ACCREDITATION AGRÉMENT CANADA
Qmentum

Accreditation Report

St. Mary's General Hospital, Kitchener

Kitchener, ON

On-site survey dates: June 2, 2019 - June 6, 2019

Report issued: September 13, 2019

About the Accreditation Report

St. Mary's General Hospital, Kitchener (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. As part of this ongoing process of quality improvement, an on-site survey was conducted in June 2019. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

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

Confidentiality

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

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

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

A Message from Accreditation Canada

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

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

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

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

We look forward to our continued partnership.

Sincerely,

Leslee Thompson
Chief Executive Officer

Table of Contents

Executive Summary

St. Mary's General Hospital, Kitchener (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. Accreditation Canada is an independent, not-for-profit organization that sets standards for quality and safety in health care and accredits health organizations in Canada and around the world.

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

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

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

Accreditation Decision

St. Mary's General Hospital, Kitchener's accreditation decision is:

Accredited with Exemplary Standing

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

About the On-site Survey

- **On-site survey dates: June 2, 2019 to June 6, 2019**

- **Location**

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

  1. St. Mary's General Hospital

- **Standards**

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

  System-Wide Standards

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

  Service Excellence Standards

  5. Ambulatory Care Services - Service Excellence Standards
  6. Biomedical Laboratory Services - Service Excellence Standards
  7. Critical Care Services - Service Excellence Standards
  8. Diagnostic Imaging Services - Service Excellence Standards
  9. Emergency Department - Service Excellence Standards
  10. Inpatient Services - Service Excellence Standards
  11. Perioperative Services and Invasive Procedures - Service Excellence Standards
  12. Point-of-Care Testing - Service Excellence Standards
  13. Reprocessing of Reusable Medical Devices - Service Excellence Standards
  14. Transfusion Services - Service Excellence Standards

- **Instruments**

  The organization administered:

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

Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
 Population Focus (Work with my community to anticipate and meet our needs)	43	0	0	43
 Accessibility (Give me timely and equitable services)	63	0	1	64
 Safety (Keep me safe)	536	0	24	560
 Worklife (Take care of those who take care of me)	105	3	1	109
 Client-centred Services (Partner with me and my family in our care)	253	4	1	258
 Continuity (Coordinate my care across the continuum)	47	0	2	49
 Appropriateness (Do the right thing to achieve the best results)	863	3	5	871
 Efficiency (Make the best use of resources)	56	0	0	56
Total	**1966**	**10**	**34**	**2010**

Overview by Standards

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

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

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

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

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	49 (98.0%)	1 (2.0%)	0	36 (100.0%)	0 (0.0%)	0	85 (98.8%)	1 (1.2%)	0
Leadership	48 (96.0%)	2 (4.0%)	0	94 (97.9%)	2 (2.1%)	0	142 (97.3%)	4 (2.7%)	0
Infection Prevention and Control Standards	40 (100.0%)	0 (0.0%)	0	29 (100.0%)	0 (0.0%)	2	69 (100.0%)	0 (0.0%)	2
Medication Management Standards	68 (100.0%)	0 (0.0%)	10	63 (100.0%)	0 (0.0%)	1	131 (100.0%)	0 (0.0%)	11
Ambulatory Care Services	45 (100.0%)	0 (0.0%)	2	77 (98.7%)	1 (1.3%)	0	122 (99.2%)	1 (0.8%)	2
Biomedical Laboratory Services **	72 (100.0%)	0 (0.0%)	0	105 (100.0%)	0 (0.0%)	0	177 (100.0%)	0 (0.0%)	0
Critical Care Services	60 (100.0%)	0 (0.0%)	0	105 (100.0%)	0 (0.0%)	0	165 (100.0%)	0 (0.0%)	0
Diagnostic Imaging Services	66 (100.0%)	0 (0.0%)	2	68 (100.0%)	0 (0.0%)	1	134 (100.0%)	0 (0.0%)	3

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Emergency Department	72 (100.0%)	0 (0.0%)	0	107 (100.0%)	0 (0.0%)	0	179 (100.0%)	0 (0.0%)	0
Inpatient Services	57 (96.6%)	2 (3.4%)	1	80 (97.6%)	2 (2.4%)	3	137 (97.2%)	4 (2.8%)	4
Perioperative Services and Invasive Procedures	113 (100.0%)	0 (0.0%)	2	109 (100.0%)	0 (0.0%)	0	222 (100.0%)	0 (0.0%)	2
Point-of-Care Testing **	38 (100.0%)	0 (0.0%)	0	46 (100.0%)	0 (0.0%)	2	84 (100.0%)	0 (0.0%)	2
Reprocessing of Reusable Medical Devices	87 (100.0%)	0 (0.0%)	1	40 (100.0%)	0 (0.0%)	0	127 (100.0%)	0 (0.0%)	1
Transfusion Services **	71 (100.0%)	0 (0.0%)	5	68 (100.0%)	0 (0.0%)	1	139 (100.0%)	0 (0.0%)	6
Total	**886 (99.4%)**	5 (0.6%)	23	1027 (99.5%)	5 (0.5%)	10	1913 (99.5%)	10 (0.5%)	33

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

Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client Identification (Inpatient Services)	Met	1 of 1	0 of 0
Client Identification (Perioperative Services and Invasive Procedures)	Met	1 of 1	0 of 0
Client Identification (Point-of-Care Testing)	Met	1 of 1	0 of 0
Client Identification (Transfusion Services)	Met	1 of 1	0 of 0
Information transfer at care transitions (Ambulatory Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Critical Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Emergency Department)	Met	4 of 4	1 of 1
Information transfer at care transitions (Inpatient Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Perioperative Services and Invasive Procedures)	Met	4 of 4	1 of 1
Medication reconciliation as a strategic priority (Leadership)	Met	3 of 3	2 of 2
Medication reconciliation at care transitions (Ambulatory Care Services)	Met	5 of 5	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Critical Care Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Emergency Department)	Met	1 of 1	0 of 0
Medication reconciliation at care transitions (Inpatient Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures)	Met	4 of 4	0 of 0
Safe Surgery Checklist (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
The “Do Not Use” list of abbreviations (Medication Management Standards)	Met	4 of 4	3 of 3
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management Standards)	Met	4 of 4	1 of 1
Concentrated Electrolytes (Medication Management Standards)	Met	3 of 3	0 of 0
Heparin Safety (Medication Management Standards)	Met	4 of 4	0 of 0
High-Alert Medications (Medication Management Standards)	Met	5 of 5	3 of 3

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Infusion Pumps Training (Critical Care Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Emergency Department)	Met	4 of 4	2 of 2
Infusion Pumps Training (Inpatient Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Perioperative Services and Invasive Procedures)	Met	4 of 4	2 of 2
Narcotics Safety (Medication Management Standards)	Met	3 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Client Flow (Leadership)	Met	7 of 7	1 of 1
Patient safety plan (Leadership)	Met	2 of 2	2 of 2
Patient safety: education and training (Leadership)	Met	1 of 1	0 of 0
Preventive Maintenance Program (Leadership)	Met	3 of 3	1 of 1
Workplace Violence Prevention (Leadership)	Met	5 of 5	3 of 3
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Compliance (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2

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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Venous Thromboembolism Prophylaxis (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2

Summary of Surveyor Team Observations

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

St. Mary's hospital is commended on their continued efforts to promote quality improvement and patient safety and participating in the Accreditation Qmentum program. St. Mary's General Hospital (SMGH) is a 153-bed hospital that is part of St. Joseph's Health System and is a Regional Cardiac Care Centre located in Kitchener with large urban and rural catchment area that includes Guelph, Wellington, Dufferin, Grey-Bruce communities.

St. Mary's is the regional cardiac center and provides additional core programs of: medicine, surgery, cardiac, respiratory, emergency, integrated comprehensive care and ambulatory care. The organization serves more than one million people served by a team of 1,500 staff, 175 shared medical staff, and 330 volunteers. The organization has provided patient experiences during 54, 800 emergency department visits, 78,000 outpatients' visits and 8,400 admissions where team members performed 8,100 cardiac procedures and 23,500 surgical procedures.

Health organizations in this region, including St. Mary's, are undergoing significant change as part of provincial restructuring within the health sector. Whilst some senior leadership positions have been filled there are a number of leadership positions which remain vacant. The organization is to be commended for their continued focus on excellent patient care, quality improvement and patient safety during this time of change. The organization is encouraged to be mindful of the pace of change and importance of open communication and maintaining relationships with internal and external stakeholders as they navigate and respond to internal and external changes. Supporting and stabilizing leaders and leadership within the organization and identifying emerging leaders to continue to "model the way" through compassion, innovation and respect are ongoing priorities for the organization.

The organization is committed to building strong partnerships. The organization has strong relationships with their community and community partners. SMGH has extended their community reach to include private industry, specific academic programs and NGO's. The organization shares several integrated leadership positions, and strategic projects as well as a joint medical staff with their neighbouring hospital Grand River. The leadership team represents St. Mary's on a number of external committees. As a result, the team and organization are able to participate in shaping the longer-term vision for the system overall. Many of the hospital programs and services are experiencing growth in health service demands and as a result have been challenged to meet the increasingly complex patient care needs within existing budget and space allocations. Despite these constraints the staff and leadership of St. Mary's meet these challenges with enthusiasm and with an innovative "problem solver" approach.

The recent development of a Regional Cardiac Strategic Plan, cardiac rehab hubs, and an Optometry Vision Care Strategy (developed in collaboration with University of Waterloo) are a few examples of how the organization is working towards supporting a patient care closer to home philosophy and collaborative

approach to planning and service design. In addition to implementing new programs and services the leadership team has been working to improve wait times, utilization and have implemented a number of quality improvement initiatives.

