	Medication storage areas are clean and organized.	!
13.11	Medication storage areas are regularly inspected, and improvements are made if needed.	
15.10	Medication orders are accurately transcribed into clinical documents such as medication administration records.	!
Surveyor comments on the priority process(es)		
Priority Process: Medication Management		

There is an active interdisciplinary Pharmacy and Therapeutics Committee dedicated to the safe delivery of medication practices in Almonte. They regularly assess the appropriateness of all medication-related policies, promote best practice and the use of evidence in clinical care and make policy recommendations to the Medical Advisory Committee. All patient safety incidents and near misses for medication management are reported, reviewed and analyzed to look for opportunities to prevent the same or similar incidents or near misses from recurring. Through incident reporting the team has identified a need to improve transcription practices to reduce errors.

The pharmacy team provides support within MRHA working collaboratively to provide expertise to the frontline to ensure the safe delivery of medication. They participate in patient care rounds with an interdisciplinary team to review and advise on medication for patient care. Pharmacists are available to provide resources for physicians and staff on call after hours using internal and an external resource. Pharmacy technicians work collaboratively with nursing to complete the best possible medication history (BPMH) for admitted patients.

There is an antimicrobial stewardship program to optimize and monitor the use of antimicrobials. The program includes interventions such as auditing and feedback, a formulary of targeted antimicrobials and approved indications, education, antimicrobial guidelines, and clinical pathways for antimicrobial use. The team has a good relationship with the physician group and find that they are used as a valuable resource in guiding practice.

There is a need to move forward with closed loop medication administration through integration and

upgrading of the current health information system (HIS). The use of technology through automated dispensing units and barcoding of medications is a step towards closed loop medication administration but is not consistently set up across the units. With the implementation of a new health information system (HIS), the whole medication cycle (prescribing, processing, dispensing and administration) will ensure correct medication serving, reducing risks of medication errors and adverse drug events. Computerized physician order entry will also be part of the upgrade to the new IHS. The team is encouraged to engage all stakeholders to ensure a successful implementation.

Work has been completed on issues noted during the last survey with unit dose packaging, updated policies, and the storage and handling of look-alike, sound-alike medications and high alert medications. Additionally, the team has been involved in the roll out of a new fleet of smart infusion pumps across MRHA helping to improve patient safety through automation.

During direct observations on various units, it was noted that there is variation in medication delivery and storage processes. Ward stock cabinets allow for easy access for staff after hours to have the available medications to begin treatment. There is a large binder that allows staff to know where various medications are located across units when they find they do not have what they need. There is already a plan in place to make this information available electronically to improve ease of access. Some units have medication rooms, others have dispensing cabinets and there are units with a combination of both. It was noted that there was variability in practice for locking medication rooms or carts. The teams would benefit from regular audits of medication rooms and carts to provide better standardization, organization of areas, and compliance with best practice.

Standards Set: Obstetrics Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.3	Service-specific goals and objectives are developed, with input from clients and families.	
2.3	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.	
2.5	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
2.6	A universally-accessible environment is created with input from clients and families.	
5.2	Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from clients and families where appropriate.	
Priority Process: Competency		
3.1	Required training and education are defined for all team members with input from clients and families.	!
Priority Process: Episode of Care		
11.9	Established policies on handling, storing, labelling, and disposing of medications and breast milk safely and securely are followed.	!
Priority Process: Decision Support		
14.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
15.2	Policies on the use of electronic communications and technologies are developed and followed, with input from clients and families.	
Priority Process: Impact on Outcomes		
16.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
16.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!

16.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
16.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
17.1	A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families.	!
17.2	Strategies are developed and implemented to address identified safety risks, with input from clients and families.	!
17.3	Verification processes are used to mitigate high-risk activities, with input from clients and families.	!
17.4	Safety improvement strategies are evaluated with input from clients and families.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The OBS leadership team uses the Stoplight report to identify unit specific objectives, which are regularly reviewed and updated. Connection is made with the corporate goals and objectives. The team members report that this approach has made them feel engaged and heard.

The team is encouraged to continue with the assessment of appropriate mix of skill level and experience and overall staffing levels. Both staff and patients realize that the workload is high, which makes it difficult to meet all the patient needs.

Formalizing a patient/family advisor role on the OBS program team meeting is encouraged.

Priority Process: Competency

The OBS team members have access to ongoing education to maintain their competency in obstetrical care. They are recognized for the educational partnership with Ottawa Hospital to develop new OBS staff.

The team leader role has been instrumental for providing training and mentorship. This role has also focused on the development of policies and procedures as resource material for staff to reference as they are gaining their expertise and they are encouraged to continue the work.

