ACCREDITATION CANADA

Driving Quality Health Services

Accreditation Report

Prepared for:

Halton Healthcare Services Corporation

Oakville, ON

On-site Survey Dates:

May 2, 2010 - May 6, 2010

September 7, 2010

Accredited by ISQua

Accreditation Report

About this Report

The results of this accreditation survey are documented in the attached report, which was prepared by Accreditation Canada at the request of Halton Healthcare Services Corporation.

This report is based on information obtained from the organization. Accreditation Canada relies on the accuracy of this information to conduct the survey and to prepare the report. The contents of this report is subject to review by Accreditation Canada. Any alteration of this report would compromise the integrity of the accreditation process and is strictly prohibited.

Confidentiality

This Report is confidential and is provided by Accreditation Canada to Halton Healthcare Services Corporation only. Accreditation Canada does not release the Report to any other parties.

In the interests of transparency, Accreditation Canada encourages the dissemination of the information in this Report to staff, board members, clients, the community, and other stakeholders.

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About the Accreditation Report

The accreditation report describes the findings of the organization's accreditation survey. It is Accreditation Canada's intention that the comments and identified areas for improvement in this report will support the organization to continue to improve quality of care and services it provides to its clients and community.

Legend

A number of symbols are used throughout the report. Please refer to the legend below for a description of these symbols.

Items marked with a GREEN flag reflect areas that have not been flagged for improvements. Evidence of action taken is not required for these areas.

Items marked with a YELLOW flag indicate areas where some improvement is required. The team is required to submit evidence of action taken for each item with a yellow flag.

Items marked with a RED flag indicate areas where substantial improvement is required. The team is required to submit evidence of action taken for each item with a red flag.

Leading Practices are noteworthy practices carried out by the organization and tied to the standards. Whereas strengths are recognized for what they contribute to the organization, leading practices are notable for what they could contribute to the field.

Items marked with an arrow indicate a high risk criterion.

Accreditation Summary

Halton Healthcare Services Corporation

This section of the report provides a summary of the survey visit and the status of the accreditation decision.

On-site survey dates	May 2 to 6, 2010
Report Issue Date:	September 7, 2010

Accreditation Decision	Accreditation

Locations

The following locations were visited during this survey visit:

1 Georgetown Hospital
2 Milton District Hospital
3 Oakville Trafalgar Memorial Hospital

Service areas

The following service areas were visited during this survey visit:

1 Ambulatory Care
2 Diagnostic Imaging
3 Emergency Department
4 Intensive Care Unit/Critical Care
5 Managing Medications
6 Maternal/Perinatal
7 Medicine
8 Mental Health
9 Operating Room
10 Rehabilitation
11 Sterilization and Reprocessing of Medical Equipment
12 Surgical Care

Surveyor's Commentary

The following global comments regarding the survey visit are provided:

The Halton Healthcare Services Corporation (HHS) is commended for its accomplishments. The organization has demonstrated strength in achieving the strategic priority of improving patient safety. A patient safety culture is embedded throughout HHS. Leaders and staff are committed, engaged and energized in providing a positive patient experience. The HHS has made significant strides in developing and implementing quality initiatives that have improved patient outcomes and patient safety.

The board and leadership are committed to quality improvement and patient safety, and expect good outcomes.

The organization has incredible capacity to meet goals and objectives. This is accomplished with perseverance, partnerships and staff engagement. Leaders at all levels use data to make informed decisions.

Team work and collaboration between staff, physicians, volunteers, and community partners was evident in all areas. Staff and physicians comment that HHS is a great place to work. New staff feel welcomed and supported.

The HHS is viewed as a leader in responding to community needs within the local health integrated network (LHIN). Members are active participants in several community initiatives such as the Baby Friendly Coalition, family physician support for the management of mental health patients, and presentations to the community relative to promoting health.

The organization uses ethics in decision making and it has completed an ethics needs assessments. Significant work in this area has resulted in a good foundation for the development of a framework. The organization should now develop an ethical framework to guide ethical decisions in clinical care, business, governance and research. A plan to educate staff and physicians on the new framework should be developed.

The medication management system does not use a unit dosing system except for the Georgetown site, where automated distribution units (ADU) are used. The HHS should continue with plans to implement ADUs at all sites.

A code green evacuation exercise has not been completed for several years. Education and has occurred. The HHS should carry out its plans in the fall to conduct a code green exercise.

The HHS is well aware of the future community health care needs and the exponential growth in its communities. It has developed plans to address these needs, which involve major capital redevelopment. The organization has been successful in securing funds for the new Oakville site redevelopment project. It is faced with a significant challenge for being able to provide safe care in the current Milton site, with such exponentially realized and projected growth and no approvals for capital redevelopment.

The HHS will be faced with the challenge of balancing the redevelopment of the new Oakville site hospital and continuing all of the planned initiatives. Since the new building will not be completed for a number of years, the organization will be challenged to make decisions related to aging of the building and how to accommodate current growth such as crowding in emergency (ER) at the Oakville site.

The HHS has been successful in creating a professional practice model that facilitates best practice and excellent patient outcomes. Accountability for doing a great job is evident across the organization. The program titled: "Good to Great" is viewed positively by several staff.

Several effective modes of communication are used internally and externally. Staff at all sites indicate that they are provided with adequate communication. The use of individual e mails is an effective tool to disseminate information at the sites. The senior team is visible and approachable.

The community does receive updates via newspapers, board newsletters and Foundation material. There are several community engagement activities at which the president and chief executive officer (CEO) present.

The board would benefit from developing a detailed annual communication plan, which should include an evaluation process to determine its effectiveness. Community partners suggested additional communication about proposed clinical services changes, including the rationale for the change for example, the movement of services from HHS to other hospitals in the LHIN.

The community partners involved in clinical care have a collaborative relationship with all members across the HHS. The organization is viewed as proactive and resilient when faced with challenges and also for being proactive in meeting the health care needs of the communities.

The commitment of the volunteers is outstanding.

Organization's Commentary

The following comments were provided to Accreditation Canada post survey.

The new Qmentum Accreditation program, involving an in-depth self-assessment, priority processes and the tracer methodology was viewed by all members of our organization as an engaging, worthwhile and comprehensive process. The survey team members from Accreditation Canada were non-threatening, very flexible, knowledgeable and excellent at engaging all of us, including our staff, physicians and volunteers. They readily recognized the staff for their accomplishments and quality initiatives.

Findings in the Report / Portal
We were very pleased with the results and felt our efforts and practices were recognized and acknowledged. For a few of the 'unmet' criteria, it would have been helpful to have clearer, more detailed 'Surveyor Comments'. There seemed to be some inconsistency between the on-site report 'comments' and the 'rationale' as outlined in the portal.

Accuracy of Findings in capturing successes/challenges
The survey team did an excellent job of recognizing our successes and safety-quality culture. For example; recognition of "committed, engaged and energized staff, embedded safety culture", "great capacity to meet goals and objectives because of our perseverance, partnerships and staff engagement":, "viewed as a leader in responding to community needs in the LHIN". They recognized our current and ongoing challenges related to balancing day-to-day operations with the re-development demands placed on the organization related to the New Oakville Hospital and Milton expansion. The survey team also recognized our significant space constraints as related to growth pressures and aging buildings, both of which create stressful works environments for patients and staff.

What did HHS Learn from the Qmentum Process?
The self-assessment process, pulse surveys and tracer methodology clearly supported engagement at all levels in our organization, particularly front-line staff. This enabled us to understand the significance of the standards and embedded safety and quality practices. The on-site survey process served to validate just how engaged we all were in understanding, believing in and meeting the standards (score of 97%).

Actions Currently Underway to Address Improvement
We are on a continuous quality improvement journey. For example: plans are already in place to embed our ethical framework throughout the organization and to build capacity. We will continue to test the robustness of our emergency codes to evaluate the emergency preparedness system. The implementation of medication reconciliation at admission and transfer points across the entire organization is a priority, as we implement the Medication Management Plan.

Meeting our Immediate and Long-term Actions to Improve Quality and Safety
HHS has made significant strides in developing and implementing quality initiatives that have improved patient outcomes and safety as noted by our surveyors. We will continue to be innovative in our approach to identifying opportunities for improvement and effectively spread, monitor and sustain changes.

Leading Practices

Recognizing innovation and creativity in Canadian health care delivery

Leading practices are commendable or exemplary organizational practices that demonstrate high quality leadership and service delivery. Accreditation Canada considers these practices worthy of recognition as organizations strive for excellence in their specific field, or commendable for what they contribute to health care as a whole. They may have been identified as a leading practice in a particular geographic region, or for a particular service delivery area or health issue.

