ACCREDITATION AGRÉMENT CANADA

Accreditation Report

Qmentum Global™ Program

St. Mary's General Hospital, Kitchener

Final

Report Issued: 30/08/2023

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About Accreditation Canada

Accreditation Canada (AC) is a global, not-for-profit organization with a vision of safer care and a healthier world. Together with our affiliate, Health Standards Organization (HSO), our people-centred programs and services have been setting the bar for quality across the health ecosystem for more than 60 years, and we continue to grow in our reach and impact. HSO develops standards, assessment programs and quality improvement solutions that have been adopted in over 12,000 locations across five continents. It is the only Standards Development Organization dedicated to health and social services. AC empowers and enables organizations to meet national and global standards with innovative programs that are customized to local needs. Our assessment programs and services support the delivery of safe, high-quality care across the health ecosystem.

About the Accreditation Report

The Organization identified in this Accreditation Report is participating in Accreditation Canada's Qmentum Global™ accreditation program.

As part of this ongoing process of quality improvement, the organization participated in continuous quality improvement activities and assessments, including an on-site survey from 11/06/2023 to 15/06/2023.

Information from the cycle assessments, as well as other data obtained from the Organization, was used to produce this Report. Accreditation Canada is reliant on the correctness and accuracy of the information provided by the Organization to plan and conduct the on-site assessment and produce this Report. It is the Organization's responsibility to promptly disclose any and all incidents to Accreditation Canada that could impact its accreditation decision for the Organization.

Confidentiality

Executive Summary

About the Organization

St. Mary's General Hospital (SMGH) is to be commended on preparing for and participating in the QGlobal Accreditation program, especially on the heels of a global pandemic. Congratulations are extended to the organization for the work it has done to prepare for this survey visit, although they routinely focus on safety and quality improvements, regardless of the timing of their accreditation on-site survey. It was evident that the hospital was well prepared, and that staff participated in the process.

St. Mary's General Hospital (SMGH) was founded by the Sisters of St. Joseph of Hamilton in 1923 and opened in October of 1924. It is the second-largest acute care hospital in the St. Joseph's Health System with a team of over 2,000 staff, physicians and volunteers.

Located in the heart of Kitchener, St. Mary's is home to the Regional Cardiac Centre, Regional Chest Program and Regional Eye Program.

Grand River Hospital and SMGH have been partners for over 20 years and share services such as labs, a health information system, pharmacy, a 690-person medical staff, and leadership in KW4 OHT. Together, they are partnering to build a new joint hospital as both sites have outgrown their aging buildings.

Surveyor Overview of Team Observations

St. Mary's General Hospital (SMGH) is fortunate to have a committed, engaged, and knowledgeable Board of Directors (Board). The volunteer Board's functioning is high level with a clear emphasis on strategic planning as well as quality, safety, risk mitigation, and fiscal stewardship. It is well structured around governance accountabilities and provides the appropriate level of strategic guidance and direction to allow leadership to effectively manage operations.

The Board diligently monitors the metrics, targets, and accomplishments of SMGH. Board members celebrate and recognize the organization's achievements and performance. The Board challenges SMGH to do the best it can do and is constantly exploring opportunities for excellence and efficiencies.

The Board is involved in several key strategic initiatives, most notably, the creation of a 5 year strategic plan (2021-2026) which defines the vision for "Inspiring Excellence. Healthier Together." The current plan was the end result of a robust strategic planning process which followed a clearly articulated framework. The process included revision to the mission, vision, and values, reviewing peer organizations' strategic plans, conducting an environmental scan, SWOT analysis and listening to its internal and external communities. Five strategic priorities are contained in the plan: expand equitable access to high quality, empowered care; transform connected care with our partners and community; develop our team of today and the future; embrace new ways to innovate healthcare; and build for growth.

There is an impressive leadership team with a collectively, shared, strong, patient-focused collaborative approach to care. Interdisciplinary leaders are engaged, knowledgeable, and supportive of team efforts to deliver safe, quality care . The leadership structure offers multiple layers of support for staff. The knowledge of the leaders and the support they offer are obvious. Leadership is remarkably passionate about the organization, the care it provides, and the role it plays in the community and in the broader health care system in supporting staff, physicians, and volunteers to ensure that only the highest quality, evidenced-based care is provided to all patients.

Throughout the organizational survey visit staff attested to the level of improved collaboration and communication organization -wide and expressed that the leadership structure and the Leadership Team have been instruments of change in modelling effective teamwork and interdisciplinary and inter departmental collaboration.

SMGH recognizes that it does not have the mandate or resources required to meet all of the health care needs of the communities served. As such, they have developed purposeful partnerships that enable a strong local health care system that facilitates smooth transitions from hospital care to discharge throughout the continuum of life. In particular, SMGH is a member of the KW4 Ontario Health Team (OHT). SMGH is commended for the relationships it has developed and continues to grow with its local community and various health care partners. SMGH showed leadership prior to the pandemic and was an early advocate for an Ontario Health Team. The trust and collaboration developed thought that process, was an integral part of an integrated community response to the pandemic. The Community Partners focus group confirmed the Hospital was a good community partner and they mutually supported each other throughout the pandemic.

The survey team visited most clinical areas of the organization and was impressed with the level of care provided throughout. All team members were found to be energetically engaged in the accreditation process, clearly committed to the quality journey, and very proud of their programs and services. All areas were focused on quality improvement, with commitments to ongoing quality improvement activities noted across the organization. Staff were very engaged, not only in care delivery in their immediate area, but also in the organization as a whole.

There has been a significant turnover of staff and leadership in the past few years and the organization has focused on attracting and retaining staff. This work will need to continue and new staff and managers will require support to grow within their roles

SMGH's population is growing, aging, and becoming more diverse. SMHG is already at or exceeding capacity in many areas and will not be able to properly serve the health needs of the larger population without capital and program expansion. As a result, the hospital is in the process of developing a Master Service Plan that will support its future projected growth. This process has been very robust and has included collaborations with healthcare partners, leaders, and stakeholders including the voice of the patient and family.

The ongoing evolution of patients as partners in healthcare, is an initiative that plays a significant role in the organization. Senior leadership and the governing body are passionate about creating a truly person-centred (PCC) experience at SMGH. Embedding PCC as a cultural norm will require additional resources to spread best practices from areas of excellence to those hungry to do/learn/grow more in that journey.

The surveyors met with a number of local health care providers, including representatives from area hospitals, primary care centres, education facilities, members of the KW4 OHT, and Government. All spoke glowingly of the organization's commitment to partnering with other providers and working together to meet the health needs of their shared populations. Numerous examples were shared by community partners of how SMGH works collaboratively to treat the whole person, be open and transparent, leverage expertise and support marginalized populations. Community partners shared that WCH demonstrates "finding a way forward" in a desire to provide care. The Hospital has a stellar reputation within and surrounding their catchment area, as relayed by the Community Partners.

It has been a pleasure to visit SMGH and we wish them every success in their quality journey.

Key Opportunities and Areas of Excellence

Areas of Excellence

Located in the heart of Kitchener, St. Mary's General Hospital (SMGH) is home to the Regional Cardiac Centre, Regional Chest Program and Regional Eye Program.

Grand River Hospital and SMGH have been partners for over 20 years and share services such as labs, a health information system, pharmacy, a 690-person medical staff, and leadership in KW4 OHT. Together, they are partnering to build a new joint hospital as both sites have outgrown their aging buildings.

Overall Observations Strengths

•Enabling Partnerships
•Pervasive focus on safety, collaboration, collegiality
•Leadership team-visible, approachable, accessible, receptive
•Organization-wide commitment to people-centred care
•Highly skilled and committed Board of Trustees
•Passionate, Dedicated Workforce; Physician Engagement
•Positive reputation in the community
•Caring culture – passionate, engaged and resilient staff, physicians and leaders
•Patient/Family Satisfaction
•Focus on workplace wellness

Key Opportunities

SMGH is encouraged, in tandem with its partners, to continue on the path of master service and clinical services planning to support the growth of its community, which is projected to increase by fifty (50) per cent over the next 10 years.

SMGH has an aging infrastructure. The organization is encouraged to continue to upgrade and renovate a required until the new building is in place.

Given SMGH commitment to people-centred care, it may wish to consider how patient and family advisors can play a role in the ethics structure of the organization and influencing the future evolution of the Ethics Framework and organizational structure to support ethical decision-making.

Overall Observations for Opportunities:

•Infrastructure - ongoing investments to upgrade and replace aging building.
•Continue to address space constraints and innovation of current space
•Transformation- continue to advance the program and system integration with partners
•Engagement - continue to meaningfully engage clients and families in key operational areas with stronger leverage of patient and family advisors.
•Culture – Continue to embrace the growing diversity within the community and engage them in their care decisions.
•Wayfinding

Program Overview

The Qmentum Global™ program was derived from an intensive cross-country co-design process, involving over 700 healthcare and social services providers, patients and family members, policy makers, surveyors, clinical, subject matters experts, Health Standards Organization and Accreditation Canada. The program is an embodiment of People Powered Health™ that guides and supports the organization's continuous quality improvement journey to deliver safe, high-quality, and reliable care.

Key features of this program include new and revised evidence based, and outcomes focused assessment standards, which form the foundation of the organization's quality improvement journey; new assessment methods, and a new digital platform OnboardQi to support the organization's assessment activities.