Formalizing a patient and family advisor role on the OBS program team meeting is encouraged to ensure there is input across the program.

There is a well-integrated midwifery program. Midwives work to full scope of practice.

Skills day has been highlighted positively by staff and provides a great opportunity to learn as a team.

Priority Process: Episode of Care

The development of the OBS task force has been valuable in drafting OBS hospital-specific policies and procedure that represent evidence-based, best-practice information. The program is encouraged to keep up the efforts on this important work.

The OBS team in collaboration with pharmacy is strongly urged to review their medication storage on the unit and ensure all medications are securely stored.

The team has comprehensive assessments tools implemented throughout the entire episode of care.

There is a strong philosophy on the skin-to-skin approach and the benefits are well understood. The team is encouraged to formalize a policy/procedure.

There is a strong Public Health relationship and partnership which has been an asset for supporting home visits for identified patients.

Priority Process: Decision Support

The team is encouraged to have input through patient and family representation at OBS program meetings.

The team and organization are strongly encouraged to continue with advocacy for electronic medical record implementation. The current hybrid of paper and electronic is a challenge for clinicians and is a quality and safety risk for ensuring accurate information is available.

Priority Process: Impact on Outcomes

There is a positive quality and safety culture across the OBS team where they feel open to bring issues forward for improvement.

The team is encouraged to have input through patient and family representation at OBS program meeting.

The OBS programs uses BORN (better outcomes registry and network) data for evaluating their outcomes and then make improvements if needed. The example shared was the increasing trend of vaginal trauma during childbirth which was reduced through increased education and training.

Pain control is an area identified by patients as opportunity for improvement. This feedback assisted the return of Nitrous and the team is continuing to explore other ways of improving access to pain management.

The OBS program is a member of the Champlain perinatal network, and this network has been a great resource for assisting with quality improvement initiatives.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.3	Service-specific goals and objectives are developed, with input from clients and families.	
1.4	Services are reviewed and monitored for appropriateness, with input from clients and families.	
2.5	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
2.7	A universally-accessible environment is created with input from clients and families.	
8.2	Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from clients and families where appropriate.	
Priority Process: Competency		
6.1	Required training and education are defined for all team members with input from clients and families.	!
Priority Process: Episode of Care		
11.2	The assessment process is designed with input from clients and families.	
Priority Process: Decision Support		
22.2	Policies on the use of electronic communications and technologies are developed and followed, with input from clients and families.	
Priority Process: Impact on Outcomes		
23.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
23.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
23.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!

23.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
24.1	A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families.	!
24.2	Strategies are developed and implemented to address identified safety risks, with input from clients and families.	!
24.3	Verification processes are used to mitigate high-risk activities, with input from clients and families.	!
24.4	Safety improvement strategies are evaluated with input from clients and families.	!
25.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	

Priority Process: Medication Management

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The perioperative services team and leadership has been focused on ensuring effective use of services. They are commended for achieving 91 percent use of their OR schedule and contributing to assisting the broader regional system in addressing long-waiting surgical cases.

The team is encouraged to have input through patient and family representation at the perioperative program meetings.

Priority Process: Competency

The perioperative team is high performing and show significant respect and support for each other. There is recognition of the leadership for setting a culture of being open to learning from each other.

While the clinical competencies were clearly evident, it was impressive to see the genuine caring competencies they have with patients.

The team is encouraged to have input through patient and family representation at perioperative program meetings.

Priority Process: Episode of Care

There is evidence that there are comprehensive processes and procedures in place to ensure a safe and effective surgical patient journey at AGH.

From a patient perspective it was important that the team continually kept them informed and reassured them about all the safety steps they were taking.

Priority Process: Decision Support

The majority of the perioperative medical record is paper, with some electronic components. Continued efforts to implement a fully electronic medical recorded are strongly supported.

The team is encouraged to have input through patient and family representation at perioperative program meetings.

Priority Process: Impact on Outcomes

The team uses ORNAC standards to guide best practice processes in the operating room.

The team is encouraged to have input through a patient and family representation at OBS program meetings.

Quality improvement opportunities are generated through the Stoplight program, which has been successful in identifying capital equipment needs to improve patient care and efficiency.

The team is looking at potential future opportunities for perioperative services that will include supporting the larger regional surgical services needs.

Priority Process: Medication Management

The perioperative team have demonstrated evidence on the procedures for managing medication in the surgical area.