Leading Practices
- are creative and innovative
- demonstrate efficiency in practice
- are linked to Accreditation Canada standards
- are adaptable by other organizations

Halton Healthcare Services Corporation is commended for the following:

Safer Elder Care

Of the patients admitted to Halton Healthcare's Oakville Hospital, 65% are age 65+, while those 85+ represent the fastest growing age group in the Halton Region. Clinical staff at Halton Healthcare Services recognized the unique needs of this population, and initiated an interdisciplinary 'delirium prevention' project in 2007 which evolved in 2009 to the 'Safer Elder Care' program which encompassed three other related projects – falls and restraint prevention and skin and wound care. A key aim has been to heighten awareness and hardwire best practices to address common inter-related geriatric issues.

Central to knowledge translation are a number of new clinical tools for staff, i.e., electronic screen prompts; practice protocols; screening tools (e.g. CAM and MORSE), physician order sets; new teaching tools for patients and families, a physician consultation process. Expertise was developed with 11 front-line Elder Care Mentors completing a month long intensive internship to gain proficiency in geriatric issues and 65 Champions spread across all 3 sites of HHS. Measures were set to evaluate our progress and patient outcomes.

An inter-professional steering team, engagement of frontline staff, and support from senior administration have been keys to our success in advancing our Safer Elder Care Program. In May 2009, our commitment to excellence in geriatric care was recognized when we were awarded NICHE designation, becoming the first non-teaching community hospital in Ontario to do so and connecting us to over 200 other NICHE organizations across North America. (Medicine Services)

PPID - Positive Patient Identification -Lab

Barcodes connect patients and samples to reduce error rate
To reduce the potential for errors that can and do occur while collecting, transporting and reporting patient tests, Halton Healthcare Services turned to barcode technology. In 2007, it became the first Canadian hospital to implement an electronic system to ensure positive patient identification (PPID). This bedside barcode technology identifies the patient and prints specimen labels, ensures that specimens are collected from the right patient, at the right time, and into the right specimen container.

This system-wide collaborative project, led by the Laboratory, was in response to a concerning error rate with specimen collection. The positive patient identification (PPID) project began incrementally, beginning with Lab collection service of all inpatients and Emergency patients; expanding to ICU (2008) and the Emergency department (2009) in partnership with Nursing .
PPID has reduced the specimen identification error rate from 3-3.5 collection errors per 1000 patients before PPID to a current rate of 0.02-0.04 collection errors per 1000 patients. Staff report improvements in collection accuracy, efficiencies through reduced turn-around times and a decreased need to repeat phlebotomies; and patients report increased confidence in their safety as a result of this initiative. The culture has shifted to a collaborative partnership between nursing and lab staff, and phlebotomy staff members are now vigilant ambassadors of safety for specimen management. (Critical Care Services)

Caring Rounds

The 'Caring Rounds' Program started in late 2009 as a collaborative effort among patients and families, teams in Medicine Services, and the Volunteer Program as a strategy to enhance patient satisfaction during hospitalization and improve readiness for discharge. Patients in the Medicine program are randomly surveyed by a specially recruited and trained group of Volunteers to assess their satisfaction with care, call bell responsiveness, pain management and preparation for discharge home. Any patient questions or concerns are promptly relayed to the key care providers and addressed quickly.

Early findings obtained from surveys of staff, volunteers and patients/families demonstrate that this patient-centered initiative serves as a catalyst for discussion of both positive and negative experiences of patients; is contributing to a closer relationship and rapport between the clinical staff and volunteers; provides an opportunity for patients and families to work with us to improve quality and contribute to 'just in time' response to problems; and demonstrates a genuine concern and responsiveness from team members. Data collection is underway and findings will be compared to our NRC-Picker data for similar time periods to determine the impact of the new process on the indicators being tracked. (Medicine Services)

Overview by Quality Dimension

The following table provides an overview of the organization's results by quality dimension. The first column lists the quality dimensions used. The second, third and fourth columns indicate the number of criteria rated as met, unmet or not applicable. The final column lists the total number of criteria for each quality dimension.

Quality Dimension	Met	Unmet	N/A	Total
Population Focus (Working with communities to anticipate and meet needs)	64	1	0	65
Accessibility (Providing timely and equitable services)	98	0	0	98
Safety (Keeping people safe)	427	29	8	464
Worklife (Supporting wellness in the work environment)	124	5	1	130
Client-centred Services (Putting clients and families first)	125	2	2	129
Continuity of Services (Experiencing coordinated and seamless services)	52	0	0	52
Effectiveness (Doing the right thing to achieve the best possible results)	587	6	11	604
Efficiency (Making the best use of resources)	61	2	1	64
Total	**1538**	**45**	**23**	**1606**

Overview by Standard Section

The following table provides an overview of the organization by standard section. The first column lists the standard section used. The second, third and fourth columns indicate the number of criteria rated as met, unmet or not applicable. The final column lists the total number of criteria for that standard section.

Standard Section	Met	Unmet	N/A	Total
Sustainable Governance	90	1	0	91
Effective Organization	98	6	0	104
Infection Prevention and Control	99	1	3	103
Ambulatory Care Services	104	4	12	120
Critical Care Services	106	3	0	109
Diagnostic Imaging Services	100	3	1	104
Emergency Department Services	102	3	0	105
Managing Medications	126	7	2	135
Medicine Services	104	0	0	104
Mental Health Services	104	4	1	109
Obstetrics/Perinatal Care Services	114	5	0	119
Operating Rooms	101	0	0	101
Rehabilitation Services	97	4	2	103
Reprocessing and Sterilization of Reusable Medical Devices	94	1	2	97
Surgical Care Services	99	3	0	102
Total	**1538**	**45**	**23**	**1606**

Overview by Required Organizational Practices (ROPs)

Based on the accreditation review, the table highlights each ROP that requires attention and its location in the standards.

All Required Organizational Practices (ROPs) have been met by this organization. There is no follow-up required.

Detailed Accreditation Results

System-Wide Processes and Infrastructure

This part of the report speaks to the processes and infrastructure needed to support service delivery. In the regional context, this part of the report also highlights the consistency of the implementation and coordination of these processes across the entire system. Some specific areas that are evaluated include: integrated quality management, planning and service design, resource allocation, and communication across the organization.

Findings

Following the survey, once the organization has the opportunity to address the unresolved criteria and provide evidence of action taken, the results will be updated to show that they have been addressed.

Planning and Service Design

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

Surveyor Comments

The organization is working on several initiatives and has indicated that it has the capacity to meet these, as well as achieving positive outcomes.

Good planning processes are in place to determine future needs and how the health care needs of the community should be addressed currently, and into the future. Examples are the new Oakville site hospital, and renovations in the maternal child area and mental health areas. The HHS has developed excellent plans to address the health care needs in the form of capital planning and continues to press for approval by the funder.

Members across the organization were involved in the development of the strategic plan.

Community partners indicate that the organization forms strong partnerships that improve patient care, with mental health services, maternal child services, clinical realignment, pandemic and N1H1 planning being a few examples. The HHS is viewed as proactive and resilient when faced with challenges.

Several community partners commented that HHS consults and works with them when planning programs and services.

Although partners commented that there are several modes of communication to the community; they did identify improvement areas. For example, progress towards the achievement of the strategic plan, and when changes in services are being made to include the rationale for the decision.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Effective Organization		
The organization's leaders develop and implement an ethics framework which is adopted by the governing body, where applicable.	5.3	↑

Resource Management

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

Surveyor Comments

Financial and utilization reports are comprehensive.

The board makes financial decisions, based on the organization's mission, vision, values (MVV) and the health care needs of the community.

All levels of management are well engaged in the budget and variance analysis process and are supported by the business operations consultants.

No Unmet Criteria for this Priority Process.

Human Capital

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

Surveyor Comments

The organization has implemented Kailo as an approach to employee wellness and it has been demonstrated as a success from various staff surveys (best practice). The employee wellness is a priority for the organization. Volunteers are very happy working at the three sites They are very motivated and satisfied with the organization.

The sustainable work force project (SWFP) is a success and has proven to benefit the organization as a whole.

Staff are very satisfied with their employment at HHS, as demonstrated in the staff satisfaction survey. Action has been taken to address the areas of concerns.

Performance appraisal completion is at seventy four percent. The organization needs to make an effort to complete all performance appraisals of staff, even in the ever changing environment.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Effective Organization		
The organization’s leaders implement policies and procedures to monitor performance.	12.9	

Integrated Quality Management

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

Surveyor Comments

The board is very supportive of creating a culture of patient safety and has developed an effective corporate performance dashboard to monitor quality and patient safety. Annually, each of the programs/departments provides a comprehensive quality report to the board that includes all of the quality dimensions. The HHS has been successful in developing a culture of patient safety and staff across all sites and it is committed to improving patient safety and providing quality service.

Evidence is used to develop best clinical practices and management decisions.

There are several corporate initiatives that facilitate patient safety. These include safer elder care, senior team walk abouts, safety huddles, and the wound management program.

Staff and leaders are proud of their accomplishments and continually strive for excellence.

The organization's leaders and staff are very focused on patient safety and improving quality.

The HHS is recognized for its innovative Patient Safety Expo 2009 Celebrating Achievements Awards, at which staff are rewarded for their contribution towards patient safety.