The organization will action the new Qmentum Global™ program through the four-year accreditation cycle the organization is familiar with. As a driver for continuous quality improvement, the action planning feature has been introduced to support the identification and actioning of areas for improvement, from Steps 2. to 6., of the cycle.

To promote alignment with our standards, assessments results have been organized by core and specific service standards within this report. Additional report contents include, the comprehensive executive summary, the organization's accreditation decision, locations assessed during the on-site assessment, required organizational practices results and conclusively a Quality Improvement Overview.

Accreditation Decision

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

Accredited with Exemplary Standing

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

Locations Assessed in Accreditation Cycle

This organization has 1 location.

The following table provides a summary of locations[1] assessed during the organization's on-site assessment.

Table 1: Locations Assessed During On-Site Assessment

Site	On-Site
St. Mary's General Hospital	☑

[1]Location sampling was applied to multi-site single-service and multi-location multi-service organizations.

Required Organizational Practices

ROPs contain multiple criteria, which are called Tests for Compliance (TFC). ADC guidelines require 75% and above of ROP's TFC to be met.

Table 2: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Medication Reconciliation at Care Transitions - Ambulatory Care Services	Ambulatory Care Services	5 / 5	100.0%
Client Identification	Ambulatory Care Services	1 / 1	100.0%
	Critical Care Services	1 / 1	100.0%
	Diagnostic Imaging Services	1 / 1	100.0%
	Emergency Department	1 / 1	100.0%
	Inpatient Services	1 / 1	100.0%
	Perioperative Services and Invasive Procedures	1 / 1	100.0%
	Point-of-Care Testing	1 / 1	100.0%
	Transfusion Services	1 / 1	100.0%

Table 2: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Information Transfer at Care Transitions	Ambulatory Care Services	5 / 5	100.0%
	Critical Care Services	5 / 5	100.0%
	Diagnostic Imaging Services	5 / 5	100.0%
	Emergency Department	5 / 5	100.0%
	Inpatient Services	5 / 5	100.0%
	Perioperative Services and Invasive Procedures	5 / 5	100.0%
Medication Reconciliation at Care Transitions Acute Care Services (Inpatient)	Critical Care Services	4 / 4	100.0%
	Inpatient Services	4 / 4	100.0%
	Perioperative Services and Invasive Procedures	4 / 4	100.0%
Falls Prevention and Injury Reduction - Inpatient Services	Critical Care Services	3 / 3	100.0%
	Inpatient Services	3 / 3	100.0%
	Perioperative Services and Invasive Procedures	3 / 3	100.0%

Table 2: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Pressure Ulcer Prevention	Critical Care Services	5 / 5	100.0%
	Inpatient Services	5 / 5	100.0%
	Perioperative Services and Invasive Procedures	5 / 5	100.0%
Venous Thromboembolism (VTE) Prophylaxis	Critical Care Services	4 / 4	100.0%
	Inpatient Services	4 / 4	100.0%
	Perioperative Services and Invasive Procedures	5 / 5	100.0%
Patient Safety Incident Management	Diagnostic Imaging Services	7 / 7	100.0%
	Leadership	7 / 7	100.0%
Patient Safety Incident Disclosure	Diagnostic Imaging Services	6 / 6	100.0%
	Leadership	6 / 6	100.0%
Medication Reconciliation at Care Transitions - Emergency Department	Emergency Department	1 / 1	100.0%
Suicide Prevention	Emergency Department	5 / 5	100.0%
Accountability for Quality of Care	Governance	6 / 6	100.0%
Hand-hygiene Education and Training	Infection Prevention and Control	1 / 1	100.0%

Table 2: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Hand-hygiene Compliance	Infection Prevention and Control	3 / 3	100.0%
Infection Rates	Infection Prevention and Control	3 / 3	100.0%
Client Flow	Leadership	5 / 5	100.0%
Workplace Violence Prevention	Leadership	8 / 8	100.0%
Medication Reconciliation as a Strategic Priority	Leadership	5 / 5	100.0%
Patient Safety Education and Training	Leadership	1 / 1	100.0%
Preventive Maintenance Program	Leadership	4 / 4	100.0%
Antimicrobial Stewardship	Medication Management	5 / 5	100.0%
High-alert Medications	Medication Management	8 / 8	100.0%
Heparin Safety	Medication Management	4 / 4	100.0%
Narcotics Safety	Medication Management	3 / 3	100.0%
Concentrated Electrolytes	Medication Management	3 / 3	100.0%
The 'Do Not Use' List of Abbreviations	Medication Management	7 / 7	100.0%
Safe Surgery Checklist	Perioperative Services and Invasive Procedures	5 / 5	100.0%

Table 2: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Infusion Pump Safety	Service Excellence	6 / 6	100.0%

Assessment Results by Standard

Core Standards

The Qmentum Global™ program has a set of core assessment standards that are foundational to the program and are required for the organization undergoing accreditation. The core assessment standards are critical given the foundational functions they cover in achieving safe and quality care and services. The core standards are always part of the assessment, except in specific circumstances where they are not applicable.

Emergency and Disaster Management

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the following table.

Assessment Results

The organization has an emergency preparedness team that annually/ad hoc reviews its emergency plans and performs monthly refresher drills. They have built robust plans with community partners to support them with casualty transportation, relocation and human resource support. Some of these partners include an elementary school close to the hospital, fire and police, Grand River Transit that is dedicated to the organization and Grand River Hospital. The hospital had partnered with Guelph, Ornge and fire/police to plan and execute mock Code Green exercises. As well, the hospital had to respond to a significant flood that affected the entire basement floor. Through a structured approach the event was rectified and a debrief was conducted for process improvement. Through this the Code Aqua was borne as the aging infrastructure contributes to floods of varying degrees. Strengths around pre-planning policy include a robust stock of PPE, fan out procedures to call in staff and volunteers, a morgue surge plan as well as a formalized contact with the Emergency Manager of the city. Opportunities for focus related to emergency preparedness is to continue education with a focus on Code Silver events in whatever capacity the hospital deems appropriate. The organization did face multiple surges in regards to patients requiring ventilation which had to be housed in different areas other than the ICU during the pandemic. The staff was able to support this surge and successfully manage the increase in acuity until the Level 3 patient census was stabilized to normal numbers. The organization has positioned itself well to support the community if they ever experience an emergency situation or disaster.

Table 3: Unmet Criteria for Emergency and Disaster Management

There are no unmet criteria for this section.

Governance

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the following table.

Assessment Results

St. Mary's General Hospital (SMGH) board of directors (board) is engaged and supportive of the organization's leadership and direction. Functioning is high level, with a clear emphasis on quality, safety, risk mitigation, and fiscal stewardship. Systems and processes are well developed, and as a result, the board is able to meet its responsibilities on behalf of the communities and the Hospital.

The Board has an understanding of its roles and responsibilities and those of Senior management, and clearly understand the difference. There is a strong corporate business model with well-developed collaborative partnerships. Services are readily accessible to those who need them in the context of the mission. There is a process in place for planning and service design within the framework of the corporate mission, vision and values. The values are known across the organization and used by the governing body and leaders in decision making.

The Board governs with regular meetings in addition to the board committees (Mission and Governance; Resource, Audit and Finance; Planning and Utilization; Quality; Culture and Human Development). Work is primarily accomplished by one of the high-performing board committees. These committees ensure that all board members engage appropriately in the governance of the organization. Decisions are made with expansive deliberations and discussion until consensus is reached or when board members are ready to vote. If more information or a deep dive is required, this will be arranged, and further discussion will occur as necessary.

The Board is diverse in skill set and experience. Conflicts of interest are declared at the beginning of each meeting. There is a comprehensive set of Board Policies, Corporate Bylaws, and Professional Staff Bylaws that guide the operation of the Board. From a resource oversight perspective, the board has strong processes and sets clear expectations around performance. There are good processes for operational and capital planning. There is a written process to elect a Chair as well as the process to select new Board candidates based on specific skills needed.

New Board members are orientated to their role as they join the organization. Board members describe a robust orientation that includes time with the CEO and senior staff in addition to materials regarding organizational information. More experienced board members support new board members, and the various voices and ideas are welcomed. Skills are considered when new Board members are sought. There are processes in place to evaluate the governance structure and function.

On-going Board education is noted with approval. In particular, the Board has undergone indigenous training, and has placed specific attention on Equity, Diversity and Inclusion (EDI). Each Board meeting consists of 20 minutes of generative discussion on topics/speakers/issues that were subject matter of the meeting. There was also an impressive ability to reflect on examples of Board deliberations where the values and principles of the Ethics Framework (YODA) were applied. As a member of the St. Joseph's Health System, the SGMH Board follows the Health Ethics Guide of the Catholic Health Alliance of Canada.

The emphasis on quality and safety at the board level is noted with approval. The quality framework, with direction and support from the board, ensures that SMGH is committed to providing the highest quality care to all who walk through its door. Regular reporting to the board through an aligned committee

structure ensures the organizational priorities related to quality are addressed. Quality is a regular agenda item and key performance indicators are brought to the board regularly for review. In completing its oversight role, the Board receives a comprehensive scorecard that includes a number of key metrics.

An integrated risk management approach to mitigate and manage risk is in place. The Leaders identify, assess, and monitor the risks that have been identified and ensure that systems to manage the risks are appropriate in context of the strategic objectives. The organization reports and appears to have a "just culture – no blame". At least annually, the Board reviews and monitors the Hospital's major risk exposures and the steps management has taken to monitor and control such exposures. Each Board Committee has oversight for the major risks that have been identified.