For close to a decade, the organization has invested significantly in developing structures, processes and leadership education for quality improvement and patient safety. The organization is commended for achieving international recognition as a LEAN leader and realizing more than 7,500 staff led improvement initiatives between April 2013 and March 2018. A number of leaders have undertaken regionally supported LEAN training and are actively engaged in implementing LEAN process redesign to improve efficiency and quality of care. The organization has embraced a lean philosophy which supports the vision of being the "safest and most effective hospital in Canada". St. Mary's Hospital continues to live up to its international "gold standard" reputation.St. Mary's Hospital has a strong culture of quality improvement and safety. Lean methodology is deeply rooted within the organization. Leaders, staff and some physicians have received LEAN training and are utilizing these principles to develop quality and Lean skills. The Organization continues to 'to identify opportunities for efficiency and improvement. The organization will begin working on the next phase of Lean practices, Lean 2.0.

Communication and staff engagement are enhanced by developing a culture of problem solvers. The organization is commended for their implementation of 'huddle boards' throughout the program/units. The huddle boards have been embraced as a source of information and a place to talk about quality improvement and safety. The "huddle boards" encourage staff and patients to submit ideas for improvement. There were a number of successes shared throughout the course of the survey with potential leading practices identified. Some of the successes shared included; over 385 quality tickets being raised.

Patient and Family Advisors allow the patient voice to be heard and allows for patient collaboration and input in quality improvements. The Patient and Family Advisory Committee (PFAC) has been actively engaged in quality improvements. There are currently 20 PFA's and there is a strong desire to continue to grow this valuable team to include all cultures and ages. There is opportunity to continue to engage PFAs in strategic and operational planning in a proactive fashion and continue to be involved in implementation of quality improvement projects and their outcomes. The organization should continue to identify opportunities for expanded collaboration with PFAs.

Quality and safety is the lens through which the board guide decisions. The board have implemented several patient engagement mechanisms that guides their decision making. Board meetings include a 'patient experience' and, a virtual patient is used to ensure patient centred decisions are made. Additionally, board members utilize an ethics framework to further support decision making. The board of directors embraces the lean approach and a philosophy of safety (patient and team) and quality. All board members and leaders receive training in Lean methodology.

There is strong evidence of a safe, just and transparent culture within the organization. In an effort to continue to improve the organization uses an electronic incident management system for reporting of incidents and good catches. Staff receive education on how to complete reports. The system supports the incident information to be captured, communicates the incident to various leaders, and allows for feed back

to the staff member who identified the incident. The Leadership team identified an improvement in the reporting, detail of information within the reports and engagement of staff in implementing recommendations. These incident reporting mechanisms and feedback processes have helped leaders develop improvement plans that have helped make changes in the work processes to prevent further incidents and promote safety.

The organization has identified Workplace Violence as a priority and have invested in training, promotion of the new policy and new specialist role within the hospital. The reporting and resolution of Work Place Violence incidents will provide a safer workplace for all staff. Additionally, there have been a number of noteworthy improvements made in occupational health and safety that are beginning to show improvement in overtime. In an effort to reduce staff overtime the organization has realigned staffing strategies.
The organization has identified financial stewardship as a priority. The organization is facing budget and bed pressures. A review of indicators and population health data may be helpful to identify current and future demand for services. Leadership is encouraged to continue to standardize where possible and strengthen the opportunities to utilize available beds within the hospital and within the region. Using existing principles to support the zero waste goal. Infrastructure and increased direct care staff resources were identified as a priority for the organization. These needed improvements to technology and staffing have been strategic decisions to improve patient care and service but have resulted in significant financial challenges the organization will need to be addressed in the coming years.

There is a reported strong partnership between departments, community organizations and with public health. Public health is actively engaged and provides timely feedback and advice regarding primary prevention and outbreak management. St. Mary's and Grand River Hospital continue to share accountability for shared physician professional services. The two hospitals have been working on a joint PRISM informatics information technology initiative that is set to go live at St. Mary's November 2019. The integration of Pathology and Laboratory Medicine with Grand River has provided opportunity to share resources and standardize practices.

The organization is encouraged to continue to foster strong community relationships and leverage their partnerships to share information regarding population health trends and to integrate models of care that meet the complex needs of their patients. For example, there is an increasing patient population experiencing medical complications from mental health and addictions. The organization is strongly encouraged to continue building upon regional partnerships to develop integrated models of care and processes supporting patients' diverse needs across the care continuum of care. St. Mary's is positioned well to become a learning and applied research community hub. Establishing and/or expanding relationships with academic institutions and McMaster's KW (Medical) Academic Research Centre could enable new student placement opportunities, access to population health data, and supported research potential.

The great work and commitment to quality work practices have been challenged to meet the required standards of 2019 in a building that is aging. The infrastructure has been maintained and renovated over the last 90 years. This presents numerous challenges. The Cardiac Catheter Lab and several outpatient areas are located in space and physical design that do not meet current service demands. The physical design also makes it difficult to maintain privacy and confidentiality. The infrastructure is in need of repair and continues to require upgrades WiFi is available in the building but continued demand presents challenges for some devices to perform at an optimal level.

Patients and families speak very highly of the hospital and are very positive about seeing many changes and improvements over recent years. Patients express feeling comfortable, respected and safe receiving care at the St. Mary's General Hospital. The organization held a career fair and were able to attract 600 individuals to come to the fair. This resulted in approximately 65 new employees being hired.

The communities in Kitchener Waterloo and surrounding area are experiencing rapid growth and increasing culturally diverse population. Additionally, there are significant changes occurring and anticipated within the regional and provincial health system. Many of the planning decisions and controls are unknown and outside the control of the organization. The organization is challenged by the changing system environment and increasing service demands. The complex needs of the increasing and aging population, new technology and staffing models have been implemented to improve care and back office efficiency. The organization can support staff by providing education and training to team members on how to work respectfully and effectively with clients and families with the diverse cultural backgrounds, religious beliefs and care needs.

SMGH has a deeply rooted history and identity in the community. Many of the hospital structures date back to 1924. The organization is commended for maintaining and updating the hospital and doing their best to provide efficient and safe care within the space limitations. A master planning process has been initiated. The organization is strongly encouraged to expedite this process and ensure appropriate authorities are aware of the safety, accessibility and infection control challenges facing staff providing and patients receiving care in the current physical space.

The common theme heard and observed throughout this onsite accreditation visit was the commitment to deliver excellent patient centred care. There is a strong sense of community, teamwork and pride at being part of the "St. Mary's Family" and belonging to the "St. Mary's Way" of work together to achieve and celebrate success and live the mission, vision and values of the organization.

Detailed On-site Survey Results

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

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

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

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

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

See Appendix B for a list of priority processes.

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

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

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

Priority Process Results for System-wide Standards

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

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

Priority Process: Governance

Meeting the demands for excellence in governance practice.

Unmet Criteria	High Priority Criteria
Standards Set: Governance	
2.8 Each member of the governing body signs a statement acknowledging his or her role and responsibilities, including expectations of the position and legal duties.	!

Surveyor comments on the priority process(es)

The governing board of St. Mary's hospital is commended for their strong leadership and commitment to quality and patient safety. The skill-based board has embraced the LEAN philosophy with most board members having undergone lean training. Board members identify themselves as a "coalition of the willing" and strive to be "authentic" in their service to the hospital and their community. Board meetings include safety as a standing agenda item and include patient narrative or 'patient voice' to ensure decisions are made with a lens to patient safety and patient centred care. Board members have also initiated 'gemba walks' that coincide with scheduled board presentations.

The governing body utilizes the mission, vision and values along with the ethics framework and patient input to guide decisions.

The board receive quality and financial reports regularly and there is a process in place to ensure they are made aware of risks and emerging trends.

The board acknowledges the significant changes and challenges facing the organization and broader health system. The board are committed to maintaining a quality lens and providing strategic leadership to the organization through this period of system change.

There have been a number of leadership changes within the organization and the board has a succession plan in place for CEO (and leadership positions).

The board has a defined director recruitment and nomination process. There is written documentation that acknowledges directors role and legal responsibilities and intent to continue as a board member after 1st and subsequent years. However, their is no written documentation initially acknowledging role and legal responsibility when first joining board.

The board has completed governance evaluation survey and additionally conducts formative evaluations after each meeting. Additionally, each meeting concludes with reflective questions regarding whether decisions made were patient centered and made with a "lens of quality". Again, the board is commended for "showing up with curiosity and respect" and role modeling strong leadership during turbulent times.

Priority Process: Planning and Service Design

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization has a robust planning and service design process. A mission, vision and values statements are in place and utilized regularly to guide planning and service development. All levels of the organization have embraced a collaborative decision making approach that includes patients, family and external partners as applicable and appropriate.

Including and engaging patients and families in decision making is a well embedded guiding principle within the organization.

St. Mary's leadership is well respected by their community partners and has developed a reputation for their efforts to integrate services and support effective transitions in care across the continuum of care both locally and within the region. The organization has demonstrated this through their collaboratively developed Regional Cardiac Care Strategic Plan.

Priority Process: Resource Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization has a process in place to review operating and capital budgets. A financial resource allocation matrix has been developed to assist prioritizing of budget allocations across the program areas. Leaders and PFAC members have an opportunity to provide input into the budget. Various budget reports and expense forecast analysis are shared with leaders and board members regularly. The board utilizes the ethics framework when indicated to support decision making of scare allocation of resources.

The organization is projecting a significant deficit for the 2019/2020 period. The deficit largely links to critical information technology upgrades (PRISM). The board and leadership has reallocated project resources for the 2019/2020 period towards supporting the True North goal of financial stewardship and the identification of multi-year cost savings, revenue opportunities and organizational efficiencies.

Financial challenges experienced by the organization are a result of increased volumes, 2018/19 enrichment plan short-fall and other unfunded infrastructure costs. The organization is commended for the commitment to patient safety and strategic systems thinking to their decision making.