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: November 7, 2022 to November 30, 2022**
- **Number of responses: 10**

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.	0	0	100	93
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	0	0	100	94
3. Subcommittees need better defined roles and responsibilities.	90	10	0	70
4. As a governing body, we do not become directly involved in management issues.	0	10	90	87
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	10	90	95

	% 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	10	90	95
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	10	90	95
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	0	10	90	92
9. Our governance processes need to better ensure that everyone participates in decision making.	70	10	20	61
10. The composition of our governing body contributes to strong governance and leadership performance.	0	0	100	92
11. Individual members ask for and listen to one another's ideas and input.	0	0	100	95
12. Our ongoing education and professional development is encouraged.	0	10	90	89
13. Working relationships among individual members are positive.	0	0	100	95
14. We have a process to set bylaws and corporate policies.	0	0	100	93
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	96
16. We benchmark our performance against other similar organizations and/or national standards.	0	20	80	77
17. Contributions of individual members are reviewed regularly.	10	20	70	71
18. As a team, we regularly review how we function together and how our governance processes could be improved.	0	10	90	77
19. There is a process for improving individual effectiveness when non-performance is an issue.	10	10	80	64

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	0	30	70	83
21. As individual members, we need better feedback about our contribution to the governing body.	50	10	40	44
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	0	10	90	78
23. As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	94
24. As a governing body, we hear stories about clients who experienced harm during care.	0	0	100	82
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	0	0	100	91
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	0	10	90	88
27. We lack explicit criteria to recruit and select new members.	90	0	10	79
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	0	0	100	87
29. The composition of our governing body allows us to meet stakeholder and community needs.	0	0	100	87
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	92
31. We review our own structure, including size and subcommittee structure.	0	0	100	86
32. We have a process to elect or appoint our chair.	0	10	90	87

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	10	10	80	83
34. Quality of care	10	10	80	82

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2022 and agreed with the instrument items.

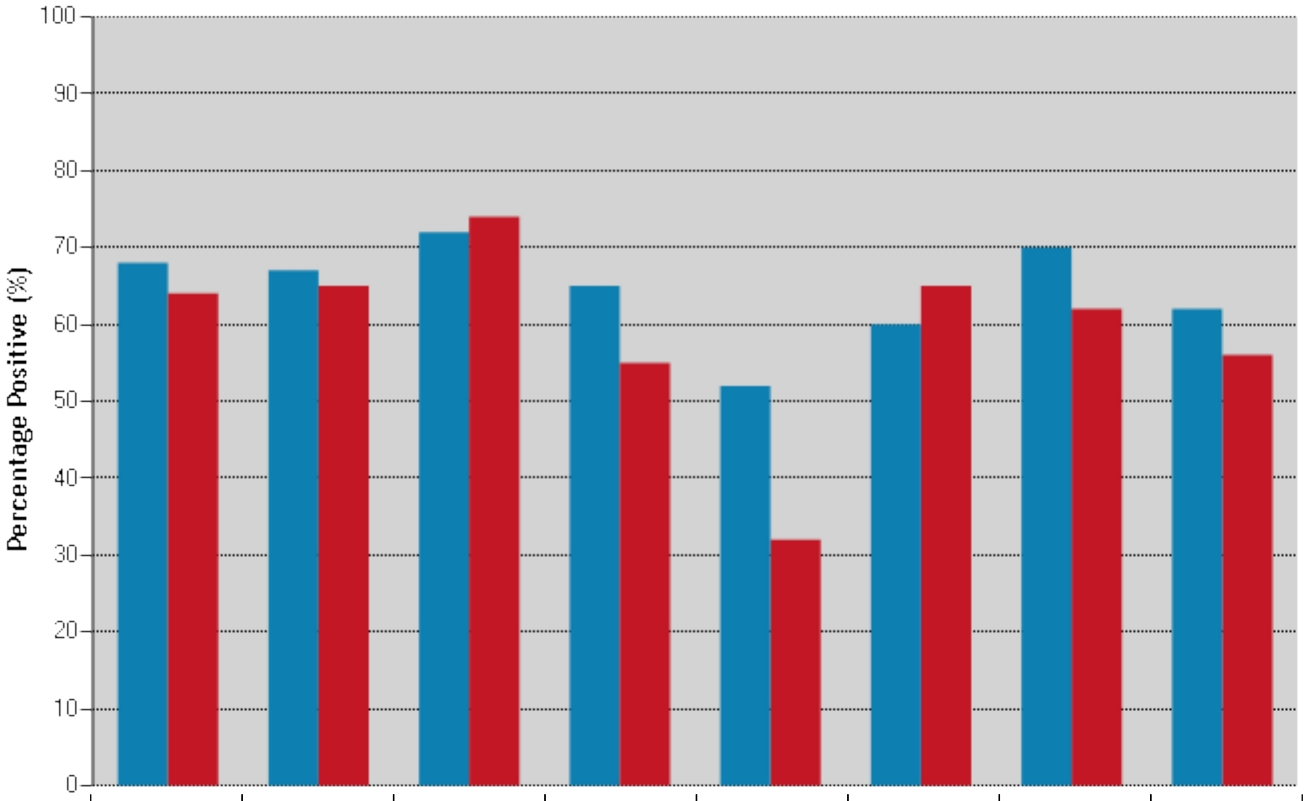
Canadian Patient Safety Culture Survey Tool