The CEO's performance review is completed annually by the SMGH Board in accordance with policy, with results shared with the St. Joseph's Health System (SJHS) CEO. There is annual review of compensation with SJHS CEO and the SMGH Officers of Board.

The organization has a well-established process for reviewing and granting health care privileges. There are also sound processes in place to address performance issues or disputes related to health care professionals with privileges.

Patient and family stories are shared at board meetings. The board is encouraged to continue to bring the voice of patient's and families to their meetings.

As noted by the Senior Leaders and the Board of Directors, the demographics of the population that is served by SGMH is changing. The Board will need to ensure its membership continues to reflect the diverse community served by the organization.

The Board is encouraged to continue to strengthen their oversight of SMGH effectiveness and achievement of targeted strategic milestones. Governing an organization during a period of instability is a challenge and the SMGH board is to be commended on its efforts to support the organization. Future efforts will be on building the hospital infrastructure of the future to address the growing demands of the community and health human resources shortages.

The board should be proud of the leadership role it has played in bringing the organization to where it is today, and equally proud of the steps is now taking toward ensuring the organization continues to meet the health care needs of the populations it serves.

Table 4: Unmet Criteria for Governance

There are no unmet criteria for this section.

Infection Prevention and Control

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the following table.

Assessment Results

The IPAC team is a group of individuals that bring together a very diverse skill set. The first thing that is evident is their passion for high quality care delivery. They are an important subspecialty in the organization that has transcended its borders to seamlessly bring in the community. Tasked with overseeing a LTC facility, a retirement home and an MCSS funded group home to assess infection prevention and control processes during the pandemic was a large undertaking. As well, the team fielded many queries from neighbouring organizations regarding Covid related practices and concerns. They have a partnership with Grand River IPAC team and have cultivated their relationships with intertwining departments such as Environmental Services and MDRD. This multifaceted team has a laser focus on data mining and analysis, and uses this to drive their policy. Striving to ensure standardized processes and communication strategies between St. Mary's and Grand River is one of their number one priorities to ensure all patients and families receive evidence-based, timely care.

At times IPAC can be unintentionally excluded from certain projects, renos or capital purchases where their expertise is needed for guidance. The importance of intertwining the team's knowledge and skills throughout both clinical and support areas should be nurtured.

Table 5: Unmet Criteria for Infection Prevention and Control

There are no unmet criteria for this section.

Leadership

Standard Rating: 98.4% Met Criteria

1.6% of criteria were unmet. For further details please review the following table.

Assessment Results

Planning and Service Design

Few organizations are as advanced as SMGH in the area of planning and service design. The organization is commended for the focus it has placed on proactive strategic planning. Planning is consistently done in partnership with other providers, and in particular, with The Grand River Hospital and the KW4 OHT, which has allowed SMGH to truly focus on the organization and community's top priorities as it relates to health care across this region.

Efforts to advance master Planning (in partnership with Grand River) across the system are noted and the organization is clearly defining future requirements from a development perspective. Population growth and increases in medical complexity has resulted in a high demand for space and has put pressure on existing aging facilities at SMGH.

Advocacy for a new Acute Care Hospital for Kitchener/Waterloo has been underway for several years. While not quite at the Functional Programming stage, the proposed timeline for the new build is the end of 2034 of 1 Acute Care Hospital and re-purposing the Grand River Site.

Involvement of interested community and local, regional, and provincial leaders have been meeting since 2017 to lend advocacy for the build/fundraising.

Communication between levels of the organization is open and transparent. There are opportunities and methods for staff, physicians, service providers and community to provide input into service planning. Strategies to engage hard to reach populations are in place.

The survey team was very impressed with the alignment that existed throughout , from the Board setting the high level focus right through the day to day delivery of care at the front lines. Planning is comprehensive, clear, and concise. The operational planning is sound and involves all programs and services in establishing goals and objectives, with strong metrics. There are impressive strategic roadmaps in place, with clear responsibility assignments, and quality improvement and annual operating plans are well aligned with strategic imperatives.

Since the last accreditation, SMGH has renewed its strategic plan (2021-2026): inspiring Excellence. Healthier Together, through a consultative process engaging with internal and external stakeholders including patients and families. Five strategic priorities, supported by two enablers were the outcome of the process: Expand equitable access to high quality empowered care; Transform connected care with our partners and community; Develop our team of today and the future; Embrace new ways to innovate health care; and Build for growth.

SMGH uses a corporate scorecard to measure progress against their five year strategic plan. KPI results are reviewed quarterly with actions taken when necessary to ensure performance remains on track. There are Executive Sponsors for each of the Priorities. The organization uses the strategic plan to guide decision-making throughout the organization.

Planning for a Board retreat, with the focus of a midpoint check-in of the Strategic Plan will occur in the Fall.

The strategic plan guides the workplan for the organization with goals and objectives cascading down to individual units. The leaders are encouraged to continue to work with frontline staff to reinforce how their work contributes to the strategic plan's strategic directions to ensure alignment throughout the organization.

The ongoing evolution of patient partners is an initiative that plays a significant role in the organization. SMGH is commended for their continuing work to advance People-Centred Care in the organization. The organization has enabled structures and support for people centred care. Resources are in place to support a strong and dedicated patient and family experience program which has expertise in partner engagement, engaging priority populations, health literacy, and patient experience evaluation.

The surveyors met with a number of local health care providers, including representatives from area hospitals, primary care centres, education facilities, members of the KW4 OHT, and Government. All spoke glowingly of the organization's commitment to partnering with other providers and working together to meet the health needs of their shared populations. Numerous examples were shared by community partners of how SMGH works collaboratively to treat the whole person, be open and transparent, leverage expertise and support marginalized populations. Community partners shared that SMGH demonstrates "finding a way forward" in a desire to provide care. The Hospital has a stellar reputation within and surrounding their catchment area, as relayed by the Community Partners.

Resource Management

SMGH has several systems and controls in place to support resource management processes. There is well-established budgeting and decision-making processes for the development of operating and capital needs. SMGH undertakes a principle-based approach when determining operating and capital budget requirements and at the same time ensuring financial accountability. The annual operating cycle includes the identifying the needs of the business including service pressures and quality gaps and priorities of government.

SMGH is committed to operational efficiency, transparency and accountability. Evidence-based decisions to enhance financial health, conduct business under the principles of fiscal prudence, and with integrity and good judgment when allocating resources, is noted with approval. Full engagement, from front line through the Board of Directors, occurs when undergoing operating and capital planning cycles. Regular reports are provided to all areas of the organization to monitor and track performance on an ongoing basis.

The ability to generate information necessary for Senior Leaders and managers to manage and lead their respective portfolios is noted with approval. The utilization of financial analysts and decision-support making criteria has strengthened the budgeting knowledge, analysis and monitoring within the organization. In addition, this allows for better program engagement in the financial process and supports the fiscal education of the front line managers.

Program Performance reports are generated for individual budget owners on a monthly basis. These reports summarize the program performance both financially and statistically and highlights key variances. The Business partners also work with budget owners to identify root causes of variances and ensure accuracy of reported expenses. Program performance reports include efficiency and benchmarking reviews. A roll-up of Corporate Financial Performance Reports are submitted to the Executive Senior Leadership Team and Resource, Audit and Finance Committee of the Board.

There is a 5 year outlook plan for capital investments, that is refined on an annual basis. Similarly as with the operating budget, the capital budget is determined based on the priorities identified in the Strategic Plan, and is prioritized against a number of criteria to be considered including the impact on risk, safety needs, replacement or new when setting a prioritized list of capital items. la The Foundation continues to be a key partner in the Hospital's capital planning process. The Foundation works closely with the Executive Team to align available dollars and future fundraising efforts with Hospital priorities.

The impact of resource allocation decisions is regularly analyzed. Reports on financial performance include an analysis of the utilization of resources and outline opportunities to improve the effective and efficient use of resources. The organization's leaders verify that the organization meets legal requirements for managing financial resources and financial reporting, e.g., audit, running a deficit.

Throughout all resource discussions, the organization ensures extensive Patient and Family engagement. This input helps ensure that the focus on the needs of the patient remain front and centre and will likely drive new models of service delivery moving forward.

Human Capital

St. Mary's General Hospital (SMGH) has a clear commitment to create and maintain an environment where people are valued, recognized, and performing at their best. There is a dynamic team leading and supporting the People Services portfolio. At the current time, there are 1,780 staff, 700 jointly credentialed Physicians (with Grand River Hospital) and 130 Volunteers. There is a 10.4 per cent vacancy rate with equates to 227 vacancies with 51 percent of those vacancies being for nurses (RN and RPN).The organization also supports learners from local universities and colleges.

There is no doubt that as an organization, SMGH believes in their people and is investing in their career development and professional education as well as ongoing educational opportunities to support the quality and safety agenda. The organization can be proud of the investment and commitment to develop leaders and staff wellness. In partnership with Homewood Health, any staff member that is interested in management development can partake in the Emerging Leaders training program. Current leaders take part in the Leeds leadership development program.

There is a People and Culture Strategy that outlines five areas of focus designed to attract, retain, develop, and support SMGH people of today and the future. The Five areas of focus are: Recruitment & Growth, Engagement & Culture, Leadership Support, Health Promotion, and Developing People Resources.