The organization provides monthly incident reports to the quality care committee. However, in following the adverse event tracer it became evident that there is not a consistent approach to reporting the adverse event and the follow up to the board on a quarterly basis. Currently, the process is that the quality committee receives monthly reports that include incident report statistics. The board receives annual, program quality reports hence, it could be up to one year before the plans to address the adverse event is brought to the attention of the board, unless there is potential media involvement.

No Unmet Criteria for this Priority Process.

Principle Based Care and Decision Making

Identifying and decision making regarding ethical dilemmas and problems.

Surveyor Comments

The governing body has used multiple sources of information to confirm that staff are living the values. Sources include annual program presentations, medical staff appointment process, recruitment process, and 360 performance review.

The board receives first hand information on the values in the complaints and compliments stories that are presented regularly to the quality committee of the board of directors.

There is an established process for review of research proposals from both a resources utilization and in terms of scientific merit. This work could be strengthened from an ethics perspective, with the involvement of an ethicist as the implementation of the newly developed ethics framework moves forward in the organization.

Outstanding foundational work has been completed to conduct a corporate ethics needs assessment and develop a best practice ethics framework, which is intended to guide ethical decision making in clinical care, business processes, and research.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Effective Organization		
The organization's leaders assign responsibility for monitoring the ethics framework and the processes to address ethics-related issues.	5.7	↑
The organization's leaders build the organization's capacity to apply the ethics framework by encouraging the governing body, leaders, staff, and service providers to develop and enhance their ethics-related knowledge.	5.8	↑

Communication

Communication among various layers of the organization, and with external stakeholders.

Surveyor Comments

The board is very active in its three local communities.
Each of the clinical program presents an annual quality report to the board quality committee.
The board fully understands the quality initiatives occurring at HHS.
The board did hired an external consultant to assist with the communication of the new Oakville hospital. This has proven an effective process.
Staff at all sites are all very pleased and appreciate the pizza with the president event, as it is an effective communication method.
The board communicates to the community via a variety of speaking engagements and its newsletter.

An information technology (IT) audit was completed in 2007. It may be worthwhile to repeat this audit over the next 12 months.
The board would benefit from a detailed, annual communication plan that should include an evaluation process to determine effectiveness.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Sustainable Governance		
The governing body works with the CEO to establish a communication plan.	11.3	

Physical Environment

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

Surveyor Comments

The Green initiative is a valued services (best practice) as it decreases the impact of waste on the environment. The team has implemented various communication tools to engage stakeholders and this has proven very successful overall.

The three establishments at Oakville, Milton and Georgetown are aging. Maintenance initiatives are in place for restoration. Repairs to floors and walls in the outside hallway of dialysis and in the dialysis area are recommended to ensure safety.
Space for work at all three sites is an issue and the organization must monitor the situation to ensure that safety to patient, staff or volunteers does not become a problem in this environment.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Effective Organization		
The organization’s physical space meets applicable laws, regulations, and codes.	10.1	↑

Emergency Preparedness

Dealing with emergencies and other aspects of public safety.

Surveyor Comments

The organization has started implementing the incident management system (IMS) model when dealing with emergencies. The IMS model is not fully implemented currently, but will become the main process used to deal with all emergencies. Staff were very enthusiastic and engaged in the recent mock codes.

There is need to ensure that the mock code green will be done in September 2010, as it has not been performed recently.

The pandemic H1N1 was well done and changes for improvement have been implemented in the policy.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Effective Organization		
The organization's leaders regularly test the organization's disaster and emergency plans with drills and exercises.	11.8	↑

Patient Flow

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

Surveyor Comments

Significant work has been done to address the flow through in the emergency department s (ER) .This includes the development of the rapid assessment zone (RAZ) in Oakville and the rapid assessment fast track (RAFT) in Georgetown and Milton. The provincial health minister has extended congratulations regarding this progress.
The ER staff are very pleased with the addition of an emergency room discharge planner, which facilitates flow in the department .
The electronic transfer record allows for clear, current patient information from the ER to the unit, and the ER staff and unit nurses are very pleased with this document.
The adoption of the joint discharge operations (JDO) meetings has facilitated excellent sharing of strategies across all the HHS sites. This has contributed to a dramatic reduction in alternate level of care (ALC) rates.
The hospital is initiating a data driven estimated date of discharge (EDD) to appear on all patients' charts at the time of admission. This will assist with length of stay.
The surgical leadership has substantially decreased the non urgent surgeries performed after hours and on weekends.
The use of white boards on clinical units has provided an excellent communication tool for the physicians and the nurses. This facilitates not only better coordination of care but also potential discharge difficulties.

The sites should continue to work with Community Care Access Centre (CCAC) and their local communities to strategically plan for an aging population that will require increasing long term care (LTC) or supportive housing support. This is especially important for their hard to serve clientele.

No Unmet Criteria for this Priority Process.

Medical Devices and Equipment

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

Surveyor Comments

The Milton site appears to have a lack of bio medical resources to ensure that all preventive maintenance (PMs) are performed on the equipment in a timely manner. A greater amount of resources is required.
The bio medical staff have an insufficient amount of space to perform their functions safely. For instance, they must go outside to spray, as there is a lack of appropriate ventilation in the work environment.
The operating room (OR) and CSR departments have made tremendous improvements in the functioning of these areas, using the "lean" initiative. This lean initiative was extremely well done with patient safety and quality set as a priority.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Reprocessing and Sterilization of Reusable Medical Devices		
The team follows manufacturers' instructions to select and perform appropriate cleaning methods.	8.5	↑

Direct Service Provision

This part of the report provides information on the delivery of high quality, safe services. Some specific areas that are evaluated include: the episode of care, medication management, infection control, and medical devices and equipment.

Findings

Following the survey, once the organization has the opportunity to address the unresolved criteria and provide evidence of action taken, the results will be updated to show that they have been addressed.

Ambulatory Care Services

Clinical Leadership

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

Surveyor Comments

The plan to open a satellite site in Burlington to provide a dialysis service is an excellent initiative.
Best practices are being used as a guideline in the operation of the service.
Excellent Initiatives such as foot care is moving the organization forward to decrease incidences of amputation with a closer monitoring of patient/client feet.
Strong relationships are established with partners in providing pre dialysis and dialysis service.
There is a great team approach in providing the service between physicians, management and staff.
Work environment space is of concern, and monitoring for potential of safety issues is recommended.
The initiative for fall risk assessment will be implemented to minimize falls of hemodialysis patients.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team has access to designated, private treatment or service areas.	10.1	

Competency

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

Surveyor Comments

No comments are identified for this section of the report.

No Unmet Criteria for this Priority Process.

Episode of Care

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

Surveyor Comments

The kidney function clinic is providing excellent education to all its patients and this includes classes on a variety of health issues and any other related topic.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team reconciles the client's medications as part of the assessment process, with the involvement of the client.	8.3	↑
There is a demonstrated, formal process to reconcile client medications upon admission.	8.3.1	
The process includes generating a comprehensive list of all medications the client has been taking prior to admission.	8.3.2	
The process includes a timely comparison of the prior-to-admission medication list with the list of new medications ordered at admission.	8.3.3	
The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made where necessary.	8.3.4	

The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff, and pharmacists, as appropriate.	8.3.5
Medication Reconciliation at Admission	8.4
The team follows Accreditation Canada's protocols and definitions to collect and submit data on medication reconciliation at admission.	8.4.1
The team does not have any unaddressed priority for action flags based on their medication reconciliation at admission indicator results.	8.4.2
The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.	12.2
There is a demonstrated, formal process to reconcile client medications at referral or transfer.	12.2.1
The process includes generating a comprehensive list of all medications the client has been taking prior to referral or transfer.	12.2.2
The process includes a timely comparison of the prior-to-referral or prior-to-transfer medication list with the list of new medications ordered at referral or transfer.	12.2.3
The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made.	12.2.4
The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff and pharmacists, as appropriate.	12.2.5
The organization has a documented plan to implement throughout the organization, and before the next accreditation survey, a medication reconciliation process at referral and transfer.	12.2.6

Decision Support

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

Surveyor Comments

No specific comments are identified.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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

Surveyor Comments

No specific comments are identified.

No Unmet Criteria for this Priority Process.

Critical Care Services

Clinical Leadership

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

Surveyor Comments

The cross training initiative between the critical care areas and the wards provides surge capacity and maintenance of competency.

No Unmet Criteria for this Priority Process.

Competency

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

Surveyor Comments

Staff morale appears very high. There are currently no recruitment or retention issues.
Staff are very pleased that managers/directors encourage continuing medical education (CME).
However, across the three sites there is discrepancy in funding of these courses for the staff.
Cross training between the critical care and medical units facilitates continuity of care, capacity and maintenance of skills.

No Unmet Criteria for this Priority Process.