The organization is encouraged to continue pursuing their plans to explore opportunities for cost savings, continue updating financial policies and processes (i.e. external consultant, program review).

Priority Process: Human Capital

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The St. Mary's Hospital has developed a Human Resources Plan for 2019- 2020. The organization has developed a policy for Workplace Violence Prevention. The staff are reporting incidents of workplace violence and there is a plan for investigating these incidents and a commitment to decrease the number of incidents. There is also a commitment to support organization leaders. Information gathered in a survey conducted in 2018 identified opportunities to support leaders. Leaders and emerging leaders have had training in a variety of principles and are also embarking on a Lean 2.0 to continue to expand on the lean work that has been used in the past. The worklife pulse data has been reviewed and benchmarked against other areas in Ontario and Canada. The St. Mary's data does show positive results against their peers however there is still opportunity to improve areas such as consulting staff when changes are made to their jobs. Communication that happens at the huddle boards provides staff with timely information about their work at St. Mary's. Staff overtime has been looked at and a strategy is being implemented to try to support staff and prevent units working short. Staff sick time should continue to be monitored. Many of the organizations leaders are new to their roles and this offers opportunity to bring in new ideas. There is a desire to support existing staff and provide them with the tools to move into leadership roles. The new staff that come to St. Mary's receive an orientation and there is an on boarding process. Education of staff during the on boarding orientation has moved to an online model. This allows flexibility for the employee but may not meet the learning style of all employees. Listening to the needs of the employee should be considered to determine if this new process is still providing all the information that the staff member needs. The Employee Handbook was recently updated and provides excellent information for new staff.

Continued attention to supporting the current workforce and listening to their needs will help provide for a stable workforce. The spirit of the St Mary's way certainly was evident when you move through the building. Staff were very friendly and it was clear that there is a strong desire to provide excellent patient care.

Priority Process: Integrated Quality Management

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
16.5 Action has been taken on the client experience tool results.	!

Surveyor comments on the priority process(es)

Quality and safety are one of the 4 true north goals at St. Mary's General Hospital (SMGH). A Lean approach has been well established across the organization and in the coming year Lean 2.0 will be developed. Recently, SMGH has been recognized by the Harvard Business Review for achieving success by creating a culture of continuous improvement across the organization. Moreover, in 2012 and 2016, SMGH presented the lowest hospital standardized mortality ratio (HSMR) scores in Canada and it was considered one of the three safest hospitals in the country.

Certainly, the LEAN approach facilitates the continuous development of several quality improvement initiatives. Some of the challenges encountered by the organization will be the development of a process that centralize all the initiatives and the selection of meaningful indicators. Another challenge for the upcoming year will be to align financial stewardship with quality and safety.

A new user friendly module has been added to the incident report system, where work place violence incidents as well as complaints can be easily reported.

In relation to disclosing patient safety incidents, the process has been handled in a professional, compassionate and transparent way.

There is a process in place for medication reconciliation, although this is an identified area for improvement. Roles and responsibilities for completing MedRec are defined by each unit/program. However, because these roles may vary across units/programs, we strongly recommend that the organization revisits their MedRec policy and clearly describes staff roles and responsibilities in each unit/ program. Moreover, since an informal process exists regarding physician education training, a training module and an action plan for a formal MedRec education have been developed and will be implemented in 2019.

Finally, the organization is aware that concerns have arisen about civility and respect towards patients and staff, thus a plan is being implemented in the coming years.

Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems.

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
1.11	There is a process for gathering and reviewing information about trends in the organization's ethics issues, challenges, and situations.	
1.12	Information about trends in ethics issues, challenges, and situations is used to improve the quality of services.	
1.13	The ethics framework includes a process for reviewing the ethical implications of any research activity that the organization leads or participates in.	!

Surveyor comments on the priority process(es)

An ethics framework is in place. The organization has an ethics committee, inclusive of patient representative, to support clinical and non-clinical decision making. As part of the St. Joseph's network the organization has access to an ethicist. An ethics framework is in place and staff are aware of how to access support when facing ethical issues. The organization is encouraged to review and revise the framework to ensure it is consistent with best practice, addresses current ethical issues facing staff and provides sufficient guidance to promote independence navigating ethical dilemmas.

Ethics training and decision support tools have been developed and disseminated to staff. A staff survey was conducted to identify ethical topics of interest and education has tailored to address the identified needs. Currently, no formal process is in place to gather information regarding consultations and ethic related situations or trends. The organization is recommended to establish a process to gather information and trend ethical issues within the organization.

There is a separate research 'ethics' committee at St. Mary's to review proposed research from an ethical lens (non IRB). The research ethics committee reportedly includes 2-3 members of the senior leadership team. However, does not include a physician representative. Of note, is that all research must also be approved by a tri-hospital research ethics board (THREB). The organization is recommended to review the internal ethics committee structure and membership.

Priority Process: Communication

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization is to be commended for its excellent visual display of information.

The organization has four true North goals which are zero harm, zero weight, 100% engagement and zero waste. The organization tracks continuously various performance indicators and these indicators are reported to the Board. The Board is a very engaged board. There is extensive community involvement. The organization works continuously with the community to identify the needs of the community. This has fostered a sense of collaboration and trust. There are various links and communication through all of the various healthcare settings. Signs are posted in strategic positions in front of and inside elevators with crucial important safety information for the public and for the staff. The organization has excellent relationships with the media. The organization also meets with public sector communicators on a yearly basis to discuss common issues. An example of this is how to team with large street parties which have a significant impact on the provision of healthcare at the hospital.

There are several communication channels including a weekly internal newsletter, (grapevine), intranet, screensavers, quarterly town hall meetings, quarterly suture line newsletter and all staff have email addresses. There is an active social media and there are 3900 twitter followers. The organization has invested heavily in LEAN methodology and the senior leadership and board are actively involved in Gemba walks which allow them to be actively engaged in the organization especially with the front-line workers. There are huddle boards on the units that are used as a tool to assist staff with the development of improvement projects. There are also performance boards on the unit to measure various performance indicators which are linked to the strategic objectives of the organization. There is a communication plan which has a focus on enabling the organization as a whole to achieve its operational goals and supporting goals and targets.

Evidence-based best practice information is actively sourced through the leadership of those clinical programs. There are informal assessments of the quality and usefulness of the organization’s data and information. The organization recognizes its staff and clients through various awards. There are local service awards as well as peer-to-peer awards and employee of the month award.

The organization is achieved significant success as an excellent hospital with a Hospital Standardized Mortality Ratio (HSMR) that is in the top 10 in Canada.

The organization has a social media policy which recognizes the importance of social media platforms and the smart phone technology. The organization of knowledge is that this is a very valuable and engaging tool for individuals looking to share experiences and interact with colleagues and the community. However, the organization is well aware that social media brings with it an increased risk of threatening the privacy of patients and other risks associated with sharing of corporate information and employee communication. The organization has therefore put forward guidelines for personal and professional social media activity.

The organization is diligent in protecting privacy and confidentiality. It takes its responsibility seriously. Access to personal health information is limited to only those employees/agents with the need to know such information for the job purposes. Authorization is required before accessing, collecting, using, or disclosing personal health information. The organization has a manager of communication. New employees also sign a privacy confidentiality and acceptable use agreement. All employees receive privacy awareness training at general orientation. There is a strategic communication plan in place. All staff are given access to the intranet. There is an organizational communication plan that deals with receiving and disseminating information.

Policies regarding information management are evident and reviewed and updated regularly. Patients can access their information in the health record regularly and without any significant barriers. Information flows through the organization in a seamless manner across various departments. There is flow of clinical and administrative information throughout the organization.

Priority Process: Physical Environment

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The St. Mary's Hospital provides many services to the Kitchener Area. The facility has been maintained over many years by upgrading aging structures and adding additions. The staff provide excellent care within a building that is less than excellent. During renovations, repairs and additions the staff have tried to maintain the structure at an acceptable level of standards. The organization has a computerized monitoring system and has been able to provide computerized drawings of the building. This easily accessible computer program allows maintenance staff to have an understanding of the building which helps them carry out timely repairs. The organization has identified repairs that will need to be carried out to continue to provide a safe hospital for staff and patients.

Areas of the hospital that were designed to meet patient needs many years ago present concerns in today's health care system. The space between patient registration desks and waiting rooms in often small, this does not allow for confidentiality of patient information to be maintained. Some hallways are also very narrow which limits proper flow for patients moving from one area to another.

There has been an effort to remove wooden surfaces when the opportunity arises however stairways continue have wooden hand rails. Work should continue to ensure all surfaces are easily cleaned. Storage areas are often very full and it was noted that some items such as mattresses were stored in hallways. The lean process continues to work on removing excess items from the building this work should continue as there is a lot of equipment and supplies on the inpatient units. The clean utility areas are separated from dirty utility rooms. It was not always evident if equipment in the hallways was clean or dirty. There were tape identification strips that were available in some locations but it didn't appear to be consistently used. Dedicated hand hygiene sinks are not always readily available. The organization has installed numerous alcohol based rubs throughout the building.

A master plan should consider the feasibility for continual upgrades to the existing building against the needs of the programs and expanding services.

Priority Process: Emergency Preparedness

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The St.Mary's Hospital leadership team has processes for dealing with critical incidents. The Emergency Preparedness team provides leadership to the organization when and incident has happened. The organization has participated in a table top exercise for Code Orange. This exercise has provided valuable information from a regional (LINS) perspective. The organization has also had to manage incidents at local level. These incidents have allowed the leaders opportunity to practice the Emergency Command Centre Procedures. The organization has demonstrated an ability to manage codes and ensure the organization staff and patients are safe. The organization has elements of a business continuity plan but further work should be done to have a business continuity document that clearly outlines the various needs to sustain service. The organization would benefit from identifying the processes needed for each department to maintain critical functions during a disruptive action. It is also important to determine how long the services can be sustained during a critical event. Current documentation includes recovery information to help the organization return to regular operations. The team currently works very well and supports staff and patients when incidents occur. The communication team allows for transfer of information to clients, families and staff as needed.