The COVID-19 Pandemic has strained health human resources nation-wide. The emergency response followed by 2.5 years of pandemic response activity has had an impact on staff at SMGH. Shortages in staffing have resulted in increased pressure on the existing staff, and there are real risks of staff burnout and disengagement. Similarly, SMGH is experiencing health human resources challenges in the areas of recruitment, retention and supporting employee wellness. In response to these challenges, multi-year, multi-pronged recruitment efforts are underway, retention strategies have been put in place, and there is a big focus on mental health and wellbeing support. Through the generosity of a donor, SMGH has invested in a range of wellness activities for staff focused on providing opportunities to buoy their spirits, while also supporting their mental health. These include that Care Cart that makes weekly rounds to departments to provide snacks and treats for the staff, ice cream days, therapy dogs, mental health counselling and wellness supports.

Despite these challenges, there is a positive work atmosphere throughout SMGH. Staff who were interviewed expressed a very high level of satisfaction with the organization. They thoroughly enjoy their work and are deeply passionate about the care and services they provide as well as being part of an organization driven by its values.

Workplace related violence toward and among staff is an identified risk to the organization. There is a policy and procedure addressing violence in the workplace. Training to recognize risks is available and mandatory training is in place. Management of Resistant Behaviour (MORB) training is provided. Mitigation strategies are in place and auditing of the workplace violence and harassment program is on-going. A Code of Conduct is in place. There is a staff support coordinator that is available to support staff through any incidences of disrespectful behaviour.

Staff and volunteers are acknowledged and rewarded when appropriate through numerous staff recognition and social events. Each Staff member can apply for up to $1,200.00 annually for continuing education financial support, an enhanced EFEAP through Homewood Health, and Quality Improvement(CQuIPs) education to name a few.

It was noted that there are many individuals who are new to management or who have assumed new manager roles. As a change like this can be daunting for some, the organization is encouraged to ensure that these individuals have the support they need for their success.

Policies are in place for the completion of performance reviews. However, it was noted that performance appraisals have not been completed in several areas. The organization is encouraged to get back on track and follow through on the completion of performance appraisals as indicated in the policy.

Principle Based Decision Making

There is justifiable pride by all who describe the very comprehensive approach to Principle-based care and Decision Making in every dimension of practice (clinical, education, research and administration) at SMGH. The resources and processes to support decision making are evident at every level of the organization - board, senior leadership, project and quality improvement teams, direct care and services, and research.

Bioethics services for all of the St. Joseph's Health System are provided under an agreement with Unity Health's Centre for Clinical Ethics (CCE). CCE provides an annual report to the Board on usage and identified trends. There is 24 hour support, 7 days a week.

There is a dedicated bioethicist for SMGH. He is well known in the organization, as evidenced by the response from front-line staff when questioned about their knowledge of ethics resources that are available to them. There is ongoing education from bedside to the boardroom to ensure a sound understanding of the Ethics consultative service . The intranet home page provides a direct link to available resources and tools to guide practice. Anyone directly involved in a situation that raises ethical questions may request an ethics consultation. This includes any member of the healthcare team, patients or persons receiving care or by patients' families or significant others.

SMGH strives to create a climate where ethical issues are identified, acknowledged, discussed and resolved. There is a commitment to building capacity in ethics awareness and knowledge through staff ethics rounds, clinical ethics consults under the expertise of the ethicist as well as publications, case study reviews and a variety of educational sessions and resources.

Ethics is integrated into the Board Processes. An annual Board Education session on the Ethics Framework (YODA) is provided by the Ethicist. All decisions are framed from the values and guiding principles of SMGH.

There are Terms of Reference for a Clinical and Organizational Ethics Committee, with a long list of objectives. However, in its current form, it's focus has been primarily on coordinating education for staff. They have recently surveyed staff to assess their awareness and utilization of the Ethics Framework and to better understand what ethics-based topics SMGH is looking for more information/support on.

All research proposals go through a SMGH Internal Research Committee for approval, prior to be vetted by the Tri-Hospital (SMGH, Grand River and Cambridge) Research Ethics Board (REB). A member of the Patient and Family Advisory Council sits on the REB.

Given SMGH commitment to people-centred care, it may wish to consider how patient and family advisors can play a role in the ethics structure of the organization and influencing the future evolution of the Ethics Framework and organizational structure to support ethical decision-making.

Patient Flow

Bed Management meetings occur daily from Monday to Friday. The Patient Flow Manager, Bed Coordinator and Hospital Operations Leaders have the authority to make choices that serve the greater good of the hospital, the staff, and patients. They develop, oversee and support patient flow internally and externally and when necessary, deploy staff across the hospital to support patient care. The organization has a surge plan and there are blocked beds that can be opened when necessary to accommodate patient flow.

During the Bed Management meeting the number of discharges, admissions, staffing levels, isolation cases and "thread alerts" (patients who require one on one care) were discussed. The Environmental Services Supervisor attends the meetings and there are processes in place in the clinical areas to ensure the cleaning staff monitor and clean beds in a timely manner. Discharge times for patients is set for 1100 am and patients and families are informed of this prior to the date of discharge. Alternative Level of Care is monitored and on the day of the survey 12% of the 194 beds were designated ALC. Home and Community care are in located the hospital and provide support with transferring patients to Long Term Care, Home and Respite. An Operations Manager and a Senior Leader are on call 24/7. Staff are familiar with the processes for calling the manager on call. The organization is encouraged to work with staff so inpatient units pull patient from the ED department instead of the ED department pushing patient to the inpatient beds.

Communication

St. Mary's General Hospital has a Strategic Communication Plan (2022-2025). This plan provides a roadmap that defines goals and measurable objectives to guide the work of the Communications Team and align actions, resources, and key deliverables that will advance the organization. The Communication Plan guides internal and external communications to key stakeholders, risk mitigation strategies, transparent communication to strengthen SMGH's relationships and support achievements under the new Strategic Plan as actions affect change.

Communication occurs through the hospital's website to external partners and to Internal partners through the intranet called The Pulse. Daily briefings and huddles occur at the clinical unit level. The organization has a Social Media and a Media Relations Policy which have both been currently revised. Social media includes Facebook, Instagram, LinkedIn, YouTube, and Twitter. Virtual and in person Town Halls occur monthly. Occasionally combined Town Hall meetings occur with Grand River Hospital and messaging to both sites is standardized (e.g. Master Plan). Staff are able to submit questions prior to the Town Hall meeting and review the responses on YouTube or in the newsletter. The newsletter called The Grapevine is created by the Communication Specialist and distributed on the intranet. Topics such as policy updates, Foundation fund raising, community events and departmental updates are included in the newsletter. Through a software program, the Communication team can obtain analytical data such as number of staff who reviewed the messaging.

The Communications Manager provides daily media scans and provides this information to leadership. The President reports to the Board and completes a quarterly review of media mentions. The Communications Manager is accountable for ensuring messaging is approved prior to social media releases. The organization reports that they have good relationships with the local newspapers and radio stations. SMGH works closely with and communicates regularly with regional partners and the Ontario Health Team.

The Communications Department is currently working on "My Connect Care" and hoping to have this function available to all departments soon. They are also starting a digital "signage" project and are encouraged to include patients and community members of different cultures in this work.

Physical Environment

St. Mary's has an outstanding maintenance team. Being saddled with keeping a very old structure safe for the community's vulnerable populations has not kept them from innovative endeavours. The team has taken small steps to help contribute to becoming environmentally friendly such as LED lights, low flow toilets and monitoring energy consumptions regularly. The MESA project which the hospital has been engaged with, provides overarching guidance during much needed renovations. Here target audits are monitored and fed back to the maintenance team to evaluate their efficiencies. Through their partnership with Greening Healthcare Coalition which benchmarks St. Mary's compliance records of natural gas use, electricity and water against partner organizations and legislative scales. One initiative of note is the annual collection of labeled waste that is deconstructed and assessed to ensure recycled items are indeed recycled properly and waste is discarded accordingly. The information is fed back to the respective departments for process improvement which in turn benefits the environment. This great work needs to be showcased and adopted by other organizations for their quality improvement projects. Engaging the community when the hospital needs to communicate the purpose of construction projects was refreshing to see. The team went door to door to the neighbouring community to ensure they were abreast of the construction and the reasoning behind it. As well, the maintenance team works in tandem with the clinical teams to protect their patients from excessive noise and minimalize the disruption of services. IPAC works closely with maintenance as a partner when enhancing any aspect of the building. They have carved out robust relationships throughout the organization with a laser focus on patient experience

Medical Devices and Equipment

Medical Devices cover a wide range of products that are used in the treatment, mitigation, diagnosis or prevention of disease or abnormal physical conditions. Following CSA guidelines, the team tests, certifies, and schedules preventative maintenance which is rigorously tracked through the biomedical database. Capital requests for medical equipment are submitted by the different departments and evaluated each year with the leadership team. An opportunity to explore is ensuring IPAC is involved in all capital purchases as well as any renovations related to the purchase. Engineering is responsible for over 3000 pieces of equipment which they closely monitor to minimize risk. The organization does not reprocess single use equipment and follows all manufacturers recommendations for reprocessing of mult-use equipment. It was evident all members of the MDRD team as well as bio-medical engineering took great pride in their jobs.

Table 6: Unmet Criteria for Leadership

Criteria Number	Criteria Text	Criteria Type
1.3.6	The organization implements client-oriented research practices to ensure that research reflects the client's experience and perspective.	NORMAL
2.4.6	The organization co-designs real-time surveys with clients and families, to capture up-to-date and accurate information about their experience of care.	NORMAL

Criteria Number	Criteria Text	Criteria Type
4.3.2	The organization ensures that new spaces, or spaces that need to be updated, are co-designed with staff, clients, and families to meet their safety needs and expectations.	NORMAL

Medication Management

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the following table.

Assessment Results

The Pharmacy Department is in the basement and there is controlled access. Cameras are located outside of Pharmacy. The Department is clean and well-organized, however there is a need for this department to have more space. Pharmacy is cleaned each day by Environmental staff and the Pharmacy staff clean the compound mixing area. The refrigerators have generator backups and temperatures are monitored regularly. The department is well lit and ventilated. There are two entrances to the Pharmacy Department. Staff wear the safety alarms and would call security if necessary. Overhead pages can be heard by staff in this department.

The Pharmacy program at SMGH is integrated with Grand River Hospital. This department was accredited in February 2023 by the Ontario College of Pharmacists using National Association of Pharmacy Regulatory Authorities standards. The Inpatient Pharmacy provides clinical drug support and medication distribution for St. Mary's clinical inpatient and outpatient programs. Services are provided by more than 34 regulated staff members which include pharmacists, technicians, and pharmacy students. A Pharmacist is accessible 24/7 to support staff. The Pharmacists working the evening and night shift provide support for BPMH, medication reconciliation, drug information and sterile compound mixing.

The Joint Medication and Therapeutics Committee meet monthly. Agenda items for this meeting include Antibiotic Stewardship updates, recall medications and backorders and short supply medications. This committee approves formulary additions or removals of medications and reviews non-formulary medications on a case-by-case review. Antimicrobial consumptions are monitored on Days of Therapy per 1000 days present. The leaders in this department understand the need to enhance the indicators for monitoring and auditing for antimicrobial stewardship and have a framework and plans to work on this. The organization uses the Institute for Safe Medication Practices DO NO USE abbreviations list. They have a supporting policy and complete regular audits with feedback provided to the physicians and staff.

There is a need for the Pharmacy team to review the process of delivering medications to the clinical areas and ensure safety for their staff. Consideration should be given to having two technicians deliver medications together and the purchase of transport cabinets that lock. Performance appraisal completion has fallen behind and this is work that is currently underway.

The Pharmacy program has a well-developed Clinical Service Plan Placemat with goals and objectives that align with the Strategic Directions of SMGH. This is a program that is extremely proud of their work and the services they provide to clinical areas.

Table 7: Unmet Criteria for Medication Management

There are no unmet criteria for this section.

Service Excellence

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the following table.

Assessment Results

Co-designing services that are shaped around the patient and their family is refreshing to see. Medication management is an important part of all patients health care. Best practice medication histories are scrutinized and constantly reviewed throughout the patients' hospital journey. There has been a concerted effort from the young leadership team to support clinical teams to attract new talent and foster the environment so staff currently working are retained. ICARE is a new endeavour being trialed within the nursing body to assess strengths, opportunities and future ambitions. This allows leaders to see where they can support succession planning as well as plan for retirements to continue to offer their patients seamless care. New groups are moving into the region of Kitchener/Waterloo. With this comes challenges for these families in terms of language barriers and becoming accustomed to unfamiliar cultures. The organization has adopted the Voice service to help ensure these new populations keep abreast of their treatment and care plans. There are opportunities for the organization to harness the uniqueness that these new families bring to the region and weave it in the fabric of what makes St. Mary's special.

Table 8: Unmet Criteria for Service Excellence

There are no unmet criteria for this section.

Service Specific Assessment Standards

The Qmentum Global™ program has a set of service specific assessment standards that are tailored to the organization undergoing accreditation. Accreditation Canada works with the organization to identify the service specific assessment standards and criteria that are relevant to the organization's service delivery.

Ambulatory Care Services

Standard Rating: 98.3% Met Criteria

1.7% of criteria were unmet. For further details please review the following table.

Assessment Results

The Cardiac Rehab Team in the boardwalk building are an integral part of the patients' cardiac journey. From customizing their rehabilitation to monitoring their progress in their home environment, the team always has the patients' best interest in mind. Data drives this program and is built into the patients' care plans. Tracking patient visits or no shows and diving deep to see how the staff can accommodate each patient's unique circumstances all work to set them up for success. The patient's medication management is closely followed from the time the cardiologist clears the patient for rehab, to intake and each visit through to discharge. Close connections have been developed with support services such as lab and xray to address point of care concerns in a timely manner. As well, partnerships with the YMCA, Diabetes programs and local fitness centres have been cultivated to help participate in the patients' rehabilitation. One opportunity that would enhance the excellent service provided to the patients would be to inform them of their rights and responsibilities as well as the process to report a complaint or good experiences. This ideally would happen during patient intake. All communication is supported with patient and family input, is documented in cerner and a hard copy is given to the patient. The team has experienced a rise in patients with mental health disorders and they have built in assessments to address this in their intake process.

The Heart Function Clinic and the Airway clinic have found unique ways to serve their patient populations. Whether it be having physicians travel to locations outside of their catchment area to providing unique ways to rehab their patients from home, the team will find a way. Patients are very pleased with their relationships they have developed with their respective teams. These patients establish long term goals with the clinical health care providers and trust them with their expertise. New and innovative ways to deliver care to St. Mary's Chronic Disease patients is always on the forefront of the teams' mind. It was a pleasure to see patient-centred care in motion.

Table 9: Unmet Criteria for Ambulatory Care Services

Criteria Number	Criteria Text	Criteria Type
1.3.1	Each client's physical and psychosocial health is assessed and documented using a holistic approach, in partnership with the client and family.	HIGH

Critical Care Services

Standard Rating: 98.2% Met Criteria

1.8% of criteria were unmet. For further details please review the following table.

Assessment Results

The Critical Care Unit is a 13 medical surgical unit and cares for patients with medical/surgical issues requiring ventilation. The Cardiovascular ICU has 6-8 beds and cares for cardiac surgical patients. The CCU Director and CCU Manager are new to their roles. The recruitment of staff has been an ongoing task for this program. Agency staff are used, and the hopes is that permanent staff will soon be hired and trained for the vacant employee positions. The Manager is commended for her diligent work in completing 90 performance appraisals over the past year. She took the performance appraisal activity as an opportunity to meet staff and get to know them better.

The Quality and Opp Committee meets monthly to review service goals, objectives, and key indicator performances. There is no patient or family representative on this committee and the team is encouraged to consider this addition to their meetings. As well, transfer of communication handover is performed at the bedside and currently family members are asked to leave during this information sharing activity. The Critical Care team is encouraged to consider incorporating the lens and voice of the patient and family members in their service design and service delivery care models.

The Quality Boards are visible in the units and huddles occur when possible. The Critical Care Managers have access to their budgets and meet with the Director and Finance staff to discuss variances monthly. There are processes in place to identify and purchase capital equipment. This program is well supported by the Biomedical staff. Ceiling lifts are in each of the patient rooms, and these are regularly checked by maintenance staff. Allied health support for this program includes Respiratory Therapists, Occupational Therapists, Physiotherapists and Dieticians. An Ethicist, Spiritual Support and Patient Relations staff are always available for staff and patients/families. The Chapel has recently been tastefully remodelled and provides a calming environment for those who need quiet space. Adjacent to the Chapel is a room used for services such as smudging and Islamic Prayer. The organization is commended for providing these important spaces for their employees, patients, family members and community.

Medical Assistance in Dying does not occur at this hospital site. If a patient chooses MAID, arrangements are made to transfer the patient to another organization who provides this service. Family members are included in palliative care at SMGH and can stay with their loved one as desired by the patient and family.

The program is encouraged to practice a Mock Code Silver as well as a Mock Evacuation. Many of the patients were on respirators and it would benefit the staff to practice how to evacuate these patients who are dependent on breathing apparatuses. As well it would be beneficial for staff to become more familiar with the ethics framework and practice tabletop exercises using relevant critical situations.

The Critical Care teams caring for patients in critical conditions have an open, transparent, and respectful working relationships. There has been extensive work ensuring evidence best practices occur for Central Line Infections, Ventilator Acquired Pneumonia and Venous Thromboembolism Prophylaxis. The Critical Care services are supported by an Educator. She is resourceful and monitors and supports the learning needs of the staff. A team approach is used to care for the patients in critical condition at SMGH.

Table 10: Unmet Criteria for Critical Care Services

Criteria Number	Criteria Text	Criteria Type
2.4.3	Daily rounds are conducted by the team in partnership with the client and family.	HIGH
2.5.6	Where possible, the presence of the client's family members in the room is accommodated when life-saving measures are being taken.	NORMAL

Diagnostic Imaging Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the following table.

Assessment Results

Diagnostic Imaging and Nuclear Medicine services are provided for inpatient and outpatients, and services are provided 24 hours daily 7 days per week. Approximately 90,000 examinations are performed per year. St. Mary's General Hospital operates an integrated and comprehensive Kitchener-Waterloo Regional Nuclear Medicine Program at two locations the Grand River Hospital (GRH) and St. Mary's General Hospital. Referrals are accepted from numerous distant regions in Southwestern Ontario. The tracking and trending of referrals routinely occurs. The Cardio Diagnostics Clinic offers ECHO, Electrocardiograph, exercise treadmill testing, stress echocardiogram testing, Holter services, Pacemaker, Arrhythmia and Heart Function testing and is open from Monday to Friday with some off hours support for ECHO and ECG's.