Episode of Care

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

Surveyor Comments

Oakville's rapid response team known as C.C.O.T, has dropped the readmission rate to ICU/CCU significantly. The hospital has also noticed a very significant change in the frequency of cardiac arrests in the hospital.
The positive patient Identification device (PPID) facilitates labelling at the bedside and significantly reduces labelling error. Pre implementation, there were 3-3.5 collection errors per 1000 patients collected, as compared to 0.02-0.04 collection errors per 1000 patients when PPID is utilized.
Families and patients are very pleased with the support and education they receive from the staff and physicians.

Encouragement is offered to practice the mock codes, specifically evacuation needs to be carried out to ensure that all staff are aware of the process.
The organization would benefit from hospital wide standardization of its crash carts.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team reconciles the client's medications upon admission to the organization, with the involvement of the client.	7.4	↑
There is a demonstrated, formal process to reconcile client medications upon admission.	7.4.1	
The process includes generating a comprehensive list of all medications the client has been taking prior to admission.	7.4.2	
The process includes a timely comparison of the prior-to-admission medication list with the list of new medications ordered at admission.	7.4.3	
The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made where necessary.	7.4.4	
The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff, and pharmacists, as appropriate.	7.4.5	
Medication Reconciliation at Admission	7.5	
The team follows Accreditation Canada's protocols and definitions to collect and submit data on medication reconciliation at admission.	7.5.1	
The team meets Accreditation Canada's recommended target for medication reconciliation at admission.	7.5.2	
The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.	11.5	
There is a demonstrated, formal process to reconcile client medications at referral or transfer.	11.5.1	
The process includes generating a comprehensive list of all medications the client has been taking prior to referral or transfer.	11.5.2	
The process includes a timely comparison of the prior-to-referral or prior-to-transfer medication list with the list of new medications ordered at referral or transfer.	11.5.3	
The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made.	11.5.4	

The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff and pharmacists, as appropriate.	11.5.5

Decision Support

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

Surveyor Comments

The ICU is closed at the Oakville site. Rounds by the admitting physician occur every morning, along with the interdisciplinary team.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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

Surveyor Comments

The critical care team actively participates in continuing nursing education with the "Grow Your Own" program.
The team is actively looking at the Safer Healthcare Now Central Line (CLI) bundle results to determine potential cause for the slight increase in infection rates.

No Unmet Criteria for this Priority Process.

Diagnostic Imaging Services

Impact on Outcomes

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

Surveyor Comments

No specific comments are identified.

No Unmet Criteria for this Priority Process.

Diagnostic Services - Diagnostic Imaging

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

Surveyor Comments

The diagnostic imaging (DI) service has overgrown its capacity at all three sites due to the increase in population. Wait times in certain modalities are proving to be excessive.

Work has been implemented to improve processes in magnetic resonance imaging (MRI) using the Lean methodology.

The space allocated to DI is of concern and it needs to be assured that safety is not impeded.

There is excellent policy and procedure in MRI for safety. Work is ongoing to standardize practices at the three sites.

The safety committee is an asset to identify and remove any safety issues related to diagnostic imaging.

The interpretation on average is done within 48 hours but in certain areas, this is not achieved.

Ultrasound at Milton needs to remove contaminated biopsy items (bin) from the ultrasound work area to the soiled room to decrease cross contamination.

Overall, there is an impressive work flow that ensures patient satisfaction, safety and quality. Staff are clear about the expectation and collaborate on various strategies for improvement.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team has separate areas for administration.	4.1	
All DI reprocessing areas are equipped with separate clean and decontamination work areas as well as separate storage, dedicated plumbing and drains, and proper air ventilation.	7.6	↑
The team interprets diagnostic results as soon as possible and within 48 hours of conducting the examination.	11.1	

Emergency Department Services

Clinical Leadership

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

Surveyor Comments

The volunteers are active and respected members of the emergency teams.
There is excellent rapport between the physicians, nurses and consultants at all three sites.

The senior team and board are well aware of the issues concerning capacity of the emergency rooms at all three sites. This will continue to be a significant issue.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team has the workspace needed to deliver effective services in the Emergency Department.	2.8	

Competency

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

Surveyor Comments

It is recommended that the nurses be strongly encouraged to obtain their certification in advanced cardiac life support (ACLS), pediatric advanced life support (PALS), and neonatal resuscitation (NRP . This is very important for the Milton and the Georgetown sites.

No Unmet Criteria for this Priority Process.

Episode of Care

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

Surveyor Comments

-The EMS personnel speak very highly of the professionalism/team work the emergency room staff provide to assist with off load delays.
-The "Electronic Transfer" records between the emergency department and inpatient wards ensures excellent communication at time of transfer.
-The staff should be congratulated on becoming one of the best performing hospital in managing "admitted patients."
-The ED Controller role has been developed to improve the patient flow thru the emergency department and to ensure that the 'ED Pay for results" metrics of triage are met.

-The Oakville emergency department has out grown it's location.A LEAN initiative would help with the organization of the unit until the new hospital has been built.
-The Oakville site should be encouraged to replace the waste hopper in the acute clinical area.
-Milton has developed an excellent RAFT(Rapid Assessment Fast Track) in conjunction with the Day Surgery program.As the population has grown in Milton they will need to look at alternative solutions to this shared arrangement.
-Oakville site has completed the Med Reconciliation process,the other sites have a planned implementation plan over the next 12 months.
-Georgetown has completed a Lean program but space will continue to be an issue.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team reconciles the client's medications following triage, with the involvement of the client.	8.3	↑
There is a demonstrated, formal process to reconcile client medications at triage.	8.3.1	
The process includes generating a comprehensive list of all medications the client has been taking prior to admission.	8.3.2	
The process includes a timely comparison of the prior-to-admission medication list with the list of new medications ordered at admission.	8.3.3	
The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made where necessary.	8.3.4	
The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff, and pharmacists, as appropriate.	8.3.5	
Medication Reconciliation following triage.	8.4	
The team follows Accreditation Canada's protocols and definitions to collect and submit data on medication reconciliation following triage.	8.4.1	
The team has addressed all priority for action flags, based on results of their indicator "medication reconciliation at admission".	8.4.2	

Decision Support

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

Surveyor Comments

The development of the electronic transfer form/record has standardized the communication between the emergency department and in patients units. This provides a safe and effective hand off.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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

Surveyor Comments

New laser device namely, the PDDI scans patients identification wrist bands confirming the patient's name and printing the appropriate labels. This identification device has dramatically reduced sampling errors.

Hand washing by staff and especially physicians needs to be reinforced.

No Unmet Criteria for this Priority Process.

Infection Prevention and Control

Infection Prevention and Control

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

Surveyor Comments

There is a well established interdisciplinary team whose membership includes all stakeholders, including employee health, environmental control, and a well engaged pharmacist, which is a notable team strength.

Environmental Services' isolation team of 21 additional FTEs , along with new isolation carts and mattresses have been put in place to address the C. difficile rates

There is a well established best practice, anti microbial stewardship program, underway since January 2009 and it is showing positive results.

There is partnership and participation in the LHIN's regional infection control network collaborative to transfer infection control best practices such as for management of asymptomatic urinary tract infections.

The physical environment for the reprocessing of endoscopes does not have distinctly separate areas equipped with adequate ventilation, as required by the provincial infectious diseases advisory committee's 2006 best practices for cleaning, disinfection and Sterilization.

Molecular microbiology technology would assist in the timely detection and management of outbreaks of infection.

The team organization would benefit from a consistent process across all three sites to report surgeon specific surgical site infections back to individual surgeons and the peri operative team.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
All endoscope reprocessing areas are equipped with separate clean and decontamination work areas as well as storage, dedicated plumbing and drains, and proper air ventilation.	13.4	🡅

Managing Medications

Medication Management

Interdisciplinary provision of medication to clients.

Surveyor Comments

The pharmacy team is a motivated high functioning team that is committed to patient safety and improving outcomes.

The after hours medication system is effective and provides security.

The pharmacy and therapeutics committee is committed and effective. It has implemented several best practices that have led to improvements in patient safety for example, antibiotic stewardship. The committee is encouraged to explore strategies to improve physician attendance.

The pharmacy team is encouraged to complete audits related to outdated stock medications that is, medications with a reduced shelf life once they are opened.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Medications for client service areas are stored in labelled, unit dose packaging.	7.4	↑
The organization develops and follows a policy or procedure to maintain clinically accurate, known adverse drug reactions for each client in the ongoing medication profile.	10.7	↑
The pharmacy and other service providers accept telephone orders for medication only in emergencies.	10.10	↑
The organization provides quiet work areas where medication orders are written, transcribed, and entered into computer systems.	10.12	
The pharmacy computer system is used to perform dose range checks and to warn staff and service providers about low and high doses for high alert medications.	11.4	↑
The organization provides workspace to pharmacy staff to support safe and effective preparation of medications.	12.1	
The pharmacy dispenses medications using a unit dose packaging system.	13.3	↑

Medicine Services

Clinical Leadership

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

Surveyor Comments

The medical program has responded to the needs of a clinically diverse and aging patient populations in the following three areas: elder care across the continuum; patient safety; and, improvement of clinical outcomes.

Collaborative planning with the LHIN partners, to align activities to support the CODE STEMI project and the adoption of best practices of the acute cardiac services project, ensures timely access to cardiac care.

There is now increased renal capacity and services, with the opening of the Burlington satellite dialysis centre.

There is an anti microbial stewardship program to help decrease the incidence of C. difficile and the emergence of antibiotic resistant organisms (AROs).

No Unmet Criteria for this Priority Process.

Competency

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

Surveyor Comments

There is a well integrated team, whose members are committed to excellence via evidence based care, and continuous professional learning.

Nursing peer review and colleague to colleague feedback builds clinical capacity and ongoing professional learning.

No Unmet Criteria for this Priority Process.

Episode of Care

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

Surveyor Comments

There are good communication tools in place between the medical services and across all clinical areas.

Volunteers conduct daily "caring rounds" on all patients to proactively address patient satisfaction.

The "Home First" and "Wait at Home" programs has resulted in timely discharge of patients and has decreased ALC by seventeen percent.

No Unmet Criteria for this Priority Process.

Decision Support

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

Surveyor Comments

There exists a strong evidence based approach to care.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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

Surveyor Comments

The team is actively engaged in transfer of evidence based practices to improve patient outcomes.

The safer elder care program has significantly reduced delirium, patient falls and pressure ulcers.

No Unmet Criteria for this Priority Process.

Mental Health Services

Clinical Leadership

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

Surveyor Comments

There are well established processes in place to review the increasing referral patterns and demographics of the adult and child psychiatric patient populations to address care needs across the continuum.
The concurrent disorder program promotes management of non psychiatric medical illness in addition to the mental health needs of patient along the entire continuum of care.

An addictions psychiatrist was hired to address the specific needs of mental health patients with addictions.

An employee assistance program (EAP) is in place.

A formal debriefing is done following all code whites.

No Unmet Criteria for this Priority Process.

Competency

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

Surveyor Comments

There is a notable commitment to excellence via evidence based care, and continuous professional learning.

The Quality of Work Life process is a best practice that has resulted in a thirty two percent decrease in staff turnover and a fifty percent decrease in sick time.

Psycho geriatrics and child and adult psychiatry are high demand areas, with few specialists to recruit.

No Unmet Criteria for this Priority Process.

Episode of Care

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

Surveyor Comments

The mental health team has worked proactively with other programs to implement a corporate policy to manage off service clients/patients at risk of suicide.

Patient discharge care needs are pre booked, depending on the urgency, via a number of programs. Out patient services notify the in patient unit if the appointments are not kept in order to allow for follow up on high risk patients..

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team reconciles the client’s medications upon admission to the organization, with the involvement of the client.	7.6	↑
The process includes a timely comparison of the prior-to-admission medication list with the list of new medications ordered at admission.	7.6.3	
The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made where necessary.	7.6.4	
The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff, and pharmacists, as appropriate.	7.6.5	
Medication Reconciliation at Admission	7.7	
The team follows Accreditation Canada’s protocols and definitions to collect and submit data on medication reconciliation at admission.	7.7.1	
The team does not have any unaddressed priority for action flags based on their medication reconciliation at admission indicator results.	7.7.2	

The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.	11.3	
There is a demonstrated, formal process to reconcile client medications at referral or transfer.	11.3.1	
The process includes generating a comprehensive list of all medications the client has been taking prior to referral or transfer.	11.3.2	
The process includes a timely comparison of the prior-to-referral or prior-to-transfer medication list with the list of new medications ordered at referral or transfer.	11.3.3	
The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made.	11.3.4	
The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff and pharmacists, as appropriate.	11.3.5	
The organization has a documented plan to implement throughout the organization, and before the next accreditation survey, a medication reconciliation process at referral and transfer.	11.3.6	
Following transition or end of service, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning, as appropriate.	11.5	↑

Decision Support

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

Surveyor Comments

A shared care model of care between the hospitalist and psychiatrist ensures that non psychiatric care needs are addressed.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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

Surveyor Comments

The mental health team provides ongoing education and consultation to effectively manage off service suicide risk patients.

There has been a decrease in code whites and improvement in the use of physical and chemical restraints as a result of the de escalation training provided by the MH team. Mental health staff attend all code whites in the organization.

The MH program has achieved excellent results relative to corporate priorities.

No Unmet Criteria for this Priority Process.

Obstetrics/Perinatal Care Services

Clinical Leadership

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

Surveyor Comments

The Milton and Georgetown sites projections demonstrate that the growth in deliveries will present issues relative to inadequate space to accommodate additional deliveries. The organization is waiting for MOHLTC approval.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team works together to develop team goals and objectives.	2.1	

Competency

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

Surveyor Comments

There exist well integrated teams, committed to excellence via evidence based care, and continuous professional learning at all three sites.
The birthing staff, physicians, and midwives at all three sites of HHS are enrolled in the management of obstetrical risk (MORE-OB), which is an internationally recognized three year educational, team building, competency based program designed to improve patient safety and quality outcomes across the care continuum. Module one has been successfully completed, with demonstrated improvement for all four disciplines.

The birthing rooms at the Oakville site do not have adequate space to accommodate family participation in the birthing experience.

No Unmet Criteria for this Priority Process.

Episode of Care

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

Surveyor Comments

At the Georgetown site, discharged patients can call the in patient unit any time, 24/7 for the first six weeks post partum and also can return as an out patient and receive care/support for breast feeding, newborn care, and so on.

Patients above the level of care provided are transferred out to a designated area facility that offers a higher level of care.

The organization should be encouraged to develop a corporate consent form for all three sites.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team reconciles the client’s medications upon admission to the organization with the involvement of the client.	7.11	↑
There is a demonstrated formal process to reconcile client medications upon admission.	7.11.1	
The process includes generating a documented, comprehensive list of the current medications that the client has been taking prior to admission to the organization.	7.11.2	
The process includes a timely review of this prior-to-admission medication list with the list of new medications ordered at admission.	7.11.3	
The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made where necessary.	7.11.4	
These processes are a shared responsibility, involving the client, nursing staff, medical staff, and pharmacists, as appropriate.	7.11.5	
Medication Reconciliation at Admission.	7.12	
The team follows Accreditation Canada’s protocols and definitions to collect and submit data on medication reconciliation at admission.	7.12.1	
The team does not have any unaddressed priority for action flags based on their medication reconciliation at admission indicator results.	7.12.2	

The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.	11.3	
There is a demonstrated, formal process to reconcile client medications at referral or transfer.	11.3.1	
The process includes generating a single documented, comprehensive list all medications the client has been taking prior to referral or transfer.	11.3.2	
The process includes a timely comparison of the prior-to-referral or transfer medication list with the list of new medications ordered at referral or transfer.	11.3.3	
The process requires documentation that differences between the two lists have been identified, discussed, and resolved, and that appropriate modifications to the new medications have been made.	11.3.4	
The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff and pharmacists, as appropriate.	11.3.5	
Following transition or end of service, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning.	11.5	↑

Decision Support

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

Surveyor Comments

Evidence based tri site policies and procedures are available on line.

Certification in the acute care of at risk newborns (ACORN) is in place at the Georgetown site.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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

Surveyor Comments

The high patient and family satisfaction with the obstetrical care and service across all three sites is notable.

The organization will benefit from the work that is under way to carry out regular analysis of the performance indicators being collected in order to engage the front line team and make improvements in a more timely way.

No Unmet Criteria for this Priority Process.

Rehabilitation Services

Clinical Leadership

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

Surveyor Comments

The team participates in several LHIN wide initiatives that improve patient care. Examples are the Greater Toronto Area (GTA) Rehabilitation Stroke Steering Committee, and the Ontario Bone and Joint Network.

A significant number of program goals and objectives are developed and achieved, which have resulted in improved services. For example, the implementation of the Alpha functional independent measure (FIM) assessment tool has resulted in more appropriate admissions to rehabilitation.

No Unmet Criteria for this Priority Process.

Competency

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

Surveyor Comments

The rehabilitation team has embraced an interdisciplinary model of care that has resulted in improved coordination of services and patient outcomes. The team works well together and the physicians are engaged.

New staff commented that the orientation program is excellent. The team is very welcoming and mentors new graduates.

Patients and families are very satisfied with the care and they appreciate the team approach.

No Unmet Criteria for this Priority Process.

Episode of Care

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

Surveyor Comments

The team has a process to manage the wait list that is focused on the individual patient's needs.

The therapist's assessments have been combined, which has resulted in the patient only having to provide the information once.

Nursing should continue to increase the use of electronic charting, including the rounds discussions and care plans.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team reconciles the client's medications upon admission to the organization, with the involvement of the client.	7.4	↑
There is a demonstrated, formal process to reconcile client medications upon admission.	7.4.1	
The process includes generating a comprehensive list of all medications the client has been taking prior to admission.	7.4.2	
The process includes a timely comparison of the prior-to-admission medication list with the list of new medications ordered at admission.	7.4.3	
The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made where necessary.	7.4.4	
The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff, and pharmacists, as appropriate.	7.4.5	
Medication Reconciliation at Admission	7.5	
The team follows Accreditation Canada's protocols and definitions to collect and submit data on medication reconciliation at admission.	7.5.1	
The team does not have any unaddressed priority for action flags based on their medication reconciliation at admission indicator results.	7.5.2	
The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.	11.3	
There is a demonstrated, formal process to reconcile client medications at referral or transfer.	11.3.1	
The process includes generating a comprehensive list of all medications the client has been taking prior to referral or transfer.	11.3.2	
The process includes a timely comparison of the prior-to-referral or prior-to-transfer medication list with the list of new medications ordered at referral or transfer.	11.3.3	

The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made.	11.3.4
The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff and pharmacists, as appropriate.	11.3.5

Decision Support

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

Surveyor Comments

The team effectively utilizes best practices and research to improve outcomes and one example is the excellent improvement in wound management outcomes.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team meets applicable legislation for protecting the privacy and confidentiality of client information.	12.2	

Impact on Outcomes

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

Surveyor Comments

The interdisciplinary team is very focused on the patient goals and ensuring that the patient remains safe in meeting these. The individual patient's needs are incorporated into the care plan that is updated on a regular basis.

There is strong commitment by members of the program to provide quality and safe care. For example, the team implemented colour codes for wheeled devices that informs the health care provider of patient ambulation care needs.

Currently, the staff do use strategies to reduce falls. An organization wide enhanced falls prevention program has been developed and is planned for implementation.

Patients indicated that they receive verbal information relative to their role in patient safety. While there are pamphlets available that relate to patient safety; patients indicated that they did not read these as they were so lengthy. The team has an informative patient handout that provides information on patients' rights and responsibilities. The team should consider revising the document to include specific patient safety responsibilities.

Interdisciplinary rounds with the patient and family are well received by families and is a good practice. Ensuring privacy during these sessions is required.

No Unmet Criteria for this Priority Process.

Surgical Procedures

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

Surveyor Comments

Staff nurses are given booklets to monitor their own continuing medical education(CME),Staff appreciate that they can plan their own CME around their specific needs.-Surgical Safety Checklist has been implemented at all three sites.They are to be congratulated on their compliance.The specific surgeon data is posted within the department.-The staff at all sites (ORs and CSRs) should be congratulated on the completion of the LEAN initiative which has substantially improved the layout of the department and significant cost reductions.
Flash sterilization is rarely used. When required the documentation is appropriate.
The HHS should be congratulated on the implementation of their Acute Pain Service. Patient satisfaction at all three sites is extremely high. An audit at the Milton site demonstrated 94.75% ' very satisfied or satisfied' rate.
The implementation of the wound care PPC Program has reduced the pressure ulcer rate from 27.8(2008) to 16.%(2009).This program was modified from the Credit Valley and St Michael's program involves patients and their families in the program.
Patients were very pleased with the cultural sensitivity surrounding their religious beliefs during their surgical stay.

There is a documented plan for medication reconciliation over the next 12 months.
The organization should be encouraged to develop a corporate consent form for all three sites .
The organization should add CJD(Creutzfeldt-Jakob Disease) to the pre op check list.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Surgical Care Services		
The team reconciles the client’s medications upon admission to the organization, with the involvement of the client.	7.10	↑
There is a demonstrated, formal process to reconcile client medications upon admission.	7.10.1	
The process includes generating a comprehensive list of all medications the client has been taking prior to admission.	7.10.2	
The process includes a timely comparison of the prior-to-admission medication list with the list of new medications ordered at admission.	7.10.3	

The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made where necessary.	7.10.4
The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff, and pharmacists, as appropriate.	7.10.5
Medication Reconciliation at Admission	7.11
The team follows Accreditation Canada's protocols and definitions to collect and submit data on medication reconciliation at admission.	7.11.1
The team does not have any unaddressed priority for action flags based on their medication reconciliation at admission indicator results.	7.11.2
The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.	11.4
There is a demonstrated, formal process to reconcile client medications at referral or transfer.	11.4.1
The process includes generating a comprehensive list of all medications the client has been taking prior to referral or transfer.	11.4.2
The process includes a timely comparison of the prior-to-referral or prior-to-transfer medication list with the list of new medications ordered at referral or transfer.	11.4.3
The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made.	11.4.4
The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff and pharmacists, as appropriate.	11.4.5

Performance Measure Results

The following section provides an overview of the performance measures collected for the entire organization. These measures consist of both instrument and indicator results, which are valuable components of evaluation and quality improvement.

Instrument Results

The instruments are questionnaires completed by a representative sample of clients, staff, leadership and/or other key stakeholders that provide important insight into critical aspects of the organization's services. The following tables summarize the organization's results and highlight each item that requires attention. Results are presented in three main areas: governance functioning, patient safety culture and worklife.

Governance Functioning Tool

The Governance Functioning Tool is intended for members of the governing body to assess their own structures and processes and identify areas for improvement. The results reflect the perceptions and opinions of the governing body regarding the status of its internal structures and processes.

Summary of Results

	Governance Structures and Processes	% Agree	% Neutral	% Disagree	Priority for Action
		Organization	Organization	Organization	
1	We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	100	0	0	
2	We have explicit criteria to recruit and select new members.	100	0	0	
3	Our renewal cycle is appropriately managed to ensure continuity on the governing body.	100	0	0	
4	The composition of our governing body allows us to meet stakeholder and community needs.	100	0	0	
5	Clear written policies define term lengths and limits for individual members, as well as compensation.	100	0	0	
6	We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations.	100	0	0	
7	Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	100	0	0	
8	We review our own structure, including size and sub-committee structure.	100	0	0	
9	We have sub-committees that have clearly-defined roles and responsibilities.	100	0	0	
10	Our roles and responsibilities are clearly identified and distinguished from those delegated to the CEO and/or senior management. We do not become overly involved in management issues.	100	0	0	
11	We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decision-making.	90	0	10	

12	Disagreements are viewed as a search for solutions rather than a “win/lose”.	100	0	0
13	Our meetings are held frequently enough to make sure we are able to make timely decisions.	100	0	0
14	Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	100	0	0
15	Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	100	0	0
16	Our governance processes make sure that everyone participates in decision-making.	100	0	0
17	Individual members are actively involved in policy-making and strategic planning.	100	0	0
18	The composition of our governing body contributes to high governance and leadership performance.	100	0	0
19	Our governing body’s dynamics enable group dialogue and discussion. Individual members ask for and listen to one another’s ideas and input.	100	0	0
20	Our ongoing education and professional development is encouraged.	100	0	0
21	Working relationships among individual members and committees are positive.	100	0	0
22	We have a process to set bylaws and corporate policies.	100	0	0
23	Our bylaws and corporate policies cover confidentiality and conflict of interest.	100	0	0
24	We formally evaluate our own performance on a regular basis.	100	0	0
25	We benchmark our performance against other similar organizations and/or national standards.	90	0	10
26	Contributions of individual members are reviewed regularly.	100	0	0
27	As a team, we regularly review how we function together and how our governance processes could be improved.	90	0	10
28	There is a process for improving individual effectiveness when non-performance is an issue.	100	0	0

29	We regularly identify areas for improvement and engage in our own quality improvement activities.	100	0	0
30	As a governing body, we annually release a formal statement of our achievements that is shared with the organization's staff as well as external partners and the community.	100	0	0
31	As individual members, we receive adequate feedback about our contribution to the governing body.	100	0	0
32	We have a process to elect or appoint our chair.	100	0	0
33	Our chair has clear roles and responsibilities and runs the governing body effectively.	100	0	0

Patient Safety Culture Survey

The patient safety culture survey results provide valuable insight into staff perceptions of patient safety, as well as an indication of areas of strength, areas of improvement, and a mechanism to monitor changes within the organization.

Summary of Results

Number of survey respondents = 823 respondents

	A. Patient Safety: Activities to avoid, prevent, or correct adverse outcomes which may result from the delivery of health care	% Disagree	% Neutral	% Agree	Priority for Action
		Organization	Organization	Organization	
1	Patient safety decisions are made at the proper level by the most qualified people	9	20	72	✗
2	Good communication flow exists up the chain of command regarding patient safety issues	13	19	68	✗
3	Reporting a patient safety problem will result in negative repercussions for the person reporting it	80	14	7	△
4	Senior management has a clear picture of the risk associated with patient care	19	23	58	✗
5	My unit takes the time to identify and assess risks to patients	6	14	80	△
6	My unit does a good job managing risks to ensure patient safety	5	12	83	△
7	Senior management provides a climate that promotes patient safety	11	22	68	△
8	Asking for help is a sign of incompetence	91	5	4	
9	If I make a mistake that has significant consequences and nobody notices, I do not tell anyone about it	93	4	3	
10	I am sure that if I report an incident to our reporting system, it will not be used against me	12	21	66	△
11	I am less effective at work when I am fatigued	8	8	83	
12	Senior management considers patient safety when program changes are discussed	11	29	60	✗
13	Personal problems can adversely affect my performance	26	23	51	△
14	I will suffer negative consequences if I report a patient safety problem	85	11	4	

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15	If I report a patient safety incident, I know that management will act on it	10	24	66
16	I am rewarded for taking quick action to identify a serious mistake	26	44	30
17	Loss of experienced personnel has negatively affected my ability to provide high quality patient care	37	30	33
18	I have enough time to complete patient care tasks safely	20	24	56
19	I am not sure about the value of completing incident reports	71	18	12
20	In the last year, I have witnessed a co-worker do something that appeared to me to be unsafe for the patient in order to save time	56	17	28
21	I am provided with adequate resources (personnel, budget, and equipment) to provide safe patient care	28	29	44
22	I have made significant errors in my work that I attribute to my own fatigue	84	10	6
23	I believe that health care error constitutes a real and significant risk to the patients that we treat	11	14	75
24	I believe health care errors often go unreported	20	27	53
25	My organization effectively balances the need for patient safety and the need for productivity	17	32	51
26	I work in an environment where patient safety is a high priority	8	15	78
27	Staff are given feedback about changes put into place based on incident reports	27	28	44
28	Individuals involved in patient safety incidents have a quick and easy way to report what happened	16	23	61
29	My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures	21	25	53
30	My supervisor/manager seriously considers staff suggestions for improving patient safety	10	24	66
31	Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts	68	22	10
32	My supervisor/manager overlooks patient safety problems that happen over and over	75	15	10

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33 On this unit, when an incident occurs, we think about it carefully	6	20	74	
34 On this unit, when people make mistakes, they ask others about how they could have prevented it	12	24	64	
35 On this unit, after an incident has occurred, we think about how it came about and how to prevent the same mistake in the future	7	16	77	
36 On this unit, when an incident occurs, we analyze it thoroughly	12	28	60	
37 On this unit, it is difficult to discuss errors	68	20	12	
38 On this unit, after an incident has occurred, we think long and hard about how to correct it	12	29	59	

B. These questions are about your perceptions of overall patient safety	% Good/ Excellent	% Acceptable	% Poor/ Failing	Priority for Action
	Organization	Organization	Organization	
39 Please give your unit an overall grade on patient safety	67	30	4	
40 Please give the organization an overall grade on patient safety	55	39	6	

C. These questions are about what happens after a Major Event	% Disagree	% Neutral	% Agree	Priority for Action
	Organization	Organization	Organization	
41 Individuals involved in major events contribute to the understanding and analysis of the event and the generation of possible solutions	8	25	67	
42 A formal process for disclosure of major events to patients/families is followed and this process includes support mechanisms for patients, family, and care/service providers	8	34	57	
43 Discussion around major events focuses mainly on system-related issues, rather than focusing on the individual(s) most responsible for the event	10	31	59	
44 The patient and family are invited to be directly involved in the entire process of understanding: what happened following a major event and generating solutions for reducing re-occurrence of similar events	12	42	46	

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45	Things that are learned from major events are communicated to staff on our unit using more than one method (e.g. communication book, in-services, unit rounds, emails) and / or at several times so all staff hear about it	16	24	61	✖
46	Changes are made to reduce re-occurrence of major events	7	18	74	⚠

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Worklife Pulse

The concept of 'quality of worklife' is central to Accreditation Canada's accreditation program. The Pulse Survey enables health service organizations to monitor key worklife areas. The survey takes the 'pulse' of quality of worklife, providing a quick and high level snapshot of key work environment factors, individual outcomes, and organizational outcomes. Organizations can then use the findings to identify strengths and gaps in their work environments, 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.

Summary of Results

Number of survey respondents = 926 respondents

	How would you rate your work environment	% Disagree	% Neutral	% Agree	Priority for Action
		Organization	Organization	Organization	
1	I am satisfied with communications in this organization.	20	23	58	
2	I am satisfied with communications in my work area.	20	16	64	
3	I am satisfied with my supervisor.	12	18	70	
4	I am satisfied with the amount of control I have over my job activities.	18	18	64	
5	I am clear about what is expected of me to do my job.	5	9	86	
6	I am satisfied with my involvement in decision making processes in this organization.	25	31	44	
7	I have enough time to do my job adequately.	31	22	47	
8	I feel that I can trust this organization.	18	28	53	
9	This organization supports my learning and development.	17	22	61	
10	My work environment is safe.	9	16	75	
11	My job allows me to balance my work and family/personal life.	17	17	65	

Individual Outcomes	% Not Stressful	% A bit Stressful	% Quite or Extremely Stressful	Priority for Action
	Organization	Organization	Organization	
12 In the past 12 months, would you say that most days at work were...	15	45	40	

	% Very Good/ Excellent	% Good	% Fair/ Poor	Priority for Action
	Organization	Organization	Organization	
13 In general, would you say your health is...	63	30	7	
14 In general, would you say your mental health is...	65	27	8	
15 In general, would you say your physical health is...	56	34	10	

	% Very Satisfied	% Somewhat Satisfied	% Not Satisfied	Priority for Action
	Organization	Organization	Organization	
16 How satisfied are you with your job?	90	8	2	

	% < 10	% 10 - 15	% > 15	Priority for Action
	Organization	Organization	Organization	
17 In the past 12 months, how many days were you away from work because of your own illness or injury? (counting each full or partial day as 1 day)	92	2	5	
18 During the past 12 months, how many days did you work despite an illness or injury because you felt you had to (counting each full or partial day as 1 day)?	91	5	4	

	% Never/ Rarely	% Sometimes	% Often/ Always	Priority for Action
	Organization	Organization	Organization	
19 How often do you feel you can do your best quality work in your job?	2	18	79	

	% Disagree	% Neutral	% Agree	Priority for Action
	Organization	Organization	Organization	
20 Overall, I am satisfied with this organization.	12	22	66	⚠
21 Working conditions in my area contribute to patient safety.	10	19	71	⚠

Indicator Results

Indicators collect data related to important aspects of patient safety and quality care. The tables in this section show the indicator data that has been submitted by the organization.

Medication Reconciliation at Admission

Transition points in the care continuum are particularly prone to risk, and the communication of medication information has been identified as a priority area for improving the safety of healthcare service delivery. This performance measure will provide a practical guide for organizations as medication reconciliation is conducted more widely throughout the organization.

Medication Reconciliation at Admission

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% Formal medication reconciliation at admission
RED	Georgetown Hospital	GH Medicine Services (Medicine Services)	01/10/2009 31/12/2009	67
YELLOW	Georgetown Hospital	GH Medicine Services (Medicine Services)	01/01/2010 31/03/2010	80

Threshold for Flags
RED: < 75/100
YELLOW: >= 75/100 AND < 90/100
GREEN: >= 90/100

Surgical Site Infection

Post-surgical infection rate is a key outcome measure that reflects process interventions.

The thresholds for this performance indicator are currently in development. Performance ratings will be provided when the thresholds are finalized.

Surgical Site Infection: Post-Surgical Infection - Colorectal Surgery

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% post-surgical infections
	Georgetown Hospital	IP&CS (Infection Prevention and Control)	01/10/2009 31/12/2009	10
	Georgetown Hospital	IP&CS (Infection Prevention and Control)	01/01/2010 31/03/2010	23

The thresholds for this performance indicator are currently in development. Performance ratings will be provided when the thresholds are finalized.

Surgical Site Infection: Post-Surgical Infection - Colorectal Surgery				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% post-surgical infections
	Milton District Hospital	IP&CS (Infection Prevention and Control)	01/10/2009 31/12/2009	13
	Milton District Hospital	IP&CS (Infection Prevention and Control)	01/01/2010 31/03/2010	5.6
	Oakville Trafalgar Memorial Hospital	IP&CS (Infection Prevention and Control)	01/01/2010 31/03/2010	8.9

The thresholds for this performance indicator are currently in development. Performance ratings will be provided when the thresholds are finalized.

Surgical Site Infection: Post-Surgical Infection - Hysterectomy				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% post-surgical infections
	Georgetown Hospital	IP&CS (Infection Prevention and Control)	01/10/2009 31/12/2009	0
	Georgetown Hospital	IP&CS (Infection Prevention and Control)	01/01/2010 31/03/2010	0
	Milton District Hospital	IP&CS (Infection Prevention and Control)	01/10/2009 31/12/2009	11
	Milton District Hospital	IP&CS (Infection Prevention and Control)	01/01/2010 31/03/2010	0

The thresholds for this performance indicator are currently in development. Performance ratings will be provided when the thresholds are finalized.

Surgical Site Infection: Post-Surgical Infection - Total Joint Arthroplasty

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% post-surgical infections
	Oakville Trafalgar Memorial Hospital	IP&CS (Infection Prevention and Control)	01/10/2009 31/12/2009	2.5
	Oakville Trafalgar Memorial Hospital	IP&CS (Infection Prevention and Control)	01/01/2010 31/03/2010	0.74

Surgical Site Infection

Timeliness of administering antibiotic prophylaxis is a universal process measure applicable to many surgical procedures and with widely recognized benefits in reducing post-surgical infections in selected high risk procedures.

Surgical Site Infection: Prophylactic Antibiotics - Hysterectomy

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics
RED	Georgetown Hospital	IP&CS (Infection Prevention and Control)	01/10/2009 31/12/2009	79
GREEN	Georgetown Hospital	IP&CS (Infection Prevention and Control)	01/01/2010 31/03/2010	94
YELLOW	Milton District Hospital	IP&CS (Infection Prevention and Control)	01/10/2009 31/12/2009	88
RED	Milton District Hospital	IP&CS (Infection Prevention and Control)	01/01/2010 31/03/2010	62

Threshold for Flags
RED: < 80/100
YELLOW: >= 80/100 AND < 90/100
GREEN: >= 90/100

Surgical Site Infection: Prophylactic Antibiotics - Total Joint Arthroplasty

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics
GREEN	Oakville Trafalgar Memorial Hospital	IP&CS (Infection Prevention and Control)	01/10/2009 31/12/2009	100
GREEN	Oakville Trafalgar Memorial Hospital	IP&CS (Infection Prevention and Control)	01/01/2010 31/03/2010	100

Threshold for Flags
RED: < 80/100
YELLOW: >= 80/100 AND < 90/100
GREEN: >= 90/100

Health Care Associated Infection Rates

Health care associated C. difficile and MRSA infections represent a significant risk to the individuals receiving care and are a substantial resource burden to organizations and the health care system. Measuring infection control performance measures has the additional benefit of informing and shaping the staff's view of safety. Evidence suggests that as staff become more aware of infection control rates and the evidence related to infection control there is a change in behaviour to reduce the perceived risk.

Health Care-Associated MRSA & C. difficile - C. difficile

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection / 10,000 patient days
GREEN	Georgetown Hospital	IP&CS (Infection Prevention and Control)	01/10/2009 31/12/2009	0
GREEN	Georgetown Hospital	IP&CS (Infection Prevention and Control)	01/01/2010 31/03/2010	0
GREEN	Milton District Hospital	IP&CS (Infection Prevention and Control)	01/10/2009 31/12/2009	1.6
GREEN	Milton District Hospital	IP&CS (Infection Prevention and Control)	01/01/2010 31/03/2010	1.8
GREEN	Oakville Trafalgar Memorial Hospital	IP&CS (Infection Prevention and Control)	01/10/2009 31/12/2009	2.4
GREEN	Oakville Trafalgar Memorial Hospital	IP&CS (Infection Prevention and Control)	01/01/2010 31/03/2010	4.4

Threshold for Flags

RED:	> 80/10000
YELLOW:	<= 80/10000 AND > 60/10000
GREEN:	<= 60/10000

Health Care-Associated MRSA & C. difficile - MRSA

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection + colonization / 10,000 patient days
GREEN	Georgetown Hospital	IP&CS (Infection Prevention and Control)	01/10/2009 31/12/2009	0
GREEN	Georgetown Hospital	IP&CS (Infection Prevention and Control)	01/01/2010 31/03/2010	2.2

Health Care-Associated MRSA & C. difficile - MRSA				
Flag	**Location**	**Team Name (standard section)**	**Dates (dd/mm/yyyy)**	**# cases of infection + colonization / 10,000 patient days**
GREEN	Milton District Hospital	IP&CS (Infection Prevention and Control)	01/10/2009 31/12/2009	1.5
GREEN	Milton District Hospital	IP&CS (Infection Prevention and Control)	01/01/2010 31/03/2010	0
GREEN	Oakville Trafalgar Memorial Hospital	IP&CS (Infection Prevention and Control)	01/10/2009 31/12/2009	1.3
GREEN	Oakville Trafalgar Memorial Hospital	IP&CS (Infection Prevention and Control)	01/01/2010 31/03/2010	4.4

Threshold for Flags
RED: > 80/10000
YELLOW: <= 80/10000 AND > 60/10000
GREEN: <= 60/10000

Next Steps

Congratulations! You have just completed your Qmentum on-site survey visit. Please note the following check list items that you need to attend to in the coming days and months.

- ☐ We ask that you review this report within the next five days for errors in titles of names of services. This will help ensure the report and our records are accurate. Once you have reviewed, please send your requested changes to your Accreditation Specialist.

- ☐ In 10 business days, a letter outlining your accreditation decision and requirements will be e-mailed to your Chief Executive Officer. If revisions to the report were required, a copy of a revised report will be sent along with that letter.

- ☐ You are required to submit your quarterly reports on indicators on May 31st, every year. If you have any questions regarding this submission, please contact your Accreditation Specialist.

Appendix A – Accreditation Decision Guidelines

Quality improvement continues to be a key principle of Accreditation Canada's Qmentum program. Accreditation Canada's standards assess the quality of services provided by an organization and are constructed around eight dimensions of quality:

1. Population focus
2. Accessibility
3. Safety
4. Worklife
5. Client-centred services
6. Continuity of services
7. Effectiveness
8. Efficiency

Each standard criterion is related to a quality dimension. Organizations participating in Accreditation Canada's Qmentum program are eligible for the recognition awards: Accreditation; Accreditation with Condition (Report and/or Focused Visit) and Non-accreditation.

Under the Qmentum accreditation program, Accreditation Canada High Priority Criteria and Required Organization Practices (ROPs) are the two main factors that are considered in determining the appropriate recognition award.

Accreditation Canada High Priority Criteria

Accreditation Canada identifies high priority criteria by their alignment with several key areas:

- Quality Improvement
- Safety
- Risk
- Ethics

Required Organization Practices (ROPs)

A Required Organizational Practice is defined as an essential practice that organizations must have in place to enhance patient/client safety and minimize risk. It is a specific requirement for healthcare organizations in the accreditation program.

Based on the above, the three accreditation decisions for 2010 Qmentum surveys are:

Option 1: Accreditation
An organization is eligible for full accreditation (with a resurvey in three years) if all of the following criteria are met:

(a) 90% or more of high priority criteria met per standard section, AND
(b) Compliance with all of the Required Organizational Practices, AND
(c) Compliance with collection of all the performance measures,

If the organization is a CSSS, participating in the Joint Program with Conseil québecois d'agrément (CQA) and Accreditation Canada, the following additional criteria are required, which are specific CQA indicators relating to customer service and worklife:

(d) Compliance with ≥66.6% of Client Satisfaction Indicators AND
(e) Compliance with ≥66.6% of Employees Mobilization Indicators

Option 2: Accreditation with Condition: Report and/or Focused Visit
An organization will receive Accreditation with Condition: Report and/or Focused Visit if any of following criteria is met:

(a) More than 10% and less than 30% of high priority criteria unmet in any standard section,
OR
(b) Non-compliance with any one of the Required Organizational Practices
OR
(c) Non-compliance with the collection of any one of the performance measures

If the organization is a CSSS, participating in the Joint Program with CQA and Accreditation Canada, the following addition criteria apply:

(d) Compliance with less than 66.6% of Client Satisfaction Indicators,
OR
(e) Compliance with less than 66.6% of Employees Mobilization Indicators

The condition, i.e. submission of a report or focused visit; and timeframe, i.e. 6 months or 12 months; is based upon the nature of the recommendations. If the organization is a CSSS, and their compliance with the Client Satisfaction Indicators OR Employees Mobilization Indicators is less than 66.6%, they must conduct the survey(s) again within 18 months following the onsite visit as a condition of accreditation.

Organizations are required to submit follow-up reports as a condition of maintaining accreditation status. If a satisfactory report is not submitted within the required timeline, Accreditation Canada may grant a one-time extension of 6 months, based on surveyor input, proof of progress, and a plan to meet the conditions. Failure to comply with these requirements within the maximum allotted time extension will result in removal of accreditation status, at the discretion of Accreditation Canada.

For organizations that fail to complete a satisfactory focused visit within the required timeline, Accreditation Canada may grant a one-time extension of 6 months, based on surveyor input, proof of progress and a plan to meet the conditions. Failure to comply with these requirements within the maximum allotted time extension will result in removal of accreditation status, at the discretion of Accreditation Canada.

Option 3: Non-accreditation
An organization will NOT be accredited if the following conditions exist:

(a) One or more ROPs not in place
AND
(b) 30% or more high priority criteria unmet in one or more standards sections
AND
(c) 20% or more criteria unmet overall for all standards applied to the organization

Should an organization wish to have their non-accreditation status reviewed within 6 months post survey, they are required to complete a focused visit within 5 months. Organizations that fail to complete a satisfactory focused visit within the required timeframe will maintain a non-accreditation status.

If the organization is a CSSS, and their compliance with the Client Satisfaction Indicators OR Employees Mobilization Indicators is less than 66.6%, they must conduct the survey(s) again within 18 months following the onsite visit as a condition of accreditation.