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: November 23, 2022 to December 14, 2022**
- **Minimum responses rate (based on the number of eligible employees): 150**
- **Number of responses: 165**

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
	68%	67%	72%	65%	52%	60%	70%	62%
	64%	65%	74%	55%	32%	65%	62%	56%

Legend

Almonte General Hospital / Fairview Manor

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2022 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.

The organization used an approved substitute tool for measuring the quality of worklife.

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

Organization's Commentary

After the on-site survey, the organization was invited provide comments to be included in this report about its experience with Qmentum and the accreditation process.

In May 2021 our MRHA Integrated Clinical Service Plan was released. Input was obtained from the community via open community forums. The advisory panel membership included PFAC members, board members, MD's, community partners (Home and Community care, Ottawa Valley Midwives, CMNRP, Lanark County Mental health and sexual assault services, staff, and managers. This plan involves Inpatient care (Acute, CCC and LTC), Outpatient services, Surgical Services, OBS, ER and clinical support services.They reviewed future planning, future programming, future roles and service profiles. PFAC reviewed + feedback around Staff Satisfaction Survey, Patient Safety Survey. Client/Family Feedback is obtained via Post discharge P/C, Complements, concerns, complaint, Pt Rounding Leaders sitting on various local and regional committees. Patient Safety Incident/Concerns analyzed + improvements are implemented. Reviewed at QIRM,MAC and Board Quality. Critical incident reviews done, facilty debrief Quality Improvement Initiatives are built into their yearly departmental goals. Developed by looking at the Integrated Clinical Service plan that had involved of PFAC, community, and health care partners, QIP, Trends in complaints/concerns. They also relate to the Corporate Goals for the facility. These QA/goals are recorded on the leaders individual LEM, involve time specific targets, outcomes, steps to be taken. They are based on a quarterly workplan. Indiv department (QA initiatives/goals)reviewed with staff when developing new processes (such as starting Bedside Shift report where staff not only received education about what it was but the reasons why it needed to happen)Barriers in health care Besides being looked at with our MRHA Clinical Service plan
Pts have access to contracted Translation service.All staff assigned mandatory AODA education ER: These are recorded on the score card that is reviewed at various committees. Included in the Clinical Service plan-Standardized process to investigate and respond to concerns is in place.-PFAC had input into the turn around time and avenues in which the facility should respond. As well as the wording on the website -Transition from one ER (AGH) to Inpatient (CPDMH) has a solid process in place that was designed following input received from patients/families/MD and Community members. Process in place to run reports in Cerner to audit documentation Corporate polices on electronic communication/technologies developed in partnership with GBIN partners and PIDAC
-Best practice guidelines are followed when standardizing process, feedback from other health care facilities When reviewing policies, processes streamline policies with CPDMH.- Two person identification, medication reconciliation, falls prevention, are some examples of verification process.Client/Family Feedback are encouraged to provide feedback using compliments, concerns and complaint process, patient handbook identified how we solicit feedback, website has link. Quality Improvement Initiatives are built into department yearly goals by reviewing Clinical Service plan, QIP, Trends in complaints/concerns. They also relate to corporate goals. These QA/goals are recorded on the leaders individual LEM, involve time specific targets, outcomes, steps to be taken. They are based on a quarterly workplan. Individual department (QA initiatives/goals) are reviewed with staff when developing new processes (ie Bedside Shift report), location of outpatient blood transfusion etc) memos to staff, rounding with staff Standard Set: Inpatient Services-See clinical service plan above.Feedback is obtained from post discharge p/c, pt rounding, compliments, concerns,complains. Hospital follows best practice guidelines as well as works very closely with