Wait Time Information Systems (WTIS) are used and wait lists are maintained for CT, Ultrasound, Nuclear Medicine, Bone Density, General Radiography exams and case types performed by the Cardio Diagnostics clinic. Strategies are put into place to manage and reduce waitlists such as joint equipment downtime planning or increasing clinic times and physician/staff availability.

This DI program monitors quality indicators that align with the strategic direction of the organization. Quality indicators, Kudos and Concerns are discussed and shared with staff at scheduled huddles. The leaders in the DI program have a "travelling" quality board that can be moved to the staff who are in multiple areas of the department. This method of sharing QI information increases staff participation and engagement. In speaking to staff, they felt they were in the "loop" and informed of program changes and updates. The leaders are encouraged to enter this "travelling" quality initiative as a leading practice to Accreditation Canada. This program, in collaboration with GRH Medical Imaging has established integrated quality improvement initiatives and are currently working on several initiatives such patient satisfaction surveys, referring client satisfaction surveys and annual safety walkabouts.

Joint Leadership meetings occur every 6 weeks to plan and review quality initiatives, volumes, and wait times to ensure equalized access between the sites where appropriate. Operational dashboards assist in identifying quality initiatives and maximize utilization and HHR planning. Incident reports are reviewed, and incident trends identified. Both hospital sites are making attempts to standardization equipment, Standard Operating Procedures, and protocols. This benefits physicians and staff who practice at both hospital sites. Staff and physicians have input into the Capital Acquisition processes and equipment selection. The Foundation is currently raising money for a new MRI and there are redevelopment plans in place with the hopes of opening the new MRI centre in the spring of 2024. Budgets are managed by the Directors of the programs and variance are monitored and discussed with Finance and Senior leadership..

A "Joint Imaging & Nuclear Medicine" newsletter is developed and distributed monthly to staff at SMGH and GRH. Some topics for review in the newsletter are "Imaging Safety Checklist" audit review with identified areas to work on, hand hygiene, results from the Imaging Safety Survey Joint initiatives update which highlights the personal panic alarms, staff preference for communication, improved Way-finding and lead garment testing. In speaking to staff, they noted it would be appreciated, from a staff and patient perspective, if coloured lines or focal markers could be used to guide patients to the correct areas in DI.

The Electrophysiology Team recently won the Biosense Webster Centre of Excellence in Fluoroscopy Reduction Award, being one of three Canadian hospitals to receive this honour. This award is given to cardiac centers who perform a minimum of 100 atrial fibrillation ablations without the use of fluoroscopy and replace it with computer mapping systems. This process improves patient safety by decreasing the amount of radiation patients are exposed to.

The leaders and staff of the Diagnostic Imagining and Cardio Diagnostics program are extremely proud of the work they do and the services they provide to the community. They are encouraged to continue their quality journey and standardization of equipment, policies and procedures across two hospital sites. Consider patient participation and input in service designs and decisions.

Table 11: Unmet Criteria for Diagnostic Imaging Services

There are no unmet criteria for this section.

Emergency Department

Standard Rating: 98.3% Met Criteria

1.7% of criteria were unmet. For further details please review the following table.

Assessment Results

St. Mary's General Hospital (SMGH) provides 24/7 emergency for patients with life-threatening, serious, urgent and emergent medical issues. There are two entries into the ER, one for walk in patients and a parking garage for EMS. A helicopter pad is located about a 5-minute drive from the hospital. Kiosks are used by patients who are required to enter pertinent information and are then triaged based on the Canadian Triage and Acuity Scale and wait times.

Currently the nursing practice at triage or the nursing staff working in the ER, is to complete the Colombia Suicide Severity scale based on patient complaints, clinical judgement and or patient's self-report. Not all patients are assessed and only those who present or self-identify have the Columbia scale completed. In reviewing patient charts, this was identified as the practice. Based on this current practice, there are many patients who could be missed and are at risk of suicide or self -harm and not identified. SMGH has a draft policy (2023) entitled "Identification and Management of Patients at Risk for Self-Directed Harm or Suicide". The policy statement notes, "it is the policy of the hospital that all patients will be assessed for self-harm and or suicide". In the procedure below the policy statement, the Emergency Department is only identifying those patients who present themselves and not all patients are screened. The organization is encouraged to review their draft policy and ensure the procedures are consistent with the policy statement and move to the practice of assessing and completing the suicide tool on all patients presenting to the Emergency Department.

The Emergency Department program is supported by a dyad of the Medical Director and Clinical Director. A Nurse Manager and Assistant Nurse Manager have offices within the ED unit. This program has 160 staff which includes Physicians, RN's, RPN's, NP's, a GEM Nurse, Attendants and Clerical Staff. The leaders of this program work closely with internal and external partners and find the Regional meetings extremely beneficial. The Quality and Opps committee meets regularly and committee members review service goals and objective targets, incidents, sick time, overtime, wait times, EMS offloading times and other important quality indicators. The Managers have access to their ER budget and together with the Director of the program are accountable for viewing and explaining variables at monthly meetings with Finance. They appreciate the support provided by the Finance team. A Pharmacist provides around the clock support to the ED department and completes the BPMH and medication reconciliations.

Recruiting for the ER has been an ongoing task; however they now have only two temporary full time and 2 temporary part time positions to fill. Staff receive a comprehensive orientation to the organization followed by a tiered approach to learning in the ER department. New staff are supported by a mentor. Performance appraisals have not been done due to the pandemic and currently about 20% have been completed in the department. There is, however, feedback in the moment and coaching provided regularly to staff. Performance appraisals are a focus of the managers over the next few months.

The physicians work at both the Grand River and St. Mary's site. All staff working in the ED have input into capital equipment lists. The Biomedical staff provide preventative maintenance and repairs on most of the ER equipment. There are no negative pressure rooms in the ED but there are rooms with laminar flow and hepa-filters. Pediatric cases are mostly transferred to Grand River, however for those situations that do occur, the ED has a Braslow cart, Administration Dispensing Unit designated for pediatric medications, Pediatric Defibrillator and supporting supplies to treat children. The EMS staff work collaboratively with the ED staff and noted that offloading of patients varies in time based on the business

of the department or stretcher spaces. The EMS staff noted it can be frustrating at times when they have to wait and cannot return to their work.

A research pilot is currently in place and an OT has been providing support to ED patients. Over the course of 12 months, approximately 211 patients have returned home with functioning support and have not been admitted to the hospital. The ED program is hoping to move toward an allied model of care in the ED and continue to provide timely services to patients and reduce admissions. The program and staff are congratulated on the success of this pilot initiative.

The cleaning carts used by the Environmental Services staff have toxic and poisonous solutions sitting in the open (e.g. Clorox) and are easy access to visitors in the ER. The organization is encouraged to buy carts that have cupboards for storing cleaning agents and can be locked.

The ED program is encouraged to consider including patients at committee levels and with service design. It is a very busy department with limited space. However, it is evident in observing and in speaking to staff that they work collaboratively and together to provide the best care possible.

Table 12: Unmet Criteria for Emergency Department

Criteria Number	Criteria Text	Criteria Type
2.4.8	Seclusion rooms and/or private and secure areas are available for clients.	HIGH
2.5.1	Each client's physical and psychosocial health is assessed and documented using a holistic approach, in partnership with the client and family.	HIGH

Inpatient Services

Standard Rating: 98.9% Met Criteria

1.1% of criteria were unmet. For further details please review the following table.

Assessment Results

The on-site inpatient assessment included 2 floors of Medicine (700 and 400) and the Chest unit (600). Patient care in each area is supported by an interprofessional team, that predictably includes but is not limited to Medicine, Nursing, Social Work, Pharmacy, Dietary, and Occupational & Physiotherapy. The majority of admitted patients to the units come from thess sources--ER, OR, or ICU. There is smooth transition of these patients from the referring sources.

The leadership in each area ensures both medical and operational oversight for assessing needs, influencing corporate strategy and planning, and aligning service level goals and activities to the corporate priorities. The Inpatient Quality Team, and Professional Practice are examples of program level forums that support planning, implementation and evaluation of performance and improvement initiatives. While these forums have not yet formalized patient partners as members, patient input is actively sought in a variety of ways (satisfaction surveys, rounds), and patients have been directly engaged in specific projects.

The focus on patient safety strongly influences the ways that competency is supported in the clinical areas. Orientation programs are designed to ensure that staff have the knowledge, skills and access to tools and resources. New staff are provided with a corporate and program specific orientation. Orientation to the safe use and operation of equipment, devices and supplies was noted.

On admission a full physical and psychosocial assessment is conducted by nursing staff and the results documented electronically. Assessment and care planning is comprehensive taking into account physical, developmental, emotional, and mental health needs and by engaging the right mix of inter professional team members to support needs. Patient care is well coordinated and engages patients and families in planning and optimizing self care. Ongoing care are well documented and the initial care plan developed , reviewed and up dated as necessary. The standard assessments for high risk such as DVT , pressure ulceration and falls are recorded and monitored regularly.

The Hospital does not provide inpatient paediatric care but does care for a number of older adults. A geriatric assessment is begun in the Emergency department by members of the care team. The hospital is currently experiencing a high demand for inpatient beds and moving patients requiring admission from the Emergency department to an inpatient bed is a priority for the hospital. Bed meetings are held each day and overflow protocols are in place to support patient flow from the emergency department to the inpatient units.

Space challenges were evident in each of the inpatient areas and support the compelling need for the current and future construction projects. Despite the limitations in the physical space, the actual care delivered to patients is solid and patients are satisfied with the outcomes as well as the customer service they receive.

Safety is a high priority with processes in place for medication reconciliation, falls and pressure injury prevention, and consistent patient identification practices. Patient discharge planning is detailed and attentive to specialized needs of patients.

Multidisciplinary rounds take place daily with participation by the interdisciplinary team. The Critical Care Response Team supports patients who may need ICU as well as those retuning from ICU.

Staff spoke positively about the organization and the support they receive. Comments such as we are "proud to work here" and "we are all in this together" were such examples. Staff have a good understanding of quality and safety and were able to identify key initiatives they are working on that may not be displayed on the quality boards.

White boards within the patient's rooms were not up to date and there is an opportunity to remedy this. In addition, visiting hours are limited on the inpatient wards. This was implemented due to the COVID-19 pandemic but should be revisited as the community emerges out of the pandemic. The presence of family members during rounding is vital to ensure holistic care is provided to patients. Rather than limiting visitation, clear guidance for visitors could be provided.

Bedside reporting with clients was in place prior to Covid and then was halted and the team is encouraged to continue to improve and engage clients and family in this form of information transfer. The inpatient areas are encouraged to migrate back to a standardized, face-to-face bedside transfer of accountability at shift handover, and include safety checks in the process. Bedside reporting with clients was halted during Covid and the team is encouraged to continue to improve and engage clients and family in this form of information transfer.

A strength of the teams are the strong collaboration and teamwork noted. The teams work very interprofessionally, with patients and families being the centre of all that they do. Good, solid work is being done by the teams.

Table 13: Unmet Criteria for Inpatient Services

Criteria Number	Criteria Text	Criteria Type
3.3.4	The assessment process is designed with input from clients and families.	NORMAL

Perioperative Services and Invasive Procedures

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the following table.

Assessment Results

St. Mary's General Hospital (SMGH) is the Regional Cardiac Center for Waterloo-Wellington. Referrals are also accepted from Perth, Grey-Bruce, Huron, Brant, Oxford Counties as well as Haldimand-Norfolk. The integration of the surgical program happens with Grand River Hospital as much as possible. The Thoracic and Cardiac surgical procedures are offered at St. Mary General Hospital. General Surgery, ENT, Minor orthopedics, cataracts, endoscopy, urology are a few of the surgical services provided to the community. Over 24,227 Day Surgery Visits occurred in 2022-2033 at SMGH.

The Director and Manager are new to the Peri-operative Service however both are experienced nurses and leaders. The Peri-operative program operates from Monday to Friday 0730 to 1530 hours. On call is provided for after hours and on weekends. There is discussion to extending the hours of operation to deal with wait lists and increase program capacity.

Monthly Quality and Opp meetings are held with key stakeholders attending. Quality indicators, incidents, wait times, utilization of surgical blocks, case costing etcetera are reviewed at this meeting. The Chief from Grand River Hospital also attends these meetings as some of the surgeons and anaesthetists work at both hospital sites. The integration of the surgical program happens with Grand River Hospital as much as possible including standardization of equipment and protocols. An example provided of were the anaesthetic carts where drug drawers and contents were standardized across both hospital sites.

Elective surgical patients are accesses by the pre-admit clinic and necessary preoperative work is ordered prior to surgery. Patients are seen prior to surgery by the anaesthetist and the surgeon is accountable for obtaining the signed consent. Access to the perioperative areas move from unrestricted to restricted. Patient flow is directed from being admitted in the Day Surgery Department, to the OR, Post Anaesthetic Unit and then discharged from Day Surgery. A family waiting room is in the Day Surgery area. All areas of this department are clean, well-lit and well organized. Communication and transfer of patient information flowed flawlessly from one department to the other. Staff felt they had the necessary resources to do their jobs, however the Day Surgery staff noted they would like a bladder scanner as currently they have to borrow from another department.

St. Mary's General Hospital and Grand River Hospital work in partnership to develop and offer digital health tools to connect clinical teams and consumers through; My Connect Care, Pocket Health, Virtual Care Appointments Using WebEx and Ontario Telemedicine Network.

This program is encouraged to consider having a patient or family member on its committees. Mock codes such as Code Silver and the evacuation of an anaesthetized patient(s) should be reviewed with staff. Tabletop exercises should be considered using the current ethics framework and relevant peri-operative scenarios. The manager is encouraged to continue her work on completing the performance appraisals for her staff.

The Peri-operative program Physicians, leaders and staff are commended for the excellent services they provide the community.

Table **14:** Unmet Criteria for Perioperative Services and Invasive Procedures

There are no unmet criteria for this section.

Point-of-Care Testing

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the following table.

Assessment Results

The lab has point of care testing in which interdisciplinary health care professionals are involved in such as implementation, ongoing training and support. Initial training is completed with completed with the clinical nursing staff and then they are annually recertified. Audits are conducted and reports are sent to the Point of Care Coordinator for follow up. The lab recognizes that point of care education is important and have started enrolling staff into full point of care orientation sessions to ensure they receive the training. The POC machines will alert staff that they are coming up to their recertification date, which prompts them to enroll. The lab team works very collegially with their clinical counterparts and are diligent with adhering to their policies and procedures.

Table 15: Unmet Criteria for Point-of-Care Testing

There are no unmet criteria for this section.

Reprocessing of Reusable Medical Devices

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the following table.

Assessment Results

The Medical Device Reprocessing Team has structured processes and policies that are well documented by the organization. Staff are engaged in their day-to-day work and feel comfortable bringing any concerns to leadership. Each work area has digital resources for prepping and have back up manuals with photographs if the computer system goes down. The MDRD team works closely with IPAC and biomedical engineering when new equipment is needed to be purchased or repaired. The MDRD often has members of the operating room department come down and discuss issues with instrumentation or if there is a change in the perioperative list. They work closely together to ensure patient flow is not interrupted. The MDRD team would benefit from an inventory tracking system to help manage their inventory to maintain optimal levels of supply. From the sterile area to prep to decontamination, the areas are clean and organized with pride. There is a clean to dirty flow, including the elevators. The new cart washer has been installed and is working well to optimize efficiencies. The scope area is quite efficient. The team has developed a partnership with Olympus to ensure the endoscopy program is running smoothly even when there are issues with the OER or the scopes themselves. The scopes are leased and the organization has a robust loner program. The decontamination area where the dirty scopes are cleaned is quite small, but the team in conjunction with IPAC maintains a clean to dirty flow. Biomed has a robust program that keeps all records of PMs current and easily accessible. It was refreshing to see their key performance indicators, front and centre on their desk tops with live data available. An opportunity for improvement would be to digitalize the records of the reprocessing of the high use equipment such as the scopes as a mechanism to quickly locate the particular equipment if there was an issue with nosocomial infections. The team prides themselves on the exceptional customer service they provide all while maintaining a database of more than 3000 pieces of equipment. Despite having space issues related to infrastructure, infection rates are low and there have not been any issues with outbreaks related to reprocessing. Pride in their work is weaved throughout the many departments that MDRD touches.

Table 16: Unmet Criteria for Reprocessing of Reusable Medical Devices

There are no unmet criteria for this section.

Transfusion Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the following table.

Assessment Results

The lab team is a very cohesive group. Their huddle generates many quality improvement ideas that encompass process changes to work-life balance ideas. Closely linking with Grand River Hospital, the lab has worked to standardize policy and procedures and have mitigation practices in place when blood products are in short supply. The team has developed workload standards that can accommodate the Massive Transfusion Protocol seamlessly into their day if it is activated. The lab offers rapid response services and is nimble in processing their chemistry lab specimens. Monthly clinical audits are performed and the data is automatically fed back to the respective units to ensure blood transfusions are administered safely and in a timely fashion. Any adverse reaction is documented and the blood tested. Any findings are communicated back to the respective clinical unit. In the clinical areas where the nurses administer blood products, the patient is consented by the prescriber and educated of the risks and benefits of the transfusion required. This includes substitute decision makers. The hospital has brought in MLAs to support their MLTs within the lab. This has been a welcome addition to the team. There is a level of professional proficiency in which the team members should be quite proud.

Table 17: Unmet Criteria for Transfusion Services

There are no unmet criteria for this section.

Quality Improvement Overview

Integrated Quality

St. Mary's General Hospital (SMGH) has a strong and genuine focus on quality improvement and making this a strategic priority for the organization, is addressed in the "Expand equitable access to high quality, empowered care" 2021-2026 Strategic Plan. The team is proud to report that it is transitioning to an organizational Quality Framework (framework) based on quality dimensions and the defining the roles and responsibilities of each with regards to quality. The framework encompasses the quintuple aims of safe, effective, equitable, patient-centred, efficient and timely care and services. Quality is a notable driver at SMGH and should be commended for its overall plan for Integrated Quality Management.

SMGH is committed to building and maintaining a culture of safety that is open, honest, fair, and accountable, which aligns with the vision and values of the organization. It was very apparent that the organization embraces opportunities to improve care delivery systems with a focus on learning and system improvement.

The overall structure of the quality program certainly reinforces accountability, with a Board Quality Committee providing governance oversite, and a nice roll-up of information from the Unit Huddles to the program specific Quality and Operations committee. Huddles occur daily on all clinical areas. The Huddle Boards are all standardized with the topics of Kudos, Concerns & Ideas, In Progress, and Done.

A formalized process for the governing body (via the Quality Committee of the Board), to receive regular, written reports on the quality, risk and safety of services has been established. Leaders throughout the organization participate and lead in collaborative quality improvement initiatives. A member of the Patient & Family Advisory Council is a voting member of the Quality Committee of the Board. Patient Stories are a standing agenda item.

All Departments attend a daily 15 minute virtual Safety Sync report- out of the current surge level, occupancy rate, the time to an inpatient bed in the last 24 hours, number of days since the last: critical incident, employee lost time injury, patient fall with serious harm, and ever event. This is followed by a run-down by Department of any actual or potential safety issues identified in the past 24 hours or anticipated in the next 24 hours.

SMGH is congratulated on their commitment to Patient Safety. The organization has put in place the appropriate infrastructure and resources to support patient safety across the organization. In addition to patient safety training and education, the organization has policies and procedures in place to support a culture of quality and safety. A patient safety incident management system (RL6) is implemented to report and monitor incidents. All incidents that are reported are analyzed and followed up on. Processes (care reviews) are in place to review critical incident and adverse events as well as disclosure of events to patients and families. Patients and families who have been involved in an incident are invited to provide input into the quality review. The organization conducted a patient safety-related prospective reviews, focusing on revision to the Transcatheter Aortic Valve Implantation (TAVI) clinical care pathway and to evaluate the opportunity for same day discharge from the procedure. Appropriate improvements were made because of the review.

An integrated risk management approach to mitigate and manage risk is in place. The approach provides a structure that encourages consistency in the organization's approach to risk assessment, risk management and risk mitigation strategies/activities as well as a process for the planning and implementation of risk management within SMGH. In addition, SMGH participates in the HIROC Risk Assessment Checklists, a web-based self-assessment tool enabling healthcare organizations to systematically self-assess compliance with a number of actionable mitigation strategies for top risks leading to medical malpractice claims.

Fundamental to the success of any quality program is engagement of patients and families. The organization is making a very real effort to partner with patients. The use of Patient Advisors has

enhanced emphasis on patient relations while in hospital, which has translated to a more proactive staff and patient engagement environment. However, there is an opportunity to partner with those you serve in the design, delivery and evaluation of care and services.

SMGH is encouraged to continue on their path to continually improve the quality, safety, and the learning culture of the organization.

Person Centred Care

St. Mary's General Hospital (SMGH) embraces people-centred care (PCC) from its mission, vision, and values to its strategic priorities. The organization is fostering and building the structures, resources, and practices to embed PCC as a guiding principle for the organization's culture.

As a legacy within the community, the SMGH looks forward to celebrating its hundredth year of serving the community of Kitchener and surrounding areas in 2024. The hospital is a part of the Kitchener, Waterloo, Wilmot, Wellesley, and Woolwich Ontario Health Team (K4W OHT). A member of the SMGH Patient and Family Advisory Committee (PFAC) is a Co-Chair of the OHT West PFAC, and there is also another PFAC member on the K4W OHT.

Information and resources for patients and visitors can be found on the SMGH's website about Emergency Department Wait Times, Planning Your Stay, Patient Experience & Patient Relations, the PFAC, current Visiting Guidelines, and healthcare definitions/acronyms. Despite the current information provided by the K4W OHT about the growth in diversity and languages spoken within this catchment area, the organization might consider whether providing information in alternative languages could be helpful as the population within this community continues to grow.

The main door entryway of the SMGH reveals a small alcove with seats and wheelchairs for patient and family use. A foyer showcases a staircase to the second floor with light illuminating from the second-floor windows down into the first-floor foyer. There are posters, art, and signage displayed on the hallway walls for patients and families, staff, and visitors' information. Wayfinding to the various departments and within specific departments was challenging due to sign location or lack of signage. The organization is encouraged to collaborate and co-design with the PFAC to improve navigation within the building.

The Board of Trustees is a very enthusiastic team that is highly aware of the changing factors impacting the organization's capacity to provide meaningful care to the patients and families in its region. Board members have received ongoing education about PCC through patient stories, gemba walks, Unconscious Bias Training, San'Yas Indigenous Cultural Safety Training, and a Diversity, Equity, and Inclusivity (DEI) retreat. The Co-Chair of the PFAC is on the Quality Committee of the Board, and embedded within the Quality Committee's action plan is an annual PFAC Annual Report. As the Board continues providing oversight to the organization, they and Senior Leadership are strongly encouraged to explore how the organization can continue revisiting equity-seeking strategies within SMGH to ensure equitably, just care for all patients and families within this growing community.

SMGH's Leadership team is eager to engage in innovative new ways to receive education and provide clients with high-quality, safe, equitable care informed by the diverse population the organization serves. As the hospital revamps services, the leadership team is encouraged to explore how clients and families might co-design and collaborate on co-created goals with staff on quality improvement and safety initiatives.

SMGH has a PFAC with a patient/family member and staff co-chair model. Recruitment of PFAC members until recently was by word of mouth and Patient Experience/Patient Relations. Currently, candidates interested to join the PFAC can apply, go through the interview process, and receive a formal invitation to join the committee upon successful selection. New members receive orientation aligned with the education elements from the general Volunteer Orientation and role-specific training. The organization is urged to consider additional content for onboarding orientation, models, and structures necessary to support, execute and sustain the new strategy.

The PFAC has established Terms of Reference (TOR) describing the membership, terms, and roles, with principles and ground rules. There are eight active members on the PFAC and one ADHOC member. The ADHOC PFAC role was introduced to meet the need of PFAs who might want to be more flexible with their ongoing involvement with the hospital, and the organization is excited to showcase this opportunity in its recruitment strategy. PFAC members at SMGH are also highly engaged in other healthcare committees and community groups within the region. Despite having connections within the community, opportunities to increase diversity in the committee's membership have been an ongoing challenge. The organization can continue to look at how different methods might be implemented to hear from and include other patient populations.

Requests PFAC members on quality and or safety initiatives are emailed to PFAC members who can elect to accept or decline the request. The number of requests for PFAC members is currently tracked. Some of the PFAC's successes through consultation have been the Patient Portal Project, being on the Tri Hospital Ethics Board and creating the medical acronym list posted on the SMGH website. PFAC members look forward to continue engaging with the organization. They hope to purposefully be proactive in their ongoing relationship with the staff of SMGH, especially with the new Senior Leadership team. They hope to be successfully integrated into all areas of the organization. "We want the staff to know that we have their back – we are your allies – like the wind at their backs."

The Cardiac Rehabilitation Clinic is located off-site on the third floor of the organization's Boardwalk location. Upon exit from the elevator, there is a clinic receptionist and waiting area available to clients and families, with an entrance to the gym through a set of doors. The gym has a variety of equipment and a walking track for patients.

Cardiac Rehabilitation Clinic patients are referred to the program. They are assessed at the onset of service. A holistic approach is incorporated in partnership with the client and family. Goals and the expected results of the service are identified and co-produced with preferences and an individualized care plan executed. Information about the client is shared in a timely way and reassessed with documentation when there is a change in health status. Clients are encouraged to self-manage their care and are actively involved in preparing for transitions. Clients in Cardiac Rehabilitation Clinic mentioned that they are glad to live where they receive "compassionate, empathetic, and professional care – from triage to now". Clients also noted that SMGH staff "enjoy their work, are professional and made what could've been a horrible experience – ok".

The Emergency Department (ED) has two new kiosks to assist staff in identifying patients who might require more immediate care despite the arrival time into the department. Although the kiosks were ordered and already in place, feedback from a PFAC member with accessibility needs has already driven improvements on the new machines to be received. Patients are assessed and, dependent on their presentation, might or might not receive a psychosocial assessment. They are involved in the information-sharing process with the goals of care, a care plan established with established outcomes and a transition plan identified. Despite the space constraints within the ED, there are committed stretchers in the hallway with wireless call bells for patient use. Resources for psychosocial services within the ED department within the community are not readily available or accessible to staff to provide to patients and families. The organization is urged to explore ways to co-create with patients and families, and community partners to provide resources or support for patients who are identified or self-identify at risk. Comments from patients in the ED ranged from "everyone is doing the best they can for what our healthcare system is – they have been fantastic" to "they are professional, they care, even when they are short staffed they still do their best – they want to help".

Patients on the Medicine and Chest floors receive complete psychosocial assessments at the shift change with any other pertinent assessment or consults being initiated. The surveyor observed contemporaneously the guiding philosophy of PCC being incorporated into an allied health consult with a patient in the presence of family where they mentioned, "we moved from nine hours away to receive the specialized care at St. Mary's". The surveyor was also humbled to have had a conversation with an Indigenous Healer after a smudging ceremony and commends the organization on the strides it has

made in creating a safe, inclusive place where cultural humility and cultural sensitivity are experienced with conscious effort and with the support of an Aboriginal Patient Navigator associated with Southwest Ontario Aboriginal Health Access Centre.

St. Mary's General Hospital is commended for its commitment to embedding within its fabric a culture of PCC that will flourish in continuous, purposeful engagement about what is meaningful to its patients and families.