Priority Process: People-Centred Care

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization is commended for their efforts and innovative ways in which they are engaging patients and families in the care, decision making and quality improvement across the organization. Supported by a Patient Experience coordinator there have been processes developed and implemented to introduce patient advisers in specific programs at the hospital (i.e. visiting patient.

Additionally, patients are encouraged to identify opportunities for improvement by submitting patient generated quality improvement'pink tickets' (308 patient tickets raised), a PFAC 'huddle board', a peer-to-peer mentors, and the first PFAC work plan has been developed.

The PFAC committee acknowledged a "shift in the dialogue" and respect within the organization acknowledging the important contribution having the patient perspective brings to decision making at all levels of the organization. The committee is encouraged to continue working towards their goals to expand the PFAC, ensure members represent the cultural diversity of the community, establish driver metrics and explore outcome measures applicable to their role at the hospital.

Priority Process: Patient Flow

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

There is a focused effort on innovation and patient flow. All departments are involved in the process. Surgery has reorganized surgical time between the sites in order to match demand and supply. Some programs have expanded their outpatient services while others have expanded their human resources to deal with the increased demand. Other departments have used the LEAN process to deal the process of flow. Dyad leadership, streamlining flow of patients and collaboration with the diagnostic imaging department to optimize the flow of patients have also been used. There has been close collaboration with the various departments.

There is a manager in charge of patient flow. Bed meetings are held regularly daily. The status of patients is reviewed. Close cooperation between the emergency department and other departments in the hospital is maintained. There is an electronic whiteboard that helps with the discharge of patients.
The organization has policies in place to support patient flow. The impression is that patient flow is part of quality and safety and that this is to meet the unmet needs of the patients. The teams have used numerous PDSA cycles and various other tools to drive these quality improvement initiatives.

Several strategies have been undertaken. The organization may wish to undertake a strategy that involves a comprehensive understanding of barriers in emergency, medicine, surgery, diagnostic imaging, echocardiography, information management and across inpatient units and within the outpatient community. This may allow the organization to develop, plan and coordinate a comprehensive patient flow strategy. This coordination and implementation may need to be at a very senior level in the organization. There is a daily bed meeting to discuss various options to improve patient flow. Daily unit team huddles discuss options for discharge for every patient.

Priority Process: Medical Devices and Equipment

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The Medical Device Reprocessing department supports the St. Mary's hospital by living the principles of lean. The department is organized and clean. The department has qualified well trained staff who are committed to providing a quality service. The Medical Device Reprocessing team works with other departments to make quality improvements. The team measures quality indicators and shares the indicators with staff.

The Medical Device Reprocessing department has some equipment that is reaching end of life, the support of maintenance helps keep the equipment working but consideration should be given to replacing some of this aging equipment. The team has stopped the use of Immediate-use (or flash) sterilization and this is a great patient safety initiative. The flash sterilizer however has not been removed from the organization. Removing this would ensure that the practice will not reappear and will open up valuable space for other opportunities. The team is committed to having all sterilization performed in the MDR department. This will help stream line processes and move all of the expertise to one location. It was defined that scope reprocessing would stay in its current location. Communication in the department is documented. The daily status sheets provides valuable information to the manager and allows them to remain connected and informed of events or concerns that may arise when she is not on site. This is a great team who have pride in their work and the part they play as part of the St. Mary's Team.

Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Point-of-care Testing Services

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

Clinical Leadership

- Providing leadership and direction to teams providing services.

Competency

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

Episode of Care

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

Decision Support

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

Impact on Outcomes

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

Medication Management

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

Organ and Tissue Donation

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

Infection Prevention and Control

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

Diagnostic Services: Imaging

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

Diagnostic Services: Laboratory

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

Transfusion Services

- Transfusion Services

Standards Set: Ambulatory Care Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
3.4 Education and training are provided to team members on how to work respectfully and effectively with clients and families with diverse cultural backgrounds, religious beliefs, and care needs.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	
Surveyor comments on the priority process(es)	
Priority Process: Clinical Leadership	

The Ambulatory Care Airway Clinic and the Heart Function Clinic provide patient centered care to their clients. Services are designed with consideration to the patient needs. There are partnerships with other services and external partners. The Airway clinic has made service improvements by offering extended hours of service. This change was made to meet the needs of their clients. The clinics allow patients and families to have input into their care but designated patient advisers are not specifically part of the team. Addition of a patient and family adviser to team meetings will provide a voice of the patient to decision making.

Priority Process: Competency

The Ambulatory Care Airway Clinic and Heart Function Clinic staff are qualified and provided training to work in the specialized clinic. The interdisciplinary team supports the needs of the patient. The staff however do not receive specific training on how to work with clients and families with diverse cultural backgrounds, religious beliefs and care needs. Implementation of specific training in these areas will support staff when caring for patients from diverse backgrounds and cultures.
The team collaborates within the team and external partners to meet specific needs of the patient.

Priority Process: Episode of Care

The Ambulatory Clinics have identified wait times as a priority item to be tracked and managed. The Airway clinic has increased hours of service and the Heart Function clinic continues to provide service within the specified guidelines. Clients and families are involved in the patient care decisions and in the Heart Function clinic it is encouraged to have a family member support the patient during their visits to the clinic.

The organization does provide translation services for patients who may need this service. The staff however were not familiar with the process for accessing this service. There is an opportunity to provide information at huddles or via newsletter on the interpretive service. It was also identified that there are St. Mary's staff who speak a variety of languages and can provide interpretive services if needed. The organization should explore the lack of consistency that may be provided with translators who are not trained interpreters. It was also identified that there may be a reliance on family members to provide interpretive services. I would challenge the organization to explore the risk to patient confidentiality in some situations. The organization is consistently identifying patients who may be a risk for falling. This improved practice will help ensure patient safety. Staff work collaboratively to provide patient care, support and teaching.

Priority Process: Decision Support

The Ambulatory Care Heart Function Clinic maintains a patient record for each patient. The files are paper charts. The PRISM project may provide opportunity to integrate the paper charts into an electronic record that will allow for easy transfer of information. The current record does not allow for transfer of electronic laboratory results for outside providers. Trending of laboratory results in the Heart Function Clinic is done manually on a paper chart. The records are consistently written and information is transferred to practitioners in a timely manner based on the client needs.

The Air way clinic gathers patient information and dictated reports are provided to clinicians.

Priority Process: Impact on Outcomes

The work of the Ambulatory Clinics is measured against indicators. The data is used to make improvements. The Heart Function Clinic has not implemented the lean strategies however they have plans to implement the principles. The quality improvement work that will be initiated with this process will allow staff to identify specific indicators that they can track. Current data that is tracked and monitored includes wait times and admission rates. This data could be shared and analyzed by the team to help them initiate changes and improvements.

The Airway clinic has implemented the huddle boards and have initiated improvements based on the ticket ideas provided by staff. The Airway clinic has expanded hours however this has resulted in times when staff will be alone in the department with patients. Various options have been explored to provide staff with the ability to notify others in the area if they require support during the patient visit. A implementation of additional security or notification system will support staff and maintain a safe work environment.

Standards Set: Biomedical Laboratory Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Episode of Care

This priority process was previously rated by Accreditation Canada in response to evidence provided by previous Laboratory Accreditation.

Priority Process: Diagnostic Services: Laboratory

The Laboratory Service is a joint service with Grand River. The organizations have identified areas of opportunity to consolidate services without negatively affecting patient care. The organization works to with other teams to determine service improvements. The team follows applicable laws and regulations. The team uses a positive patient identification system this system provides for opportunity for increased patient safety. Staff identify the patient at the bedside and labels are printed from the system which are used to label the specimens. The system does work on WIFI and the WIFI is not always reliable. The current system used for positive patient identification will be replaced with the PRISM project. Patient samples should always be labeled at the bedside, if a system such as this is used reliable wifi is essential. Transportation of specimens from the inpatient units to the laboratory is currently done in clear bags it is suggested that an opaque bag is used to provide for added patient confidentiality.

The Laboratory service has worked with the Canadian Society for Medical Laboratory Science on a Diversity Training Research Project. This work has supported the development of an education tool that teaches staff how to "Understand Workplace Responsibilities in an Ethically Intriguing Time". This power point was shared with staff as part of their continuing education opportunities. This challenged staff to think about ethical issues be also specifically talked about diverse cultures.

The team has also identified many areas for improvement and have established a visual in the managers office which allows staff and leaders to see ongoing projects. The board shows progress that has been made in completing tasks and identifies areas where one person who may have been tasked with a variety of items could benefit from help from another staff member to move the project to completion. This was a great way for staff and leaders to visualize progress.

Standards Set: Critical Care Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Critical care patients are managed in a medical ICU and coronary care unit and also a cardiovascular ICU. The cardiovascular unit manages patients who have recently received cardiac surgery. The medical ICU and coronary care unit manage patients who have medical problems and require a ventilator. The coronary care part of this unit manages patients with significant coronary artery disease. These two units are closed critical care units. Patients in these units are managed by cardiovascular surgeons and intensivists and cardiologists.
Strong leadership is evident in critical care. The organization has a team of dedicated energetic and committed healthcare providers involved in caring for the most acutely ill and vulnerable in society. There is exceptional team work and interdisciplinary team collaboration. The team is driven to provide high quality care and uses best practice and evidenced-based medicine to provide that care. The team has demonstrated significant commitment to patient and family centered care through on-going and consistent involvement of patients and their families. Staff and physicians are committed to working as a team using best practice evidence to improve patient outcomes. Performance metrics utilize the True North goals to improve performance. These indicators are being measured and worked upon by all staff in

the units. There has been extensive work utilizing evidence-based best practice medicine on the indicators of Central Line infections (CLI), Ventilator Acquired Pneumonia, (VAP), and Venous thromboembolism Prophylaxis (VTE) and Hand Hygiene.

There are students of various disciplines being educated and trained.

A critical care responds outreach team has been created that provides support to other areas of the hospital where there may be deteriorating patients. This team responds to criteria of deteriorating patients to ensure that these patients receive appropriate and timely care. This team also follows critical care patients for 48 hours after they have been transferred to a medical floor.
Information on the journey of care and on services is easily available to patients and families.

Priority Process: Competency

The organization has provided staff with ample opportunities and exposure to continuing education and resources to deliver safe quality care.
The multidisciplinary team approach is evident and has resulted in an engaged motivated staff
There is very strong support for education of all health care providers and patients at all sites.
New recruits into the system undergo a rigorous orientation program. There is also an orientation program for physicians.
Performance evaluations appear to be done consistently

Priority Process: Episode of Care

The critical care team is a multidisciplinary team. The team has an open transparent and respectful relationship with its clients. Clients and families are encouraged to be actively engaged in their care. There are various educational pamphlets, and websites that catered to patients educational needs. The team is very focused on ensuring that required organizational practices were met. There is emphasis on medication reconciliation as well as falls prevention and pressure ulcer prevention. The team is supported by 24 hour access to several supporting services including lumbar tree testing and diagnostic imaging. There is an individualized patient care plan. Several order sets are evident including withdrawal of life support, admission, and discharge order set. There is access to palliative care services and cultural care considerations are entertained in the delivery of care. Families are actively involved in bedside rounding and a family satisfaction ICU survey was performed in the past. Patients are provided great feedback on the care delivered in the unit. An example of disruptive cell phone use by staff and the effect that it had on patients resulted in a significant reduction in cell phone use by staff in the unit. Improvement ideas that have been brought forward by patients and family members have been implemented. There is a surge planning policy. There will be a more tabletop surge exercise in two weeks.

Priority Process: Decision Support

A significant number of available educational resources and tools are available for the team to perform their professional work. There is extensive online education as well as numerous rounds and education opportunities. The information system and other communication modalities is robust. Staff able to provide input horizontally and vertically with regards to required resources and tools for care delivery. The teams are involved in application of evidence based practices.

Priority Process: Impact on Outcomes

This is a high performing team, which exhibits significant levels of commitment to the delivery of safe quality care through engagement of staff. The team promotes patient and family involvement in care and safety through multiple engagement opportunities and education. The commitment to quality improvement is evident through the presence of performance improvement boards and the ongoing effort to solicit patient feedback and be as responsive as possible to changing patient needs and demands. The unit has a huddle board and a performance board. Performance indicators are linked to the strategic priorities and goals of the organization. There is visualization of the indicators on performance boards. This has helped staff to obtain an instant visual of the indicator. The indicators for the critical care include zero waste in which they hope to achieve a greater than 3% over time reduction of work hours. This translates into nine shifts per pay period. The team also hopes to admit emergency department patients within 90 minutes from decision to admit by the emergency physician. There is an anticipation of 100% engagement which will involve increased transparency involving unit initiatives and the “Cheers for Peers” recognition initiative. The team is also committed to zero harm.

Priority Process: Organ and Tissue Donation

There are policies and procedures on organ and tissue donation. Physician and nursing staff are aware of these policies and have received the training and education on organ donation. Staff are aware of how to notify Trillium gift of life network. The donor manager then comes to St. Mary’s General Hospital and manages the entire process of organ donation.

Standards Set: Diagnostic Imaging Services - Direct Service Provision

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

The organization has met all criteria for this priority process.

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

The organization has a full suite of medical imaging equipment to meet the needs of the population. There is clear signage to direct patients to the appropriate area. However the signs are raised high and are not easily seen.

The organization has ultrasound as well as CT scan and mammography, nuclear medicine, x-rays and the cardiac diagnostics. The diagnostic imaging department works very closely with Grand River Hospital. There is integration of these services with Grand River Hospital. The organization is aware of the service volumes and wait times for various procedures. The organization has implemented various strategies in order to reduce wait times. These strategies have resulted in significant improvements in wait times. The organization has reduced the wait time for priority level for elective patients to less than 28 days.

There has been significant improvements in the risk for falls. He falls prevention strategy has been implemented.

The organization has voice recognition system as well as a PACS system that was upgraded.

The team is aware of the diagnostic imaging needs of the referring physicians and the community.

The team has developed a Quality Improvement Plan that has identified various goals and objectives. The team has strong medical, safety and technical leadership and has an interdisciplinary team. The team collects and reviews data regularly and has metrics for all of its goals. The team is very much focused on safety for the patients and clients and staff. There are three safety officers within the Department. The chief radiologists and medical leads of the department and the administrative leader director of the department are heavily invested in safety in the department. All of the staff have done the three-hour LEAN course. The regional Chief for nuclear medicine Dr. Richard Debeau is very much engaged in the lean process and in quality improvement. The team has produced several quality improvement projects. Several of these quality improvement projects were initiated through the conversations that were held at the safety huddles. The nuclear medicine team has used a new solid-state camera in order to reduce the doses that are used. This has resulted in images being better with better contrast and resolution. The dose of radiation is less by as much as 50% and the imaging time for conducting the study has been reduced.

The team is to be commended for its work with diagnostic reference levels. The team has been involved with research that revealed that St. Mary's General Hospital patients received less radiation compared to other hospitals. This work was a result of research done by the department.

Applying dose reduction software has resulted in a rejection rate in general x-ray of less than 4.5. The team is actively involved in teaching students. Many of the students who were taught at St. Mary's organized themselves so that they have become much more efficient. They have streamlined the General Hospital are then recruited and hired into positions in the organization. The radiologists have organized themselves so that they have become much more efficient. They have streamlined the reporting of investigations. They have reduced the turnaround time from an ordered exam by the emergency department to report being available to less than three hours. The radiologists have a peer review process in which they meet weekly and review randomly selected CT scans across the St. Mary General hospital and the Grand River Hospital sites. They are trying to know standardize the interpretation of the results. The team has also developed regional requisition forms for imaging studies including CT scan, and bone mineral density.

Staff are engaged to bring forward ideas. Staff media box with the quote "your gift to us is your opinion". Improvement tickets from staff have resulted in several improvement ideas. Some of these ideas have resulted in initiatives that have improved the knowledge of patients about CT wait time and about privacy in nuclear medicine.

Monthly spill training exercises are held in nuclear medicine. Weekly contamination monitoring of the nuclear medicine space is performed. Harp testing for x-ray and CT areas is performed regularly. Preventative maintenance is done routinely on all imaging equipment and it is documented and logged. The team has continued to build on the extensive development of its extensive policy and procedure manual.

Extensive monitoring and trending of turnaround times and subsequent analysis is used to deal with significant variations in service.

Cardiac imaging is performed in the cardiac diagnostics space. Cardiac investigations perform in the cardiac diagnostics space include echo-cardiograms, exercise treadmill testing, trans-esophageal echocardiogram, and the stress echocardiogram. Echo cardiology technologists are normally regulated profession as of January 2019. It is a two-year program and it is fully accredited.

There is extensive and ongoing education of all individuals and providers in the department. All of the personnel in the department are strongly encouraged to be involved in educational activities and must have a certain number of credits yearly in order to have their licence renewed.
The reception area in the medical imaging department is very close to the waiting area. Moving the reception or waiting area may result in improved privacy and confidentiality. The physical space is clean and easily accessible. Safety for patients is paramount. The nuclear medicine regional program is situated at St. Mary's General Hospital.

Standards Set: Emergency Department - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The organization has a strong team in the emergency department. There are adequate professionals to service the needs of the population that come to the emergency department. The staff are engaged and seek improved care for their patients.

Priority Process: Competency

They are fully qualified personnel working in the emergency department. The team comprises physicians as well as nurses, social workers, pharmacy student and nurse practitioners. There are additional support services that work in the emergency department. There is orientation of all new recruited staff. Additional training is provided and staff are encouraged to continue to gain knowledge. Performance reviews are carried out regularly and are documented. There are adequate numbers of specialists and these specialists respond in a timely manner to requests for specialized care.

Priority Process: Episode of Care

The entrance to the emergency department is clearly marked. The triage assessment of the patients is by the Canadian triage and acuity scale. Patients entered the main the emergency doors and immediately direct to a computer terminal and to a hand hygiene station. Activating the computer terminal results in the production of a form that is filled in by the patients. Patients are then seen by the triage nurse and triage assessment is by the Canadian triage and acuity scale (CTAS) and patients are then directed to appropriate areas. Appropriate investigations are then obtained. Appropriate treatment is then initiated and instituted. 24/7 diagnostics and laboratory investigations are available. Appropriate management is then performed by the team. Depending on the CTAS level the required personnel are utilized. There are very few pediatric patients that are managed in this emergency department. Most pediatric patients are managed at Grand River Hospital. Patients are appropriately monitored in the emergency department and are reassessed appropriately. Standardized assessment tools are used. There is access to palliative care services.

Education and training is provided to all staff in the emergency department. There is education and training and orientation and recruitment. Staff are encouraged to continue professional development during their period of employment. Standardized clinical care guidelines are evident. A transfer of care accountability hospital is formed and shows that there is ongoing continuing care when patients are transferred between hospitalists.

There is extensive collaboration with the community with respect to several community festivals that occur on a yearly basis. These festivals result in dramatic increases in patients seeking emergency care. Thus St. Mary's General Hospital must be proactive in increasing staff and services during those times. There is engagement of family in formal and informal ways. Feedback from patients is shared among the medical and nursing staff. Patients send emails to the manager outlining issues about care. The manager will respond to these issues. There are patient health education brochures that are used to inform patients about services within St Mary's General Hospital. Patients have had input into the development of several of the patient brochures. There is a regular monthly process of evaluation that emergency leaders attend where issues of patients' care are discussed and acted upon. One example is the issue of why patients left emergency without being seen. There is a fall prevention strategy initiative in place.

Medication reconciliation is done in the emergency department by a PhD pharmacy student. Safety incidents are reported through the incident management system. There are several research studies that are ongoing within the cardiac unit. The department also has a patient flow group that is actively looking at ways to improve flow in the ER.

Priority Process: Decision Support

Client records are well kept. There is an element of ensuring privacy and confidentiality of the health record. The organization will soon have a new electronic medical system in place. The new system is called PRISM.

Priority Process: Impact on Outcomes

There is a huddle board and there is a performance board. There is significant engagement of front-line staff at the huddle board. Staff and physicians meet at the boards and discuss various initiatives. All new staff received a three-hour orientation in LEAN Methodology. Several indicators are being followed. These include Physician Initial Assessment time and the time from decision to admit to Inpatient bed. The department is also tracking its overtime hours with a target of less than 12 hours.

Priority Process: Organ and Tissue Donation

It is rare for organ and tissue donation to be initiated in the emergency department. However, staff are aware of protocols through orientation. Staff are knowledgeable as to whom to contact with respect to organ donation.

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

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

The organization has met all criteria for this priority process.

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

The Infection Prevention and Control team are skilled and qualified. The team consists of clinical and microbiology expertise. This staffing pattern provides opportunity to reflect on the Infection Prevention and Control program from various aspects. The team works collaboratively with the Grand River Hospital and share an Interdisciplinary Infection Prevention and Control Committee and Microbiologist.

The team utilizes patient and family advisers to help review the program and provide input into program changes. The Interdisciplinary committee should also consider adding a patient adviser to their group to provide additional patient input. Staff and volunteers receive training on hand hygiene each year and audits are conducted on the units. Information on hand hygiene rates are shared with the inpatient units however more of a focus on auditing and sharing results could be utilized in the ambulatory care clinics. The Infection Prevention and Control staff provide support to the staff and utilize data to monitor for potential risks of outbreaks. Staff proactively communicate with the staff on the inpatient units to prevent outbreaks which provides a safe environment for patients. The Infection Prevention and Control staff attend inpatient unit huddles to discuss opportunities for improvement. As well as ensuring proper PPE is used for patient and staff safety the Infection prevention and control staff have also provided information to staff on the situations when they should not be wearing PPE.

Environmental services staff have training in appropriate work practices and are an important part of the team which maintains a safe environment for patients. It was identified that because the units are cluttered it would be challenging for staff to clean the areas. Improvements could be made to minimize the equipment in the patient rooms and hallways. The surveillance rates are tracked and are published on the St. Mary's web site these indicators consistently meet expectations. The Infection Prevention and Control team are available to support staff and to improve the safety for patients.

Standards Set: Inpatient Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
3.4	Education and training are provided to team members on how to work respectfully and effectively with clients and families with diverse cultural backgrounds, religious beliefs, and care needs.	
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
14.1	There is a standardized procedure to select evidence-informed guidelines that are appropriate for the services offered.	!
14.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
14.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

There have been a number of clinical leadership changes recently within the medical program. New clinical leaders are supported by experienced leaders. Staff are provided the opportunity to take leadership roles in quality initiatives and rotate taking lead in huddle board discussions.

The medical program has both program and unit level goals and objectives. Medical involvement in co-design of programs is reportedly limited and informally defined. The organization and medical program are strongly encouraged to consider ways in which they can engage physicians and the MDT in program and service planning and design to meet the evolving patient needs.

Information regarding population health and community demographics is collected and shared with

organizational leadership. Decisions are reportedly data driven. The program / leadership are encouraged to revisit the extent to which data is informing decisions to ensure evidence and emerging patient trends and needs are not being overlooked in decision making.

Resource requirements (i.e. staffing) are communicated to leaders and staff feel organization is more responsive in addressing gaps and identified needs raised.

Priority Process: Competency

Service specific goals and objectives are developed by program leadership and discussed at unit leadership counsel meetings. Each medical unit has a LEAN huddle board that serves as a way to monitor improvement initiatives and communicate safety to team members. Nursing staff are provided the opportunity and support to lead 'huddle board' discussions. Patients, family and physicians do not routinely attend 'huddle board' discussions. However, the boards are located in publicly accessible areas and patients / families are able to view and comment on improvement initiatives in the clinical units.

Staff in each unit report receiving mandatory and ongoing education. Staff also note an improvement in collaboration, teamwork and leadership communication. Staff reported that staffing levels had been identified as a challenge and safety concern. Recent changes to staffing levels and communication processes have reportedly had a positive impact to the work environment.

Hospitalists serve as MRP to patients in the medical program, with NP's providing care to some cardiac and geriatric patients. The addition of a 5th physician has been well received. Physician's expressed the positive impact to patient outcomes with the recent introduction of a nurse-led critical care response team.

Physicians reported being aware of, and involved in, some aspects of planning and service design. The organization is encouraged to review the process by which physicians and NP's are engaged in service review and future planning of goals and objectives.

Patients and families feel they are very engaged with their care and care decisions. Patients and families are very pleased with the care and services at St. Mary’s. They consistently report feeling respected and safe.

The medical program has experienced significant leadership turnover and have taken measures to provide a smooth transition for staff and ensure continuity of decisions and continued quality momentum.

The medical unit (500) has a large ‘quality of life’ room available to patients and families. The room is filled with large windows, TV, comfortable seating and kitchen area. Unfortunately, the room design has patient and family area window overlooks the roof whilst the other panoramic view (opposite side of room) is restricted and filled with stored equipment. The kitchen space is also crowded with housekeeping supplies and stored equipment. The organization is encouraged to review the design of this room to fully leverage the rooms potential benefits for patients and families.

There is a robust bed utilization and discharge planning process in place. Bed management support is available on-site 24/7. Each unit utilizes a patient tracking board to assist patient care coordination and discharge planning. Physician led multidisciplinary rounding is in place and staff report rounding has had a positive impact in streamlining care and reduced length of stay.

The medical program has a 1 hour bed turn-around target (discharge, clean, admit). There is a reportedly fluctuating ALC population. There is a strong relationship with (former LHIN) discharge planning liaison however the organization experiences frequent delays in discharge due to limited LTC, retirement beds and/or wait times to access community supports needed to support safe patient discharge.

The organization is commended for supporting two NP's to become certified to train 'managing resisting behavior'. The organization is encouraged to move forward with their plans to offer this education to all staff involved with patient care and consider additional training in conflict and deescalation.

Priority Process: Episode of Care

The medical program consists of a diverse patient population across several clinical units. There is significant staff turnover within the medical program. Staff are supported by a unit manager, resource nurse and clinical educator in terms of ensuring required knowledge, skills and competencies are maintained by each staff member.

The staff utilize the huddle boards and discharge (sister boards) to help monitor and manage care coordination and discharge planning. The medical program are moving towards a model of initiating discharge planning on admission. Nurse practitioners are well integrated within the medical program (cardiac and geriatric service). The patient population is reportedly becoming increasingly complex with a noted increase in patients with mental health and addiction co-morbidity. The organization is strongly encouraged to review this trend and ensure required knowledge, skills and supports are in place to safely and effectively manage care.

There is an active patient and family advisory counsel. Patient Advisers are integrated in some program areas (visiting program). Patients and families are very pleased with the care and report being included and engaged in care decisions. With the increasing complex and older adult population the organization is encouraged to expand the role patient advisers within the medical program and establish mechanisms to engage patients of diverse cultural backgrounds.

Priority Process: Decision Support

There is currently a fragmented and hybrid documentation system. The organization will be implementing an electronic health record in November 2019. Staff and leadership are excited about this planned information system (PRISM) and frequently noted how the new system would help address many identified documentation gaps.

There have been a number of policies, procedures and workflows established with input from patients / families in preparation for the new documentation system. The organization is strongly encouraged to ensure documents with patient identification are kept from public view on units and during transfer (i.e. elevator, MAR outside patient door).

Priority Process: Impact on Outcomes

The medical units utilize several preprinted orders and validated screening / assessment tools (i.e. Braden, Morse). However, there was a reported inconsistent process identified to select, develop and approve clinical policies, guidelines and protocols. The organization is strongly encouraged to develop a standardized process to select and implement evidence, and evidence-based tools into practice.

There is a strong focus on quality and patient safety in each of the clinical areas within the medicine program. All leaders and staff receive LEAN training as part of their orientation to the organization. Staff frequently state Lean and quality improvement is "just part of the St. Mary's way". Staff are actively involved in leading 'huddle board' discussions and QI initiatives. Patients are invited to raise 'safety tickets' when risks or opportunities to improve are identified. Improvement initiatives are monitored and communicated via the 'huddle boards' until the desired outcome is achieved.

Whilst the program is commended for their focus on quality and safety they are encouraged to be mindful of the number of change initiatives and the pace of changes within the program. Additionally, staff note the increasing numbers of signs, boards of various information is becoming overwhelming and challenging to manage.

Standards Set: Medication Management Standards - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Medication Management	

The organization has met all criteria for this priority process.

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

The organization has an interdisciplinary committee that is responsible for medication management processes. The organization has a Director of pharmacy who is also responsible for the pharmacy at Grand River Hospital. Bringing these two organizations together has allowed for better integration of the pharmaceutical services provided to these two institutions. There is a joint medication and therapeutics committee that oversees medications for both sides. There is also a medication and safety committee.

The organization has an antimicrobial stewardship program that was started several years ago. This has resulted in improved ordering of antibiotic medications. There is a committee that oversees this program. Several interventions to optimize antimicrobial use have been implemented including orders and feedback, education, guidelines, dose optimization, and parenteral to oral conversion of antimicrobials.

The organization has purchased an antimicrobial stewardship module for the new Cerner program that will be implemented in the fall of 2019. The new program will allow the pharmacy to flag interventions, collect appropriate data and assist overall in improving medication safety.

The team uses the boards and one of their goals is to reduce the pharmacy budget by 6% over one year.

The huddle boards have resulted in improved engagement of the staff. The boards have also helped staff with information transfer, celebration of a good job done, and identification of safety concerns. Omnicell dispensing equipment was installed approximately one year ago. This project involved development of an education and training plan as well as education of health care providers. There was a sequential rollout of the implementation. Super users were particularly useful on each unit in training staff. This has resulted in improved dispensation of medication.

There is a shortage of pharmacy technicians. This has impacted the recruitment of pharmacy technicians and there is a potential for it to impact pharmacy services in the future. Pharmacy technicians obtain a diploma and this has now become a regulated program. Similarly pharmacists now all have to have a doctorate in pharmacy if they wish to practice in a hospital setting.

The organization may wish to consider complete integration of St. Mary's General Hospital and Grand River Hospital pharmacies. Both organizations already have a single Director. who oversees them both. Furthermore, Grand River Hospital already has the infrastructure and the personnel for preparing chemotherapy medications. St. Mary's Hospital would be challenged to implement all of the NAPRA standards. There is a significant cost attached to implementation of these standards. The two organizations are also in the process of installing Cerner the information technology system in the fall. Therefore this may make an optimum time for having one pharmacy on two sites.

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

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

There is strong nursing leadership and adequate numbers of physicians and nurses for providing surgical care services. The surgery teams have strong clinical skills. The staff are very much engaged and supportive of improving the care of the patient. Goals and objectives were identified as was seen on the huddle board and the unit performance board. The process of developing and communicating those goals and objectives was variable. The surgery leadership receives and reviews OR specific information regularly, for example information on the recent audit of the surgical safety checklists. Visual display of quality improvement and safety charts has encouraged healthcare practitioners to be more aware of the progress that the unit has made in improving care for its patients. The huddle boards have assisted in driving the focus towards better quality and safety.

Priority Process: Competency

The OR team responsible for the surgical care of the patient is a multidisciplinary team that is well trained and educated. Their primary purpose is to ensure safe, high quality, surgical care for their patient. Staff

have personnel files containing their credentialing, privileging, educational, competency assessments and performance activities. Staff had orientation which is performed in a standardized manner. There has been education and training on workplace violence and improving communication. There are several disciplines that receive training.

Priority Process: Episode of Care

Work processes are enabled. The organization has optimized the patient's journey by streamlining the process of care.

The surgical journey starts with the patient in the clinic or emergency department or unit or surgeon's office where the surgeon makes the diagnosis of a condition that requires a surgical intervention. The journey of the patient then begins through the system. All day surgery patients receive a call from the pre-surgical clinic verifying and requesting several pieces of information. Some patients are seen preoperatively by Anesthesia and appropriate information is shared with the patient and documented. Informed consent is appropriately done.

The operating theater has operating suites that are of adequate size. Not all the surgical suites are being utilized at present. One operating suite is being prepared for a cardiac Electro-Physiological (EP) program. Currently patients who have had permanent pacemakers implanted are brought back to the PACU. The organization may want to consider having these patients with permanent pacemakers be recovered in the EP program space. The operating suites are well resourced with anaesthetic and surgical equipment.

However adequate tracking of the surgical activity is currently done manually. The organization has indicated that electronic tracking boards will be available in the OR in November 2019. This is all part of the installation and implementation of the PRISM electronic system with Cerner. Currently there is no good way to ensure that surgical blocks and procedures booked in the OR are done in an efficient and effective way. However, a new system NOVARI for all OR bookings will be implemented in 2019. Surgical safety checklists are evident throughout all of the operating rooms. There is variation in the extent of the surgical safety checklist. For example, the extent of the checklist for ophthalmology is much shorter than that for that of the main OR. An audit of the safety checklist for St. Mary's General Hospital between January and April 2019 revealed that there is significant variation in compliance with the various aspects of the checklists depending on the service. The organization may want to continue with appropriate strategies to optimize compliance with surgical safety checklists.

A significant critical event occurred in the cardiovascular or are in December 2017. This resulted in an external quality of care reviewed and several recommendations. The organization is to be commended for its acceptance of the recommendations and implementation of these recommendations. The recommendations focused on improving communication and teamwork. Other recommendations included adopting closed-loop communication practices, implementation of surgical safety checklists, and improving culture. The leadership has continued to support the implementation of those

recommendations. Five working groups have been developed and are continuing to work on these recommendations. The organization may want to consider the National Safety Quality Improvement Program as a way to improve surgical safety at St. Mary's General Hospital.

All cardiac patients are optimized preoperatively by having blood preservation activities.

The organization has been very active in several initiatives. Surgical ophthalmology was moved from the second floor to the fourth floor in June 2018 and this resulted in improved flow within the OR. Surgical safety checklists was mandated and implemented in the operating theaters. A better staffing model with a different mix of RNs and RPNs was installed. On the other hand there has been lots of turnover of the leadership in the program.

A conversation was held with about 20 family members of patients who were having surgery. These family members were waiting for their loved ones. A discussion was held with them about their experience waiting for their loved ones. Some of their suggestions as to ways to improve the experience were the provision of more comfortable chairs, improving privacy, and reorganization of the placement of the chairs. Other suggestions included the provision of small tables between the chairs, a tracking board to see the surgical progress of their loved one while the family were waiting in the waiting lounge and lockers. They spoke very highly about the volunteers.

Priority Process: Decision Support

Educational resources and tools are available for the team to perform their professional work. There is online education as well as clinical rounds and education opportunities. Information is documented in the patient's record. However, there is a duplication of the entry of certain information. Information written on the transfer of accountability form has to be input into the digital record as that form is not part of the medical record. The organization is encouraged to continue to explore ways to reduce nonclinical work that is performed.

Priority Process: Impact on Outcomes

The team has a huddle board as well as the unit performance board. The team has developed various activities that it wishes to accomplish. These activities where the team wishes to focus its energies include reducing the number of blood and body fluids, encouraging reporting of incidents, a respectful workplace, and the staff scheduling/assignments. The team is also working to reduce overtime in the general OR by 2% and to reduce overtime in the cardiovascular OR from 5% to 2%.

Priority Process: Medication Management

There is an adequate supply of medication for the procedures done in the operating rooms. The contents of the medication carts are standardized across the organization though there are small differences within the anesthesiologists' carts. Medications are labelled and are delivered to the sterile field using an aseptic technique. All medications and solutions on the sterile fees were labelled and documented.

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

Unmet Criteria	High Priority Criteria
Priority Process: Point-of-care Testing Services	

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)
Priority Process: Point-of-care Testing Services

Point of care testing is performed by clinical staff however the program has over site from the Laboratory. The Laboratory does not train operators but does ensure that continued competency is maintained. The interdisciplinary committee is a joint committee with Grand River. The Laboratory works with the clinics and units to determine new testing that may be required and support the implementation of new technology. The testing is performed by staff outside the laboratory, results are reported in the patient record. These results are identified as point of care results.

Standards Set: Transfusion Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Episode of Care

This priority process was previously rated by Accreditation Canada in response to evidence provided by previous Laboratory Accreditation.

Priority Process: Transfusion Services

The Transfusion service provides support for St. Mary's Hospital patients. The Transfusion service works with Transfusion at Grand River. The team implements quality improvement activities such as decreasing the number of units of platelets that are discarded. They have initiated a redistribution with the Grand River laboratory. Canadian Blood Services has recognized the benefits of this quality improvement. The team works with physicians and care providers to make improvements that will support patient care currently they are exploring the stocking of a new product in the Transfusion Service.

Transportation of blood products to the patient care areas should be done in a manner that ensures the blood product is safe and there is no risk of other patients or visitors reading paper work. It is suggested that the blood product and paperwork be contained in a bag that is opaque and protects the unit and information about the patient.

Instrument Results

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

Governance Functioning Tool (2016)

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

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

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

- **Data collection period: September 23, 2018 to October 26, 2018**
- **Number of responses: 16**

Governance Functioning Tool Results

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1. We regularly review and ensure compliance with applicable laws, legislation, and regulations.	6	6	88	94
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	6	0	94	95
3. Subcommittees need better defined roles and responsibilities.	75	6	19	70
4. As a governing body, we do not become directly involved in management issues.	0	0	100	85
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	6	0	94	95

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
6. Our meetings are held frequently enough to make sure we are able to make timely decisions.	6	6	88	96
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	6	0	94	96
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	6	0	94	94
9. Our governance processes need to better ensure that everyone participates in decision making.	81	6	13	59
10. The composition of our governing body contributes to strong governance and leadership performance.	6	6	88	95
11. Individual members ask for and listen to one another's ideas and input.	6	6	88	97
12. Our ongoing education and professional development is encouraged.	6	0	94	86
13. Working relationships among individual members are positive.	6	0	94	98
14. We have a process to set bylaws and corporate policies.	6	0	94	95
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	6	0	94	98
16. We benchmark our performance against other similar organizations and/or national standards.	6	19	75	77
17. Contributions of individual members are reviewed regularly.	6	13	81	71
18. As a team, we regularly review how we function together and how our governance processes could be improved.	38	0	63	84
19. There is a process for improving individual effectiveness when non-performance is an issue.	7	21	71	60
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	6	6	88	84

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
21. As individual members, we need better feedback about our contribution to the governing body.	75	13	13	44
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	6	13	81	81
23. As a governing body, we oversee the development of the organization's strategic plan.	6	0	94	97
24. As a governing body, we hear stories about clients who experienced harm during care.	6	0	94	86
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	6	0	94	91
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	6	0	94	86
27. We lack explicit criteria to recruit and select new members.	75	6	19	77
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	6	13	81	89
29. The composition of our governing body allows us to meet stakeholder and community needs.	6	0	94	94
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	6	0	94	93
31. We review our own structure, including size and subcommittee structure.	6	6	88	87
32. We have a process to elect or appoint our chair.	7	0	93	86

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2017 and agreed with the instrument items.

Overall, what is your assessment of the governing body's impact over the past 12 months, in terms of driving improvements to:	% Poor / Fair	% Good	% Very Good / Excellent	%Agree * Canadian Average
	Organization	Organization	Organization	
33. Patient safety	0	7	93	80
34. Quality of care	0	7	93	81

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2017 and agreed with the instrument items.

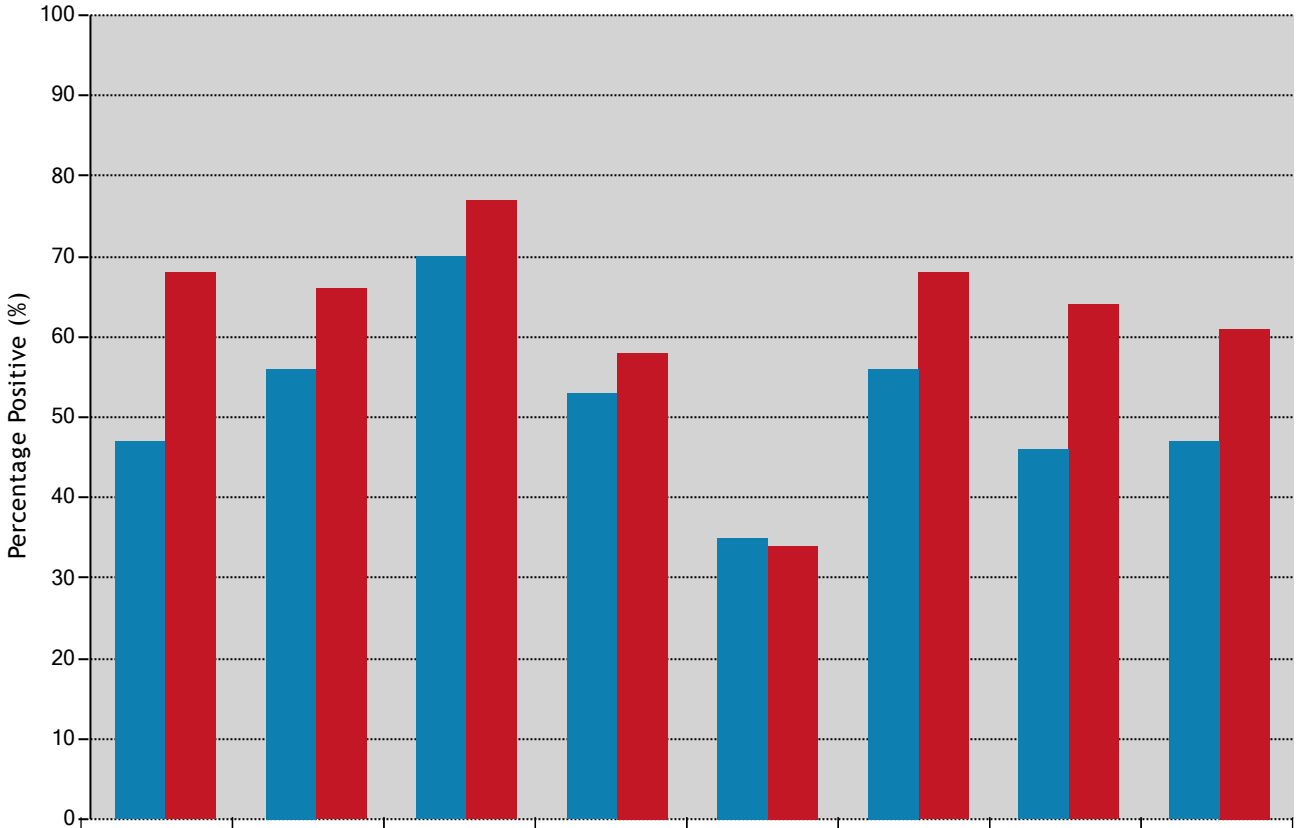
Canadian Patient Safety Culture Survey Tool

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

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

- **Data collection period: September 16, 2018 to October 31, 2018**
- **Minimum responses rate (based on the number of eligible employees): 283**
- **Number of responses: 295**

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



	Organizational (senior) leadership support for safety	Supervisory leadership for safety	Unit learning culture	Enabling Open Communication I: judgment-free environment	Enabling Open Communication II: job repercussions of error	Incident follow up	Stand-alone items	Overall Perceptions of Client Safety
	47%	56%	70%	53%	35%	56%	46%	47%
	68%	66%	77%	58%	34%	68%	64%	61%

Legend

St. Mary's General Hospital, Kitchener

* Canadian Average

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

Worklife Pulse

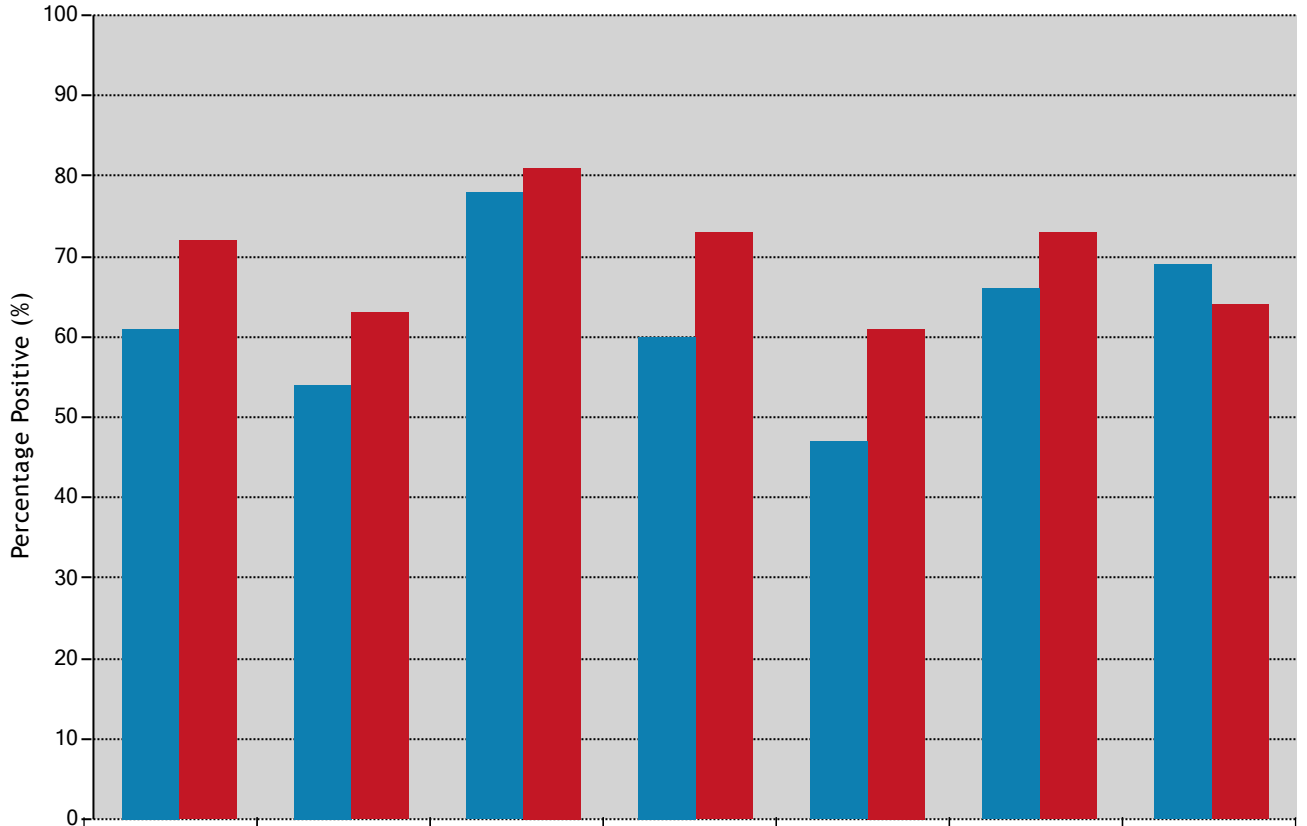
Accreditation Canada helps organizations create high quality workplaces that support workforce wellbeing and performance. This is why Accreditation Canada provides organizations with the Worklife Pulse Tool, an evidence-informed questionnaire that takes a snapshot of the quality of worklife.

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

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

- **Data collection period: September 18, 2017 to October 15, 2017**
- **Minimum responses rate (based on the number of eligible employees): 290**
- **Number of responses: 717**

Worklife Pulse: Results of Work Environment



	Job	Training and Development	Coworkers	Immediate Supervisor	Senior Management	Safety and Health	Overall Experience
	61%	54%	78%	60%	47%	66%	69%
	72%	63%	81%	73%	61%	73%	64%

Legend

St. Mary's General Hospital, Kitchener

* Canadian Average

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

Client Experience Tool

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

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

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

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

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

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

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

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

Appendix A - Qmentum

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

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

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

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

Action Planning

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

Appendix B - Priority Processes

Priority processes associated with system-wide standards

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