other community health care facilities who are the experts and follows their direction ie Ottawa Heart Institute for ACS and CHF, Regional MAiD program.
When a policy/process or procedure is reviewed attempt to do a joint policy, following best practice guidelines
Correction in Narrative There is 21 acute Med Surg meds (not 18) Long Term Care Services- Admission and annual care conferences, plus additional family meetings if requested, to set goals for residents. There are resident council minutes which reflect that this was discussed. Few accessibility issues identified and have been actioned such as implemented additional signage for accessible parking. We are also waiting for a quote to allow for a door opener for the visitor washroom. These issues were both brought up by family members. Clinical service plan that was completed included LTC. as above. Any policies go through P&T where there is a family rep on the committee. We use individual resident care orders (medical directives) which are approved at P&T. There is a family rep on this committee. Opportunity to share ideas/comments through the annual satisfaction survey from resident and their families. Education is mandated by the Ministry but if a resident or family member brings forward a care concern we try to follow up with education for staff. For example, we assigned a safe dining practices module following a concern from a family member.AODA is assigned to all staff. Family Council meetings and Resident Council meetings; admission and annual care conferences. There are consents in the admission package for submitting data to CIHI from the RAI assessments Medication Management: Pharmacy department is secure behind a key swipe door. Medication is stored in ADU and locked fridge so electronic tracked, permission to access the system. Manager does an audit every 6 months for all units in the hospital to not only inspect the environment but also to identify improvements needed. Policy on Medication Storage, disposal, dispensing clearly states that medication orders are entered onto a MAR. Obstetric Services See Clinical Service plan above, Policy Oxytocin Induction of Labour & Medication Management address this. Process in place to run reports in Cerner to audit documentation. Corporate policies around electronic communication. Policies around technologies were developed in partnership with GBIN partners and PIDAC. An example of this is that feedback was received about a baby being taken to the nursey for the night.OBS small working group then developed an order set around 24-hour rooming in. Manager sits on regional committee and they are work together to ensure that level 1 OBS units have the same criteria and process in place. Following input from pts and MDs. Process was put in place that OBS could have their Rhogam given at AGH instead of having to travel to CPDMH with the medication. Policy on VBAC and admission criteria in place to help identify/decrease risk to our patients
Two-person identifier, medication reconciliation, independent double check are all in place and require input/feedback from the patient. Periop Services: See Clinical Service plan above. Corporate policy for electronic communication. Policies around technologies were developed in partnership with GBIN partners and PIDAC. Procedures at AGH/FVM follow input from our health care partners (ORDAC Standards, our specialist) When a policy/process or procedure is being reviewed done jointly between AGH/FVM/CPDMH to ensure same procedure at either hospital it done the same.Our policies/procedures are done in partnership with Ottawa facilities and specialist. Pre op review with the nursing staff, anesthesia and patient identifies potential risk and safety measures put in place ie stopping of certain medication, blood work etc. 2-person identifier, fall risk, medication reconciliation is done in partnership with clients.Safety concerns are on the post discharge phone call

Quality Improvement Initiatives built into their yearly goals. These are developed by looking at Clinical Service plan,QIP,complaints/concerns. along with Corporate Goals.

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 15 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
Communication	Communicating effectively at all levels of the organization and with external stakeholders.
Emergency Preparedness	Planning for and managing emergencies, disasters, or other aspects of public safety.
Governance	Meeting the demands for excellence in governance practice.
Human Capital	Developing the human resource capacity to deliver safe, high quality services.
Integrated Quality Management	Using a proactive, systematic, and ongoing process to manage and integrate quality and achieve organizational goals and objectives.
Medical Devices and Equipment	Obtaining and maintaining machinery and technologies used to diagnose and treat health problems.
Patient Flow	Assessing the smooth and timely movement of clients and families through service settings.
Physical Environment	Providing appropriate and safe structures and facilities to achieve the organization's mission, vision, and goals.
Planning and Service Design	Developing and implementing infrastructure, programs, and services to meet the needs of the populations and communities served.
Principle-based Care and Decision Making	Identifying and 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	Maintaining efficient, secure information systems to support effective service delivery.
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	Partnering with clients and families to provide client-centred services throughout the health care encounter.
Impact on Outcomes	Using evidence and quality improvement measures to evaluate and improve safety and quality of services.
Infection Prevention and Control	Implementing measures to prevent and reduce the acquisition and transmission of infection among staff, service providers, clients, and families

Priority Process	Description
Living Organ Donation	Living organ donation services provided by supporting potential living donors in making informed decisions, to donor suitability testing, and carrying out living organ donation procedures.
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.
Organ and Tissue Transplant	Providing organ and/or tissue transplant service from initial assessment to follow-up.
Point-of-care Testing Services	Using non-laboratory tests delivered at the point of care to determine the presence of health problems
Primary Care Clinical Encounter	Providing primary care in the clinical setting, including making primary care services accessible, completing the encounter, and coordinating services
Public Health	Maintaining and improving the health of the population by supporting and implementing policies and practices to prevent disease, and to assess, protect, and promote health.
Surgical Procedures	Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge