ACCREDITATION CANADA



Driving Quality Health Services

Accreditation Report

Niagara Health System

St. Catharines, ON

On-site survey dates: November 22, 2015 - November 27, 2015

Report issued: March 7, 2016

ACCREDITATION CANADA
AGRÉMENT CANADA

Driving Quality Health Services
Force motrice de la qualité des services de santé

Accredited by ISQua

About the Accreditation Report

Niagara Health System (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. As part of this ongoing process of quality improvement, an on-site survey was conducted in November 2015. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

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

Confidentiality

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

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

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

A Message from Accreditation Canada's President and CEO

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

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

Your Accreditation Specialist is available if you have questions or need guidance.

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

We look forward to our continued partnership.

Sincerely,

Wendy Nicklin
President and Chief Executive Officer

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Section 1 Executive Summary

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

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

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

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

1.1 Accreditation Decision

Niagara Health System's accreditation decision is:

Accredited with Exemplary Standing

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

1.2 About the On-site Survey

- **On-site survey dates: November 22, 2015 to November 27, 2015**

- **Locations**

  The following locations were assessed during the on-site survey. All sites and services offered by the organization are deemed accredited.

  1 Douglas Memorial Hospital
  2 Greater Niagara General Hospital
  3 Port Colborne General Hospital
  4 St. Catharines Hospital Site
  5 Welland Hospital

- **Standards**

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

  System-Wide Standards

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

  Service Excellence Standards

  5 Cancer Care and Oncology Services - Service Excellence Standards
  6 Reprocessing and Sterilization of Reusable Medical Devices - Service Excellence Standards
  7 Organ and Tissue Donation Standards for Deceased Donors - Service Excellence Standards
  8 Critical Care - Service Excellence Standards
  9 Point-of-Care Testing - Service Excellence Standards
  10 Diagnostic Imaging Services - Service Excellence Standards
  11 Medicine Services - Service Excellence Standards
  12 Substance Abuse and Problem Gambling Services - Service Excellence Standards
  13 Ambulatory Systemic Cancer Therapy Services - Service Excellence Standards
  14 Obstetrics Services - Service Excellence Standards
  15 Mental Health Services - Service Excellence Standards
  16 Transfusion Services - Service Excellence Standards
  17 Biomedical Laboratory Services - Service Excellence Standards

18 Perioperative Services and Invasive Procedures Standards - Service Excellence Standards
19 Long-Term Care Services - Service Excellence Standards
20 Emergency Department - Service Excellence Standards

- **Instruments**

  The organization administered:

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

1.3 Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
 Population Focus (Work with my community to anticipate and meet our needs)	75	0	0	75
 Accessibility (Give me timely and equitable services)	101	0	0	101
 Safety (Keep me safe)	702	6	19	727
 Worklife (Take care of those who take care of me)	166	2	2	170
 Client-centred Services (Partner with me and my family in our care)	258	2	3	263
 Continuity of Services (Coordinate my care across the continuum)	80	0	2	82
 Appropriateness (Do the right thing to achieve the best results)	1074	12	12	1098
 Efficiency (Make the best use of resources)	79	1	0	80
Total	**2535**	**23**	**38**	**2596**

1.4 Overview by Standards

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

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

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

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

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	42 (100.0%)	0 (0.0%)	0	31 (96.9%)	1 (3.1%)	0	73 (98.6%)	1 (1.4%)	0
Leadership	43 (93.5%)	3 (6.5%)	0	82 (96.5%)	3 (3.5%)	0	125 (95.4%)	6 (4.6%)	0
Infection Prevention and Control Standards	41 (100.0%)	0 (0.0%)	0	27 (93.1%)	2 (6.9%)	2	68 (97.1%)	2 (2.9%)	2
Medication Management Standards	68 (98.6%)	1 (1.4%)	9	59 (98.3%)	1 (1.7%)	4	127 (98.4%)	2 (1.6%)	13
Ambulatory Systemic Cancer Therapy Services	49 (100.0%)	0 (0.0%)	1	98 (100.0%)	0 (0.0%)	1	147 (100.0%)	0 (0.0%)	2
Biomedical Laboratory Services **	68 (100.0%)	0 (0.0%)	3	103 (100.0%)	0 (0.0%)	0	171 (100.0%)	0 (0.0%)	3
Cancer Care and Oncology Services	33 (100.0%)	0 (0.0%)	0	74 (98.7%)	1 (1.3%)	1	107 (99.1%)	1 (0.9%)	1
Critical Care	34 (100.0%)	0 (0.0%)	0	95 (100.0%)	0 (0.0%)	0	129 (100.0%)	0 (0.0%)	0
Diagnostic Imaging Services	64 (97.0%)	2 (3.0%)	1	67 (100.0%)	0 (0.0%)	1	131 (98.5%)	2 (1.5%)	2

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Emergency Department	47 (100.0%)	0 (0.0%)	0	80 (100.0%)	0 (0.0%)	0	127 (100.0%)	0 (0.0%)	0
Long-Term Care Services	39 (100.0%)	0 (0.0%)	1	89 (98.9%)	1 (1.1%)	4	128 (99.2%)	1 (0.8%)	5
Medicine Services	31 (100.0%)	0 (0.0%)	0	70 (98.6%)	1 (1.4%)	0	101 (99.0%)	1 (1.0%)	0
Mental Health Services	36 (100.0%)	0 (0.0%)	0	88 (100.0%)	0 (0.0%)	0	124 (100.0%)	0 (0.0%)	0
Obstetrics Services	64 (100.0%)	0 (0.0%)	0	79 (98.8%)	1 (1.3%)	0	143 (99.3%)	1 (0.7%)	0
Organ and Tissue Donation Standards for Deceased Donors	39 (100.0%)	0 (0.0%)	0	80 (100.0%)	0 (0.0%)	0	119 (100.0%)	0 (0.0%)	0
Perioperative Services and Invasive Procedures Standards	100 (100.0%)	0 (0.0%)	0	86 (97.7%)	2 (2.3%)	0	186 (98.9%)	2 (1.1%)	0
Point-of-Care Testing **	38 (100.0%)	0 (0.0%)	0	48 (100.0%)	0 (0.0%)	0	86 (100.0%)	0 (0.0%)	0
Reprocessing and Sterilization of Reusable Medical Devices	52 (100.0%)	0 (0.0%)	1	61 (100.0%)	0 (0.0%)	2	113 (100.0%)	0 (0.0%)	3
Substance Abuse and Problem Gambling Services	30 (100.0%)	0 (0.0%)	1	73 (100.0%)	0 (0.0%)	0	103 (100.0%)	0 (0.0%)	1
Transfusion Services **	70 (100.0%)	0 (0.0%)	5	66 (100.0%)	0 (0.0%)	1	136 (100.0%)	0 (0.0%)	6
Total	**988 (99.4%)**	6 (0.6%)	22	1456 (99.1%)	13 (0.9%)	16	2444 (99.2%)	19 (0.8%)	38

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

1.5 Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Safety Culture			
Accountability for Quality (Governance)	Met	4 of 4	2 of 2
Adverse Events Disclosure (Leadership)	Met	3 of 3	0 of 0
Adverse Events Reporting (Leadership)	Met	1 of 1	1 of 1
Client Safety Quarterly Reports (Leadership)	Met	1 of 1	2 of 2
Client Safety Related-Prospective Analysis (Leadership)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Communication			
Client and Family Role in Safety (Ambulatory Systemic Cancer Therapy Services)	Met	2 of 2	0 of 0
Client and Family Role in Safety (Cancer Care and Oncology Services)	Met	2 of 2	0 of 0
Client and Family Role in Safety (Critical Care)	Met	2 of 2	0 of 0
Client and Family Role in Safety (Diagnostic Imaging Services)	Met	2 of 2	0 of 0
Client and Family Role in Safety (Long-Term Care Services)	Met	2 of 2	0 of 0
Client and Family Role in Safety (Medicine Services)	Met	2 of 2	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client and Family Role in Safety (Mental Health Services)	Met	2 of 2	0 of 0
Client and Family Role in Safety (Obstetrics Services)	Met	2 of 2	0 of 0
Client and Family Role in Safety (Perioperative Services and Invasive Procedures Standards)	Met	2 of 2	0 of 0
Client and Family Role in Safety (Substance Abuse and Problem Gambling Services)	Met	2 of 2	0 of 0
Information Transfer (Ambulatory Systemic Cancer Therapy Services)	Met	2 of 2	0 of 0
Information Transfer (Cancer Care and Oncology Services)	Met	2 of 2	0 of 0
Information Transfer (Critical Care)	Met	2 of 2	0 of 0
Information Transfer (Emergency Department)	Met	2 of 2	0 of 0
Information Transfer (Long-Term Care Services)	Met	2 of 2	0 of 0
Information Transfer (Medicine Services)	Met	2 of 2	0 of 0
Information Transfer (Mental Health Services)	Met	2 of 2	0 of 0
Information Transfer (Obstetrics Services)	Met	2 of 2	0 of 0
Information Transfer (Perioperative Services and Invasive Procedures Standards)	Met	2 of 2	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information Transfer (Substance Abuse and Problem Gambling Services)	Met	2 of 2	0 of 0
Medication reconciliation as a strategic priority (Leadership)	Met	4 of 4	2 of 2
Medication reconciliation at care transitions (Ambulatory Systemic Cancer Therapy Services)	Unmet	2 of 7	0 of 0
Medication reconciliation at care transitions (Cancer Care and Oncology Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Critical Care)	Unmet	4 of 5	0 of 0
Medication reconciliation at care transitions (Emergency Department)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Long-Term Care Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Medicine Services)	Unmet	3 of 5	0 of 0
Medication reconciliation at care transitions (Mental Health Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Unmet	3 of 5	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures Standards)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Substance Abuse and Problem Gambling Services)	Met	3 of 3	2 of 2
Safe Surgery Checklist (Obstetrics Services)	Met	3 of 3	2 of 2
Safe Surgery Checklist (Perioperative Services and Invasive Procedures Standards)	Met	3 of 3	2 of 2
The “Do Not Use” list of abbreviations (Medication Management Standards)	Met	4 of 4	3 of 3
Two Client Identifiers (Ambulatory Systemic Cancer Therapy Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Biomedical Laboratory Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Cancer Care and Oncology Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Critical Care)	Met	1 of 1	0 of 0
Two Client Identifiers (Diagnostic Imaging Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Emergency Department)	Met	1 of 1	0 of 0
Two Client Identifiers (Long-Term Care Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Medicine Services)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Two Client Identifiers (Mental Health Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Obstetrics Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Perioperative Services and Invasive Procedures Standards)	Met	1 of 1	0 of 0
Two Client Identifiers (Point-of-Care Testing)	Met	1 of 1	0 of 0
Two Client Identifiers (Substance Abuse and Problem Gambling Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Transfusion Services)	Met	1 of 1	0 of 0
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management Standards)	Met	4 of 4	1 of 1
Concentrated Electrolytes (Medication Management Standards)	Met	3 of 3	0 of 0
Heparin Safety (Medication Management Standards)	Met	4 of 4	0 of 0
High-Alert Medications (Medication Management Standards)	Met	5 of 5	3 of 3
Infusion Pumps Training (Ambulatory Systemic Cancer Therapy Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Cancer Care and Oncology Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Critical Care)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Infusion Pumps Training (Emergency Department)	Met	1 of 1	0 of 0
Infusion Pumps Training (Long-Term Care Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Medicine Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Mental Health Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Obstetrics Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Perioperative Services and Invasive Procedures Standards)	Met	1 of 1	0 of 0
Narcotics Safety (Medication Management Standards)	Met	3 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Client Flow (Leadership)	Met	7 of 7	1 of 1
Client Safety Plan (Leadership)	Met	2 of 2	2 of 2
Client Safety: Education and Training (Leadership)	Met	1 of 1	0 of 0
Preventive Maintenance Program (Leadership)	Met	3 of 3	1 of 1
Workplace Violence Prevention (Leadership)	Met	5 of 5	3 of 3
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Compliance (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Education and Training (Infection Prevention and Control Standards)	Met	1 of 1	0 of 0
Infection Rates (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Pneumococcal Vaccine (Long-Term Care Services)	Met	2 of 2	0 of 0
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Ambulatory Systemic Cancer Therapy Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Cancer Care and Oncology Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Diagnostic Imaging Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Emergency Department)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Long-Term Care Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Medicine Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Mental Health Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Obstetrics Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Perioperative Services and Invasive Procedures Standards)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Cancer Care and Oncology Services)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Pressure Ulcer Prevention (Critical Care)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Long-Term Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Medicine Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Perioperative Services and Invasive Procedures Standards)	Met	3 of 3	2 of 2
Suicide Prevention (Mental Health Services)	Met	5 of 5	0 of 0
Venous Thromboembolism Prophylaxis (Cancer Care and Oncology Services)	Met	2 of 2	2 of 2
Venous Thromboembolism Prophylaxis (Critical Care)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Medicine Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Perioperative Services and Invasive Procedures Standards)	Met	3 of 3	2 of 2

1.6 Summary of Surveyor Team Observations

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

The organization, Niagara Health System is commended on preparing for and participating in the Qmentum survey program. The Niagara Health System (NHS) has worked extremely hard in order to invest in quality and safety of care, and plan for a better future. Participating in the Accreditation Canada process demonstrates this commitment to the organization. The various sites can celebrate many successes in their work, making the accreditation process comprehensive and welcoming the surveyor team. In addition to having the opportunity to meet with a range of internal and external stakeholders during the survey, the surveyors were provided with written, verbal and visual evidence to confirm compliance with the standards. Staff members and clients made themselves readily available to answer questions and to demonstrate their skills and knowledge.

Since the organization's previous survey, the NHS has a new board and president and they are ensuring the needs of the community are met currently and most importantly, for the future. The community is beginning to see the benefit in the closure of smaller community hospitals in order to build new facilities. This restructuring is critical for consolidating medical expertise and creating a critical mass to ensure competency and therefore, the provision of safer quality care to patients. While this work commenced with a government-appointed supervisor, everyone is commended for seeing the vision through to fruition.

The board is instrumental in ensuring that oversight and direction are provided to the NHS. A favourable financial position has meant opportunities to attract and retain key clinical and administrative positions as well as consolidate and open new programs and services. The organization is now building on the supervisor’s report, moving forward with strategic planning and capital planning and clinical visioning exercises.

The Niagara Health System is aware of the challenges it faces with aging infrastructure of some “vintage” sites, and an undefined time line for the proposed south site build and occupancy. As well, there are technological needs to address going forward. Despite operating budgets being favourable, there is a significant working capital deficit and an aging population with increasing chronic diseases requiring greater robust primary care.

The surveyor team met with community partners from a range of services, academic institutions and the region, and they indicate that NHS is sharing, consultative, understanding and building a truly collaborative approach in working together. Partners across the Niagara region indicate that there is more seamless integration than ever before and according to them: “in 30 years, this is the best team to work with.” There are exciting examples of increased academic teaching opportunities and innovative approaches to ensuring services for the people of Niagara, while building capacity for future care providers and health researchers.

The community partners would like NHS to know them better and potentially collaborate even more for some needed services. For academic purposes, there is a desire to implement 'HSPnet' for monitoring clinical placement for various health disciplines. There is hope that the strong partnerships at the leadership levels will filter to the front line, and that the changes that have occurred and are still to come, stay on track. There is hope also, that the ethics lens is applied regularly to all circumstances where applicable to support decision making. There is the perception that NHS has: “come out of the dark and into the light.”

The leadership is committed to quality and safety as evidenced in the standardization and consolidation of services. There are improvements in emergency department (ED) wait times, and being responsive clinically via strategies like critical care response teams, and administratively with huddle board discussions and rhythm rounds. The NHS is comprised of more than 5,000 staff members and physicians, 850 volunteers, and residents and students in various health disciplines. The NHS has seen an improvement in staff engagement and reputation

by measuring staff worklife and seeing an increased commitment and desire to work in the NHS. Recruitment and retention have been enhanced as a result of the positive changes and opening of the new facility of St. Catharines General Hospital.

The delivery of care and services is foremost in everyone's mind, with a focus on patient safety using Accreditation Canada's required organizational practices to drive key safety elements across the NHS. The road map: "Route NHS" is used to create engagement and understanding of the accreditation process, and safety requirements is an example of innovation to which staff members have positively responded. Of benefit to the patient and family is a white board called My Space, which is placed at each bedside. Also of benefit are the huddle boards with NHS goals, indicators and safety data, and these are placed in hallways to be partners in safety and quality with care givers.

Patients and family members reported high levels of satisfaction during the survey visit. They described the little things that make a big difference like having the 'TLC' volunteers at the front entrance of the hospital. They spoke of the confidence they had in their care givers and noted the focus on safe, quality clinical care. Patients have nominated staff members for 'star awards of excellence' and during this on-site survey it was a pleasure to meet those stars in action.

Section 2 Detailed Required Organizational Practices Results

Each ROP is associated with one of the following patient safety goal areas: safety culture, communication, medication use, worklife/workforce, infection control, or risk assessment.

This table shows each unmet ROP, the associated patient safety goal, and the set of standards where it appears.

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Communication	
Medication reconciliation at care transitions With the involvement of the client, family, or caregiver (as appropriate), the team generates a Best Possible Medication History (BPMH) and uses it to reconcile client medications at transitions of care.	· Medicine Services 7.6 · Critical Care 7.7 · Ambulatory Systemic Cancer Therapy Services 9.15 · Obstetrics Services 9.6

Section 3 Detailed On-site Survey Results

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

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

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

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

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

See Appendix B for a list of priority processes.

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

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

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

3.1 Priority Process Results for System-wide Standards

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

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

3.1.1 Priority Process: Governance

Meeting the demands for excellence in governance practice.

Unmet Criteria	High Priority Criteria
Standards Set: Governance	
7.8 The governing body has a succession plan for the CEO.	

Surveyor comments on the priority process(es)

There have been significant changes and improvements for the Niagara Health System (NHS) since its previous accreditation. One major change is the establishment of a new board, with broad administrative and leadership skills. Consistent with the Management Services Agreement in place with St. Joseph's Health System (SJHS), the CEO Succession Plan is a responsibility of the SJHS Board. The SJHS Board has approved a policy and process for recruiting the CEO position in the event of a planned or unplanned CEO vacancy.

The board approached accreditation as an opportunity to listen and learn and 'move the bar higher'. The board has embraced best practices in governance by way of evaluation using the governance function tool, along with self-evaluations and education. Strides have been made in learning about and using the ethics framework in making decisions thoughtfully and with adequate procedural justice, even if that means board meetings may be longer.

The board members are passionate and knowledgeable individuals that are poised to support and direct NHS is a positive way. All board members receive a comprehensive orientation and in addition, receive ongoing and regular updates like "finance 101" repeatedly as needed. By way of board retreats and meetings they are able to set the tone in order to focus on the patient/client, and the vision and values of the organization. Board meetings are open to the public to increase transparency and openness.

The board oversaw the recruitment and selection process of the new president which began in September 2014. According to the board there is 'nothing but praise' for the new president. The board is encouraged to always have a talent management and succession plan in place. The board has also been successful in managing the budget to ensure NHS' fiscal position is favourable. The board is using a savings priority framework and identifying opportunities to improve patient care, and improve their reputation and build for the future.

The board is focused on the patient, safety and quality improvement. Decision support provides detailed information to the board in visual ways to help “people-ize” the data. For example, percentages and numbers are used so that board members know the impact in context. The board and community partners indicate that the level of trust is 'soaring' with these strong partnerships.

Work is underway to transform quality via clinical programs in order to account for quality at the point of care and ensure a culture where quality is everybody’s business. The intent is to improve health outcomes, and improve patient satisfaction and sustainability. The areas of quality focus include: efficient care, effective care, safe care, the experience (patient, staff, physicians) and financial health. The board members have demonstrated that they are committed to quality improvement and “mean what they say.”

The board is encouraged to ensure that the new draft enterprise risk management efforts are supported and that contingency planning is enhanced.

3.1.2 Priority Process: Planning and Service Design

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The Niagara Health System is a large and diverse community spanning 12 municipalities. There is a strong volunteer sector that augments the workforce of more than 5000 including physicians and staff.

In 2011/12 a supervisor was appointed and established the strategic plan which focused on quality and safety, access and flow and vision and engagement. Since that time, the NHS has engaged in public polling to understand which factors were important to incorporate into strategic planning and to determine corporate priorities. The results have improved significantly since 2011, demonstrating that nearly 50% of the community now has a positive view of NHS. There is a general sense that people are getting on board with the plan.

The NHS has conducted clinical services planning to ensure the needs of the region will be met into the future. Two large vision days, five patient-centred working groups, and a two-day future state summit were held. A project steering committee is overseeing this work.

Decision support plays a key role in providing data to support planning. The needs of the community as well as priorities set by government are taken into consideration in planning. A good example of this is the closure of in-patient beds at the Niagara on the Lake site, and ensuring that the need for convalescent care in the community was met.

Progress is reported via the Leaders Digest, which is written by the President of NHS. The public can see information regarding wait times/access to emergency and urgent care with new clocks on the external web sites, and noted estimated wait times.

The NHS leadership is sensitive to the amount of change that the organization and staff have undergone. The organization is utilizing the Kotter model for managing change and is thoughtful about capacity for change going forward.

3.1.3 Priority Process: Resource Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The Niagara Health System (NHS) is in a favourable financial position as a result of efforts from all levels of the organization. The finance group provides guidelines for budget opportunity savings to address cost pressures anticipated for the next few years. A prioritization framework is used to prepare for the Hospital Annual Planning Submission (HAPS). A decision-making tree is used to ensure fit with the strategies of the Local Health Integrated Network (LHIN), the province and NHS before proceeding.

Efforts are made to standardize and consolidate to the extent possible to improve quality and patient outcomes while reducing costs. Samples of operational improvement initiatives (OII) were shared such as: overall impact assessment, impact on staffing, operating savings summary and proposed performance indicators. Meditech training regarding the finance module is provided by the NHS accounting department. As well, business analysts support managers and leaders.

The organization has used an ethicist consultant to help with decision-making around tough choices. Process flows and time lines are in place for capital and operating budgets. As well, there is a process for unbudgeted requests to address needs as they arise.

Managers can access financial information electronically and are expected to report on variances. Sick and overtime hours are carefully monitored and reported. A physician impact analysis is conducted if a new or replacement position is required.

Recently, NHS hosted an executive forum entitled: “Spotlight on Innovation…an emerging framework”, which was well-attended and described opportunities and examples of innovations of technology, projects and cost savings.

3.1.4 Priority Process: Human Capital

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
10.4	The organization's leaders establish a talent management plan that includes strategies for developing leadership capacity and capabilities within the organization.	
10.9	The organization's leaders regularly evaluate reporting relationships and leaders' span of control.	

Surveyor comments on the priority process(es)

Occupational health and safety and wellness have been a focus for the Niagara Health System (NHS). During the survey the organization proudly described the Swift Ultraslides, which have already produced a 17% reduction in injuries in the Extended Care unit. As well, the occupational health and safety team has developed a reference tool to help support staff members in their return to work post injury. There is interest in finding ways to expand this tool nationally to share these innovative solutions. Staff members are pleased with their three new massage chairs, which are available and regularly used at the St. Catharines, Greater Niagara General Site and Welland Hospital site.

In order to help support open dialogue, the NHS has provided two courses namely: crucial conversations and crucial accountability, to help support staff members, managers and physician chiefs to promote effective workplace interactions and help improve patient safety.

The results of the NHS employee engagement survey conducted in 2014 indicate an improvement since the previous survey conducted in 2011. The NHS leaders met with their staffs' and developed action plans to improved communication and relationship building, as well as retention of staff. A program called: “Walk a Mile in My Shoes” has helped staff members to better understand other roles in the health system. Plus, union – management relations are reported to have improved, with decreased grievances. Labour relations worked with staff members affected by bed closures at the Niagara on the Lake Hospital site in order to successfully transition them to other positions, or into retirement.

Draft work has commenced regarding establishing a talent management plan to assess staffs' interest and capacity for moving into leadership positions. Some units have experienced significant management changes in the past few years, and it will be important to establish succession plans and stability going forward. Span of control is not regularly reviewed, with variability noted in the workload for managers.

An improvement is having a dedicated position focused on workplace relations. Tools and coaching are made available to staff. The Gentle Persuasive Approach (GPA) is available for helping manage patients with dementia. Other tools for staff, such as creative videos regarding workplace violence prevention (using Lego characters) and another video using a zombie theme, help capture the interest of staff members to watch and learn in an innovative way.

Volunteers play a very important role for NHS and their contributions are notable. One program, namely the "TLC" has focused volunteers that create a welcoming entrance to the St. Catharines site. In a survey, 98% of NHS staff members and volunteers indicated that TLC helps improve patient satisfaction by providing attention to the little things that make such a big difference.

3.1.5 Priority Process: Integrated Quality Management

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
12.3	As part of the integrated risk management approach, the organization's leaders develop contingency plans.	!
12.4	The organization's leaders disseminate the risk management approach and contingency plans throughout the organization.	!

Surveyor comments on the priority process(es)

The Niagara Health System (NHS) has invested in its culture of quality and safety and holds this as a strategic priority. There is a quality and safety plan and new key personnel are involved in supporting quality and safety at NHS. One key person is the Chief Safety Officer that partners to ensure actions are put in place to address needs. In order to embed quality across the organization, operational directors are assigned the required organizational practices (ROPs) as one of their accountabilities. The organization used an accreditation preparation journey approach using: “Route NHS”, which is a curving road map with stops for each required organizational practice (ROP). The intent was to bring some fun to the accreditation process, using a little bit of competition among units and incentive draws for individuals that participated. Staff members report this approach as both helpful and innovative.

The electronic incident reporting system (IRS) provides real-time information to leadership. Level 5 and 6 reports are electronically e-mailed to the senior team and a thorough and fulsome process follows for investigation and resulting actions. Throughout the NHS, and throughout the survey, staff members and physicians were able to articulate the disclosure policy and process. There is always a senior leader and quality/safety staff on call.

Medication reconciliation has been supported with dedicated financial support of $1 million, and has been implemented in pediatrics and mental health. There is new medical leadership supporting medication reconciliation, as well as nurse practitioners, and the tone is positive when this was discussed with staff and physicians. The organization has a plan to roll out medication reconciliation fully in the next three years.

The Inter-professional Education for Quality Improvement Program (I-Equip) is a partnership between NHS, Brock University and McMaster University. The program provides students from various disciplines with theory and practical application of quality improvement, leadership, and project management. The goal is to help the NHS complete valuable projects in quality improvement, while inspiring future generations of health providers and leaders. This program has been in place for a few years and has been over-subscribed to the point that interviews and a selection process now occurs for student admission.

Across the NHS, the implementation of patient white boards has been instrumental in improving communication between patients, family and care givers. These boards include critical patient safety considerations, such as handwashing, patient identification and so on as well as other important information to provide more patient-centred care. The huddle boards, including the NHS priorities and unit/departmental goals and indicator details are regularly used in all service areas, and provide transparency for staff members and patients to contribute to improved quality of care. Rhythm rounds are able to help keep the momentum of initiatives at all levels of the organization.

The organization does not currently have an integrated approach to contingency planning. Documentation reviewed during the on-site survey indicates that NHS sees this as a significant risk and there are plans to contract external support using a Request for Proposal (RFP). The risk management approach is very new and the organization has not yet had an opportunity to roll it out. The approach taken to develop the draft integrated/enterprise risk plan was robust, including literature and best practice review and the organization is encouraged to finalize this important work. There is a RFP in progress to seek support for contingency planning for NHS.

3.1.6 Priority Process: Principle-based Care and Decision Making

Identifying and decision making regarding ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization is particularly proud of the collaborative work of a group of professionals, work originating from multiple sites and group members working closely, with an expert consultant ethicist producing an innovative ethics framework that readily received full support across all programs and all sites. Introducing the situation-background-assessment-recommendation (SBAR) element, already used in other areas of care, crystallized the process that guides the discussions when addressing complex ethics issues be they end-of-life issues, allocation issues or corporate level decisions.

In addition to the unit-level internal discussions that take place when addressing care issues, the important element of this framework is the question regarding the decision to inform the public/community of any difficult decisions or situations facing the organization. This is an important component with which many organizations struggle, and having this element as part of the framework takes out all the guess work and the long deliberations whether one should come out publicly or not. It guides the discussions.

The positive outcome since the introduction of the framework, as per the users, is that it now provides team members with a voice.

The organization has a full research ethics committee fulfilling its two-fold mandate of protection of participants in research studies and facilitating research.

3.1.7 Priority Process: Communication

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization has a communications department which is robust and has responsibility for all internal and external communications. This department has played a pivotal role in enhancing positive communication for the organization.

The communication strategy involves communication tools for external contacts using twitter, Facebook, print, television and radio. There are weekly e-blasts and intranet messaging for internal stakeholders. All of these communication techniques are regularly monitored and modifications are made if required. This has resulted in a growing sense, both internally and externally that the organization is transparent and communicative.

External publications such as: Niagara Health Now, Niagara Health System Annual Report and local newspaper articles depict the patient story around care. Internal communications such as: The President's Newsletter, Leaders Digest and The Pulse focus on important staff messages. There is strong evidence at the bedside that accreditation messages were received and understood as they prepared for this survey visit.

Safety posters and the My Space patient board have enhanced communication with clients/patients receiving service from the Niagara Health System. The 'Online Community' resource for dialysis patients is an innovative approach to enhance communication and promote self-management between this patient group.

The organization has developed excellent communication channels at all levels namely: staff members, community and health care partners; and the Local Health Integrated Network and local government. These channels will be instrumental as the organization moves forward with the strategic plan and its brand renewal process.

3.1.8 Priority Process: Physical Environment

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The Niagara Health System (NHS) comprises a modern facility and several others that date back many years. The organization has made significant investment in repairing and advancing service systems in many of the older facilities. Given this context and that there are plans, already underway, to bring the entire organization into two facilities in the future, the direction taken to ensure that all situations compromising safety are addressed is working for the organization.

Power, water and heating back-up systems have undergone recent maintenance and upgrades and are regularly tested to ensure that they function appropriately. The organization has ensured that maintenance of the buildings continues and appropriate renovations have been made to ensure capacity in the site facilities. However in some areas, due to the age of the buildings, some damage to plastered walls was observed during the on-site tours. Repairs to such will facilitate cleaning of those surfaces.

There is close collaboration and coordination of efforts across multiple services as well as with the joint health and safety committee for some projects to ensure the success of projects. Examples of this are the department/unit inspection visits that address safety issues, and the Connexall project spanning, nursing, porters, environmental services and admitting for improving patient flow to the assigned bed. The team is particularly proud of its Environmental Awareness program impacting on the greenhouse effect and decreasing the carbon foot print. The team works closely with community partners such as the environmental program at Niagara Sustainability Initiative.

The team is most proud of its standardization of cleaning methods which now includes a scientific component.

Given that some services originally housed on other sites have now moved out of the facilities to the main complex in St. Catharines there is the potential for some of the offices/spaces to be occupied temporarily by staff members, but not necessarily known to management. The organization is encouraged to maintain its space allocation/occupancy list and regularly update it so as to address any potential safety issue should there be a need to evacuate the building.

Significant progress has been made to standardize signage across the facilities.

3.1.9 Priority Process: Emergency Preparedness

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
14.9	The organization's leaders develop and implement a business continuity plan to continue critical operations during and following a disaster or emergency.	
14.10	The business continuity plan addresses back-up systems for essential utilities and systems during and following emergency situations.	!

Surveyor comments on the priority process(es)

The organization has committed to the development of a comprehensive emergency preparedness approach. Significant effort has resulted in the development of an initial all-hazards plan, a reputation crisis communication plan, pandemic plan, Ebola planning, and the change to the incident command system (ICS). Plans are currently not integrated and the organization has already identified this as a risk. This has resulted in the plan to contract external support to create a fully integrated all-hazards plan including business continuity. The organization is commended on the planning of the St. Catharines site. The facility has been designed with internal redundancy in a number of areas that will enable it to respond to a variety of internal and external system failures or emergency events.

The organization has committed resources for training with a focus on staff understanding of codes, and the event-specific plans that are in place. The organization provided focused education for staff members and leaders to prepare them for the Pan American Games that were held locally in the summer of 2015. The organization is planning to issue a request for proposal (RFP) for a more robust learning management system. This initiative will be valuable for the organization to evaluate effectiveness of training as well as for accountability that training has occurred.

The organization is exercising plans on a regular basis to ensure it is prepared to respond to events should they occur. The Niagara Health System (NHS) has demonstrated a commitment to improving plans, educating staff, and implementing preventative initiatives. Some examples of these efforts include emergency preparedness and infection prevention and control as regular topics in huddle conversations and at joint occupational health and safety committee meetings. The organization also collaborated with the Ministry of Labour to ensure the code orange plans meet staff safety standards, and the NHA is seen as a champion with this work. The organization participates in local planning committees, and is working toward alignment of plans with its partners. This is clearly evident in the move to the Incident Command System (ICS). Staff members reported during the survey visit that they are establishing collaborative approaches and are participating with local emergency operations centre's table-top exercises.

The organization is in the process of developing a business continuity plan. There are aspects of the plan in place, particularly at the St. Catharines'site for specific event types. Documentation reviewed during the on-site survey indicates that NHS sees this as a significant risk and there are plans to contract external support via a Request for Proposal (RFP).

The NHS has established back-up utility suppliers for the St. Catharines site to ensure a secondary supply in a case of prolonged loss of utilities. The organization does not appear to have the same arrangement in place for the remaining facilities across the organization. The organization is encouraged to expand its contracts with suppliers to include all facilities.

3.1.10 Priority Process: Patient Flow

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The Niagara Health System has identified access and flow as an organizational client safety strategic priority. A variety of strategies have been implemented to address access and flow issues. These include department, site, and organizational level initiatives. Daily unit huddles facilitate communication among interdisciplinary team members enabling collaboration and decision making, and provide clarity on important areas of focus for the team. These unit huddles also review unit performance and recognize team success. Weekly rounds focused on reviewing performance metrics called Rhythm Rounds are helping keep momentum of initiatives. Managers are free from all meetings prior to 10 am to allow a presence on the unit to meet team members, patients and families, and to perform "standard work", which is a collection of indicator data that is used to measure goal and objective performance. This information is submitted to Directors and Executive Vice-President for review.

Services are available on a 24 hour basis out of three Emergency departments and two urgent care centres. There is a system wide approach to service delivery with mechanisms to move clients to the site that is best equipped to safely meet their care needs.
Teams are well versed in the available supports to transport clients for care; this includes home hospital repatriation, and transfer to a higher level of care. The NHS utilizes the services provided by Criticall Ontario to assist with arranging urgent transport and bed finding.

Processes have been developed to guide teams in the preparation and transfer of clients. These processes were observed during the survey visit and were effectively followed. Feedback by receiving departments report information is accurate however, at times patients can be on their way before all notifications have occurred.

Surge plans are in place across the NHS. These plans include a number of strategies from identified beds for over capacity, and available patient care units that could be made operational if circumstances required. There are twice-daily patient flow rounds at a site level, and alternate level care (ALC) rounds with community partners, and organization-wide patient flow calls. During the survey visit the collaborative approach was clearly evident at patient flow rounds.

There is a true systems approach for dealing with the complex issues that impact access and flow. The organization recently implemented a computer-based system that provides real-time information for both clients and team members on the current wait time in the emergency departments (EDs) and urgent care centres.

The NHS recently implemented a number of technology tools to assist teams with access and flow strategies. These systems provide up to date information on a number of data elements such as occupancy, patients waiting for beds, quality measures such as Emergency department admissions needing beds, surgical cases needing beds, and potential discharges. This system has provided transparency for teams to see the entire picture and to allow them to participate in improving the situation.

The NHS has made collaboration with partners a priority strategy in meeting goals and objectives. Examples that demonstrate innovation and collaboration include the regional approach to winter pressures. The NHS organized a planning session with partners from across sectors and the Local Health Integrated Network (LHIN) and developed five strategies: a nurse practitioner (NP) mobile rapid response team; an equipment repository; winter resilience command centre; advanced communication for residents returning to long-term care, and public health communication related to outbreaks. These five strategies, along with initiatives have a goal of preventing avoidable admissions, common approaches to patient flow, discharge planning, and infection prevention to allow safe transfers during outbreaks.

The NHS has made a significant impact on barriers to access and flow such as: reduction in lengths of stay in surgery; complex care; cardiology, respirology and mental health; attention to emergency department lengths of stay; avoiding night time transfers and addressing delays to discharge associated with organizational process or service. The NHS has been able to reduce the number of alternate level care (ALC) patients waiting in hospital, and has cancelled less than five cases related to bed pressures in the past year; and it has decreased lengths of stay in many programs.

3.1.11 Priority Process: Medical Devices and Equipment

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

A new reprocessing department has opened at the St Catharines site. As a result of this, the previous deficiencies identified have been addressed. Staff members had significant input to the new department particularly as to how it would look and how it would function. At the Niagara Falls site, all deficiencies identified in the previous accreditation survey report have been addressed by extensive renovations and improvement in movement of supplies and equipment. This was accomplished with input from infection prevention and control (IPAC). At the Welland site, many of the required renovations have been completed. Finishing touches will be done during the operating room (OR) closure. The major work required is the addition of pass-through doors to allow better flow of equipment between areas.

Both bio-medical and central supply reprocessing (CSR) have huddle boards. Quality initiatives have been developed specific to each department. These are aligned with the strategic plan. The bio-medical department recently underwent a successful peer review by its professional organization, The Canadian Medical and Biological Engineering Society (CMBES).

The CSR staff members must be college graduates to be employed. The majority of staff members and the manager have certification for medical devices reprocessing (MDR). Those not yet certified are currently in the process of obtaining certification. Yearly competency training is in place and mandatory for all staff. Updates occur as required. Performance evaluations occur on a yearly basis. There is now a single corporate manager in place, with site manager presence at sites where reprocessing is done.

All the policies and procedures related to reprocessing are available online and have been standardized across the organization. All the equipment sterilized is identified and able to be tracked should breaks in sterility be identified.

Environmental services and infection prevention and control (IPAC) are actively involved in maintaining a clean and safe environment for reprocessing. The frequency of areas to be cleaned is in line with the published standards. There are no external contracts in place for sterilization. All reprocessing is done in house. A policy and procedure for handling loaner equipment is in place, and familiar to all appropriate staff.

The St. Catharines' area is spacious and not cluttered. The Niagara Falls site area has some space constraints. Access to all areas in MDR is restricted. Ultrasound probe reprocessing is performed in all the NHS diagnostic imagine (DI) units. Reprocessing and cleaning is done in locations that have been deemed to be safe with input from IPAC and MDR staff. Policies and procedures have been developed providing detailed instructions related to reprocessing probes. The Trophon processor is utilized in all areas.

Sterilization of endoscopes occurs in the endoscopy unit. All scopes are processed according to manufacturers' instructions and established policies and procedures. All scopes are identified and tracked so that if any outbreaks occur they can be tracked to a specific patient.

The bio-medical department now has an organization leader in charge of all sites. All the sites have on site human resources to manage the workload. Requests for repairs are generated by the nursing staff and sent to a central department in Welland. A technician with appropriate skills and knowledge is then assigned. There is commitment to have all critical devices back in service within 24 hours. Technicians must have a bio medical technology course before they are hired. Most of the repairs are done in house. Technicians receive ongoing training and updates related to equipment in use.

All sites have in place a preventive maintenance schedule. All equipment has specific identification markers that allow technicians to narrow down their locations. This also allows them to identify the specific device and perform the required maintenance. If the bio-medical department is unable to carry out the repairs the manufacturers' service department is contacted.

The only departments that have external contracts are the laboratory and digital imaging departments.

Noted strengths are staff training and education, strong commitment to safety and quality and strong corporate leadership in both departments. Another key strength is the recent update in policies and procedures by bio-medical and the willingness to share a mobile application tool developed to aid in diagnosis and repairs of medical devices.

3.2 Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Episode of Care - Ambulatory Systemic Cancer Therapy

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

Point-of-care Testing Services

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

Clinical Leadership

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

Competency

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

Episode of Care

- Providing clients with coordinated services from their first encounter with a health care provider through their last contact related to their health issue

Decision Support

- Using information, research, data, and technology to support management and clinical decision making

Impact on Outcomes

- Identifying and monitoring process and outcome measures to evaluate and improve service quality and client outcomes

Medication Management

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

Organ and Tissue Donation

- Providing organ donation services for deceased donors and their families, including identifying potential donors, approaching families, and recovering organs

Infection Prevention and Control

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

Surgical Procedures

- Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge

Diagnostic Services: Imaging

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

Diagnostic Services: Laboratory

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

Transfusion Services

- Transfusion Services

3.2.1 Standards Set: Ambulatory Systemic Cancer Therapy Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Episode of Care - Ambulatory Systemic Cancer Therapy		
9.15	With the involvement of the client, family, or caregiver (as appropriate), the team generates a Best Possible Medication History (BPMH) and uses it to reconcile client medications at ambulatory care visits where the client is at risk of potential adverse drug events*. Organizational policy determines which type of ambulatory care visits require medication reconciliation, and the how often medication reconciliation is repeated. *Ambulatory care clients are at risk of potential adverse drug events when their care is highly dependent on medication management OR the medications typically used are known to be associated with potential adverse drug events (based on available literature and internal data).	ROP
9.15.1	The organization identifies and documents the type of ambulatory care visits where medication reconciliation is required.	**MAJOR**
9.15.2	For ambulatory care visits where medication reconciliation is required, the organization identifies and documents how frequently medication reconciliation should occur.	**MAJOR**
9.15.4	During or prior to subsequent ambulatory care visits, the team compares the Best Possible Medication History (BPMH) with the current medication list and identifies and documents any medication discrepancies. This is done as per the frequency documented by the organization.	**MAJOR**
9.15.5	The team works with the client to resolve medication discrepancies OR communicates medication discrepancies to the client's most responsible prescriber and documents actions taken to resolve medication discrepancies.	**MAJOR**
9.15.6	When medication discrepancies are resolved, the team updates the current medication list and retains it in the client record.	**MAJOR**

Priority Process: Clinical Leadership

The organization has met all criteria for this priority process.

Priority Process: Competency

The organization has met all criteria for this priority process.

Priority Process: Decision Support

The organization has met all criteria for this priority process.

Priority Process: Impact on Outcomes

The organization has met all criteria for this priority process.

Priority Process: Medication Management

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Episode of Care - Ambulatory Systemic Cancer Therapy

Clients feel well cared for and respected by all staff. They feel that staff members are vigilant, qualified and truly caring of them and for their families. They feel fortunate that their questions are responded to as quickly as possible, and that they always have a person to contact should something arise outside of clinic hours.

Staff members adhere to the high-alert policy and help one another by being freely available to each other to perform an independent double check.

All patients entering the clinic have a best possible medication history (BPMH) documented during the first visit. This history of medications is updated whenever staff members learn of any new or changed medications. The act of reconciliation was not observed in this clinic during the survey visit. The team is encouraged to explore ways that they can incorporate reconciliation into their practice, as appropriate.

Priority Process: Clinical Leadership

The St. Catharines site has a state-of-the-art facility to provide ambulatory oncology services, and the staff members contributed to the layout and design. Continuous quality improvement occurs using a combination of data and input/feedback from patients, families and staff.

The staff members recognize the need to closely align with the needs of their patients and the communities they serve. The team sought a patient and family advisor to guide them in the design of their service delivery model.

Priority Process: Competency

One of the unique design features at the St Catharines site is the workspace/office pod. This pod design facilitates an effective, comprehensive and cohesive team environment.

This unique team model includes a "DAF" pharmacy technician that supports the patient/family and team by ensuring that the patient does not encounter barriers in obtaining medications in the community. The model ensures that appropriate paperwork is completed and payment submissions receive appropriate approval.

Priority Process: Decision Support

The MOSAIQ software system provides a unique level of insight for staff members that work in the ambulatory setting in that they are able to confirm patient status as the patients flow through the myriad of assessments and treatment procedures. At any point, staff members are able to view this information along with key clinical information found in the electronic chart. This software is also visible to those that have Niagara Health System Meditech access privileges.

Priority Process: Impact on Outcomes

Staff members are engaged in the active utilization of the quality and safety board which facilitates real-time discussion of potential risks/concerns. The quality and safety board is designed in a manner that ensures that measurable objectives are identified and tracked. The board is entirely visual and transparent. It utilizes a heat-map chart format that simplifies the prioritization of recommendations and ensures that they are handled to completion.

The Niagara Health System incident reporting system (IRS) is a quick, accessible mechanism that encourages staff members to submit reports of events. The data are regularly extracted from the IRS and reviewed to identify opportunities for improvement. The team displays a strong commitment to ongoing quality improvement, with documentation of the changes that they have made in response to reported events.

Priority Process: Medication Management

There is use of prescriber ordering using provincial oncology program pre-printed orders to ensure approved comprehensive protocols. In the interdisciplinary format, the orders are reviewed by a pharmacist before they are provided to the satellite pharmacy for preparation.

The clinic has a dedicated oncology satellite pharmacy that meets the pharmacy professional guidelines. The staff members are experienced and knowledgeable in the area of chemotherapy preparation. The ambulatory clinic staff members are pleased with the rapid response of pharmacy staff members to prepare needed intravenous solutions in a timely manner. Chemotherapy infusion lines are primed with hydration solutions to remove this potential exposure risk for nurses. Although solutions are prepared just prior to administration, the primed lines are run in advance. The primed lines are then stored at room temperature until needed. The organization may wish to explore the literature regarding whether such items require refrigeration or storage at room temperature.

3.2.2 Standards Set: Biomedical Laboratory Services - Direct Service Provision

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

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

Many of the standards in diagnostic laboratory services were previously reviewed for compliance by the Ontario Laboratory Association (OLA). The team is commended for the Inter-professional Practice Team Awards that are delivered to some of the staff members for their involvement in particular projects. Some of these staff members are also members of organizational committees such as the transfusion committee and their participation in such has led to the development of the: "Lab Test Information Guide" which has had a significant impact on the quality and accuracy of the specimens received from the clinical units. Participation of staff members in committees has resulted in changes to some of the order sets with a result in changes to the laboratory test profile for some diagnoses.

The team is encouraged to continue with its daily huddle boards and monitoring of its quality metrics with the goal of informing staff members on how well they are doing and what needs to be improved.

Stringent control as to the compliance of laboratory users with the established procedures for requisition laboratory tests is done by a laboratory nurse that reviews all occurrences of non-compliance. The team is strongly encouraged to continue with this practice.

3.2.3 Standards Set: Cancer Care and Oncology Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
10.6 The team has a process to evaluate client requests to bring in or self-administer their own medication.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The program works closely with its partners both in the site and external to the site. While this has resulted in the demand for services exceeding program capacity, the team has revisited its model in order to accommodate patients awaiting their care.

Priority Process: Competency

Staff members' educational needs are fulfilled however, on occasion there is a need for more experienced members of the team to mentor the more junior team members. Staff members have access to nurse practitioners and pain control experts to assist them when needed.

Priority Process: Episode of Care

The organization has a true medication reconciliation champion, as evidenced by the chart review during the on-site survey. Of note is that the physician had completed a medication reconciliation discharge plan document that was perfectly and comprehensively completed.

Priority Process: Decision Support

Staff members have access to sufficient work stations including a mobile unit. By way of these work stations, staff members on the unit use the Meditech software platform however, they also have access to additional treatment information which is found in the oncology chart and stored in MOSAIQ software system.

Priority Process: Impact on Outcomes

The staff members utilize a number of tools to advance their quality initiatives. Tools included: the whiteboard on the unit that specifies patient precautions/risks; fall risk posters; quality and safety board and the organizational priorities and goals board. These tools are actively used to document and engage staff members in the quality improvement journey.

3.2.4 Standards Set: Critical Care - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
7.7 With the involvement of the client, family, or caregiver (as appropriate), the team generates a Best Possible Medication History (BPMH) and uses it to reconcile client medications at transitions of care.	ROP
7.7.5 The team provides the client, community-based health care provider, and community pharmacy (as appropriate) with a complete list of medications the client should be taking following discharge.	**MAJOR**
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	
Priority Process: Organ and Tissue Donation	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Niagara Health System (NHS) has implemented a number of initiatives such as department huddles, program planning, and unit and site-specific and organization-wide patient flow focus. These initiatives have had a transformational impact on the organization, as observed during the on-site survey. Staff members from each department are able to identify department, program and organizational goals and objectives. They verbalize seeing themselves as a part of the plan, the solution, and the results. The commitment of teams at all sites is clearly evident in their client-centred approach to care.

Goals and objectives have been established at all sites. The goals and objectives are aligned with organization-wide strategy and those required of the Local Health Integration Network (LHIN), as well as the provincial health ministry. Staff members review their performance at daily huddles, and weekly rhythm

rounds. The organization has a growing academic role, with increased numbers of 'learners' and a desire to participate in research. Teams are motivated to do original research that will allow them to provide new methods of caring for their patients in new and more effective ways.

The organization has made significant efforts to create work environments, processes and equipment that is standardized across all sites. During the on-site survey visits to the sites, staff members verbalized having the equipment needed to do their work; they understood the organization's approach to capital equipment planning, and felt their needs were promptly addressed.

The organization has made access and flow a strategic priority. The critical care program has responded with a number of initiatives to be able to provide the services when needed. These include surge capacity across the system. The three units work together and support the other when needed. The organization also works with adjacent partners such as Hamilton when needed.

Priority Process: Competency

There are strong interdisciplinary teams that are delivering care for critical care at each of the sites, each ensuring the right mix and number to provide care. There is robust and well-developed standardized orientation and training. A career ladder approach has been developed, allowing critical care units to offer experienced nurses from other sites and units to work in the intensive care unit. They also offer learning opportunities for brand new nursing graduates and help them expand confidence in their practice over time. Education and training is provided in a variety of ways. There are annual comprehensive skills days, designated educators, access to e-learning and funds for professional development.

Priority Process: Episode of Care

The Niagara Health System (NHS) has developed a standardized assessment and policies and procedures for critical care units across the organization. This includes the identification of individuals at risk of venous thrombo embolism. All patients are screened on admission and identified for prophylaxis. Audits are done daily to ensure patients have not been missed. At times, there is a gap where audits and documentation do not match.

A critical care response team was recently rolled out at the St. Catharines site and it operates 24 hours per day. There are established criteria in place for when to call the team, as well as roles of team members, and accountabilities of the team are identified.

The best possible medication history (BPMH) is completed on admission; this can be performed in the emergency department or in critical care within a 24-hour time frame when the client is critical in nature. It is extremely rare for a client to be discharged directly to the community and therefore, medication reconciliation on transfer processes are currently not in place. This will be addressed by the organization when it implements medication reconciliation at transfer and discharge in the spring of 2016.

Staff members use a variety of communication tools when patients are not able to communicate verbally. Staff members, patients and their families report that the white boards in the patient rooms are a valuable tool for communicating and ensuring patients have input to their plan of care.

All patients are provided with an orientation booklet at the time of admission. Information is provided for them and their families on what to expect, how to participate, and how to make the organization aware of their expectations if they are not being met.

Processes are in place to guide the team when making decisions regarding cessation of life sustaining treatment; the organization also provides access to ethical and pastoral care support. Staff members report this support has been utilized and is of significant value with some challenging and complex cases.

Priority Process: Decision Support

Patient records are kept private and confidential. A standardized assessment is used across all sites. The team has successfully obtained resources to add new equipment that will allow advances and approaches to care in new ways.

Standardized order sets and protocols are in use across all intensive care units. Evidence-based protocols for care have been established. Hamilton Health Science's expertise is drawn upon. The Niagara Health System is becoming more involved in clinical academics. Team members have been recognized for their work and have published their work. New opportunities for research are planned for the future and there is a great deal of excitement as a result.

Priority Process: Impact on Outcomes

The Niagara Health System has implemented an incident reporting system for reporting events. Staff members also identify situations with their managers and at daily huddles. Issues are reviewed, and resolution identified, implemented and evaluated.

Staff members are fully knowledgeable in how, when and why to enter events into the incident reporting system. They state safety issues are discussed at unit huddles and solutions are developed collaboratively.

The organization is measuring a number of indicators including: falls; admission to bed times; readmission rates; avoidable beds days; hand-hygiene compliance; ventilator associated pneumonia rates; central line infection rates; unplanned extubation rates; critical care response team activities; night time discharge rates and antimicrobial utilization. These topics are discussed at program committee meetings and during rhythm rounds.

All patients are provided with an orientation booklet at the time of admission. Information is provided to them and their families on what to expect, how to participate, and how to make the organization aware of their expectations if they are not being met. Client satisfaction surveys are conducted, as well as direct feedback by clients and their families.

Priority Process: Organ and Tissue Donation

The organization is not responsible for the organ and tissue program. This service is led by an external partner. The Niagara Health System has established strong linkages with this partner. Policies are in place, staff members have received education, and potential donors are identified. Missed opportunities are tracked and reviewed.

3.2.5 Standards Set: Diagnostic Imaging Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Diagnostic Services: Imaging		
4.3	For nuclear medicine, the team designates separate waiting areas to segregate clients who have been injected with radioactive substances from other clients.	!
11.14	For interventional procedures, the team labels, handles, transports, tracks and stores samples safely and appropriately.	!
Surveyor comments on the priority process(es)		
Priority Process: Diagnostic Services: Imaging		

The diagnostic imaging (DI) team is enthusiastic and has an obvious focus on patient-centred care. A comprehensive service is provided to meet the needs of the patients in this region. There is clear commitment to integration and standardization across the system. Centralized booking processes have significantly reduced wait times for some modalities including computerized tomography (CT), magnetic resonance imaging (MRI), and also have contributed to exceeding provincial targets.

Quality Indicators are monitored and posted on safety huddle boards in the department. The DI staff members are commended for their participation in initiatives to improve emergency department (ED) wait times and ensuring access to important services such as CT 24 hours per day.

Turn around times for all modalities are monitored and reviewed during daily huddles, with notable improvements. The recent project to improve the no-show rate for scheduled appointments will further enhance efficiency in the department. Two client identifiers are completed during the registration process and prior to every examination at all sites. Some significant work has been completed to ensure understanding of the importance of this process for out-patients. A unique approach to identifying fall risks in the out-patient population has resulted in high compliance in risk identification.

The new unit at the St. Catharines site is state of the art and built to ensure privacy, maximize patient flow and create appropriate care areas for both in-patients and out-patients that require services. The team is encouraged to continue the evaluation of services required at all sites as the NHS moves forward, and in relation to the digital requirements for equipment such as mammography at the Douglas Memorial Hospital site.

3.2.6 Standards Set: Emergency Department - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The organization has implemented a number of initiatives such as department huddles, program planning, and unit, site-specific and organization-wide patient flow focus. These initiatives have had a transformational impact on the organization, as observed during the survey. Staff members of each emergency department are able to identify department, program and organizational goals and objectives. They verbalize seeing themselves as a part of the plan, the solution, and the results. The commitment of teams at all sites is clearly evident in their client-centred approach to care.

Goals and objectives have been established at all sites. The goals and objectives are aligned with organization-wide strategy and those required of the Local Health Integration Network (LHIN), as well as the provincial health ministry. Staff members review their performance at daily huddles and weekly rhythm rounds.

The emergency departments (EDs) play a significant role in the development, review and exercise of the organization's all-hazard plan and more work in the area of contingency planning is encouraged. Leaders from the EDs participate on the organization's emergency preparedness committee.

The organization has made significant efforts to create work environments, processes and equipment that is standardized across all sites, including pediatric equipment. During the on-site survey visits staff members at all sites verbalized having the equipment needed to do their work. They understood the organization's approach to capital equipment planning, and felt their needs were promptly addressed.

Access to secure seclusion rooms are available at all three EDs, and both the urgent care centres have private spaces for the care of individuals that present with mental health or behavioural needs while awaiting transfer to higher level care.

Priority Process: Competency

Strong interdisciplinary teams deliver care at all sites, each ensuring the right mix and number to provide care in the respective emergency departments. There is robust and well-developed orientation. This includes a tiered orientation program, ensuring that only experienced emergency department (ED) nurses work in the triage area.

A career ladder approach has been developed, allowing EDs to accept existing nurses to allow them new opportunities. There is also a strategy focused on brand new nursing graduates and help for them to gain confidence in their practice over time. Education and training is provided in a variety of ways. There are annual comprehensive skills days, ED educators are available, and there is access to e-learning and funds for professional development.

Priority Process: Episode of Care

A tremendous effort has been expended in the standardization of processes and procedures across the Niagara Health System (NHS). Patients are able to locate the emergency department (ED) at the ED sites, and internal signage in the waiting rooms is helpful in way-finding. There is a challenge in the size of the St. Catharines site in that once inside the ED, patients and their families could feel “lost”.

The entrance to the urgent care area at the Port Colborne site has an outside door. This door leads to a small area with a second door leading to the corridor of the urgent care area. The inside door to the urgent care area is closed at 2300 hours. Clients that arrive after 2300 hours and make it through the first door are now faced with a locked door. There is a red sign on the wall instructing persons to press the red button to open the inside door. Normally, there is a security guard there after 2300 hours that will open the door if the person has not activated the red button to open the door. However, the security guard must make rounds or may be called to attend to a situation elsewhere in the building thus leaving the station outside the urgent care area vacant. The Port Colorne facility is highly encouraged to review this way of accessing the urgent care area, as clients arriving in a state of distress may not take the time to read the sign or even notice the sign's instruction.

Patient assessment and access to diagnostics and physicians allow for patients to receive timely care. All urgent care and EDs have 24/7 physician on-site coverage. This not only helps the urgent care areas, but also the units located at those sites for physician support. An evidence-based initiative on ordering of computerized tomography (CT) scans during the night has resulted in ED physicians being able to order directly without calling a radiologist. Time to care has improved, volumes have remained appropriate, and efficiencies have also been experienced.

The organization has made available access to specialists, either direct within a site, or via telephone for specialties located in other sites in the organization. Telephone access to specialists from partner organizations is made available and is arranged via Criticall Ontario.

Processes for triage of adult and pediatric patients have been standardized across all sites and are entered into the e-triage tool. Clients report being instructed to make staff members aware of a change in their condition during the triage process. Efforts to ensure client privacy are made at registration, and at the Douglas Memorial site this can be more challenging due to the size of the registration area and lack of physical division. This is more challenging when there are clinics operating and volumes are higher.

All departments have 24-hour access to laboratory (lab) testing with lab or point of care devices. All emergency departments have access to diagnostic imaging (DI) 24 hours per day. Urgent care is on a call-back basis.

Mechanisms are in place to allow accompanied transportation when required. The Niagara Health System is working with its Emergency Medical Services (EMS) partners to adjust practice and protocols to the extent the skill level of EMS teams allows.

Observations during the on-site survey indicate that the information passed between EMS and ED staff, and from ED staff to receiving units on transfers is accurate and appropriate. At times, some process items are missed such as patients being en route before notifying the receiving site has occurred. This can be problematic when the receiving unit is over census.

Priority Process: Decision Support

Patient records are kept private and confidential. A standardized triage system is used across all sites. Wait time clocks are maintained, allowing the public to see the wait times in the emergency department (ED) and urgent care waiting rooms, as well as via the external Niagara Health System (NHS) website. There is an ED wait time tracker. In-patient units are able to electronically see the number of admissions and thus, know when they are at risk of passing the standard time line and can help by “pulling” patients into their units.

Multiple order sets have been created and are standardized across all EDs. Evidence-based protocols for care have been established. Hamilton Health Science’s expertise is drawn upon. As NHS becomes more involved in clinical academics, new opportunities for research are planned for the future, and there is a great deal of excitement as a result.

Priority Process: Impact on Outcomes

Teams are focused on providing a safe and quality patient-focused care experience. Safe practices such as two patient identification, falls assessment, and handwashing have become the norm. These were observed during the on-site survey and reported during all client and family interactions.

Staff members are fully knowledgeable in how, when and why to enter events into the incident reporting system. They state safety issues are discussed at unit huddles and solutions are developed collaboratively.

The organization is measuring a number of indicators including: length of stay in the emergency department (ED) for admitted patients, time to physician assessment, ambulance off-load times, left without being seen, patient complaints, admission rates, time to treatment for things like sepsis, and falls. These topics are discussed at program committee meetings and during rhythm rounds.

Priority Process: Organ and Tissue Donation

The organization is not responsible for the organ and tissue program. This service is led by an external partner. The organization has established strong linkages with this partner. Policies are in place, staff members have received education, and potential donors are identified. Missed opportunities are tracked and reviewed.

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

Unmet Criteria		High Priority Criteria
Priority Process: Infection Prevention and Control		
2.4	The organization has an interdisciplinary committee to provide guidance about the IPC program.	
2.5	The interdisciplinary committee regularly evaluates the program's structure and functions and makes improvements as needed.	
Surveyor comments on the priority process(es)		
Priority Process: Infection Prevention and Control		

Currently, the Niagara Health System (NHS) infection prevention and control (IPAC) department includes nine staff members and a manager. The majority of the staff members are certified. Those requiring certification are in the process of obtaining such. Staff members come from a diversity of health care backgrounds. All staff members rotate at all sites.

A surveillance process is in place where all microbiological samples taken are monitored. Based on the results, certain triggers are initiated to provide safety to visitors and staff. Appropriate therapy can then be initiated. Select surveillance organisms are actively monitored. Policies and procedures are in place to provide a safe work environment.

Infection prevention and control (IPAC) and environmental services work closely to ensure a safe physical environment for all staff members and users of the facility. When outbreaks are identified, external partners such as Public Health are informed. Processes are put in place, information is analyzed and quality and safety improvements are implemented. Specimens collected are sent to an external laboratory (lab) associated with Hamilton Health Sciences. Turn around time utilizing this lab has significantly improved and is usually around 24 hours. This has improved the times for initiating appropriate triggers and care paths. The IPAC staff members do daily rounds on all isolated patients.

Data are now collected for surgical site infections and infection rates related to joint replacements.

A robust hand-hygiene monitoring program is in place. Base lines have been established and audits are done on a weekly basis. Alcohol hand-hygiene stations are strategically placed, with instructions posted. During an audit, if an area is identified as falling below the benchmark, resources and education are then targeted towards that area.

Policies and procedures are in place and regularly updated as required. They are standardized across the corporation. The information is available electronically for all staff. Several performance evaluations have not been done for several years, and this needs attention.

The program collaborates with Public Health, community partners and major teaching centres in Hamilton and Toronto. Meetings are held at regular intervals where information is shared and best practices reviewed.

In 2011 a major clostridium difficile outbreak was identified. A review of the IPAC program, outbreak management and environmental services ensued, and recommendations were made and implemented. Surveillance has improved and outbreak rates are significantly decreased.

Currently, the major challenge appears to be the recruitment of a physician to take the leadership initiative for IPAC. Due to the inability to recruit this individual no formal IPAC committee is in place. The manager prepares a report for the directors. There are several layers that the report passes through before it is seen by senior administration. A process needs to be put in place to streamline the reporting process and to allow required changes to be implemented quickly.

A comprehensive screening tool has been developed to assess all clients presenting for services.

Policies and procedures are in place for handling contaminated laundry and waste.

A huddle board has been developed specific for the department. The quality indicators are in line with the strategic plan. Base lines have been developed with quality indicators that are measurable.

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

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
12.3 The team follows the organization's process to evaluate resident requests to bring in or self-administer their medication, and monitors residents who self-administer.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The complex care team uses the quality and safety whiteboard to document and advance its quality improvement initiatives. Staff members are engaged and they support the promotion of independence and safety for their patients.

Priority Process: Competency

Regular, interactive interdisciplinary bullet rounds ensure that all patients are thoroughly reviewed regularly by the team. The team displays the qualities of respectful interdisciplinary collaboration. Unfortunately, a pharmacist was not in attendance at the rounds to assist in the medication utilization discussions. Staff members stated that the unit does not have a dedicated pharmacist and having one would be beneficial for the interdisciplinary team.

Priority Process: Episode of Care

The long-term care team provides the patients and their families with a comprehensive manual upon admission. The manual's contents cover many components of care including patient and family roles and rights and responsibilities. The staff members work with patients and their families to identify and develop programs and activities that have meaning and value. These programs are well attended and both staff members and patients look forward to them.

Priority Process: Decision Support

Some of the Long-term Care standards do not apply to the surveyed LTC sites as they are providing complex care services which do not align with the definition of long-term care services. The acuity level of the care provided at those sites can involve a complex care plan including intravenous medication therapies. This can be seen as more aligned with the practices on a general medicine unit.

Priority Process: Impact on Outcomes

The use of two patient identifiers presents some challenge when unique identifiers are not readily available at the bedside. For example, the medication administration record or medication labels contain this information and when they are not available, at minimum, the patient should be asked to provide their name and birth date, which is then confirmed by viewing the information on the their bracelet. The organization is encouraged to ensure consistent application of the use of two identifiers by all staff.

3.2.9 Standards Set: Medication Management Standards - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Medication Management		
17.4	Unit dose oral medications remain in the manufacturer's or pharmacy's packaging until they are administered.	!
23.6	Service providers document lot numbers and expiry dates for vaccines administered in the client record.	
Surveyor comments on the priority process(es)		
Priority Process: Medication Management		

The Niagara Health System (NHS) has invested in the implementation of safer medication practices across all sites. All sites have been equipped with AcuDose dispensers to increase safety and provide better drug monitoring.

Training and education is readily available online with education videos for all staff. As well, a regular pharmacy newsletter is circulated to share trends and information. New pharmacist positions have been created. There is a Medication Safety Pharmacist to focus on safe medication practices and improve quality for patients, and a Drug Utilization Evaluation position and Antimicrobial Stewardship pharmacist in place.

Medication reconciliation is an important priority for the NHS. A comprehensive roll-out plan has been developed and all service areas are aware of the plan. Standard medication administration times have helped improve standardization across sites. It is notable that the NHS has made efforts to achieve the required organizational safety practices of Accreditation Canada, such as antimicrobial stewardship, high-alert medication, limiting and standardizing drugs such as heparin, narcotics and electrolytes. Doctors' order sheets have the “Do Not Use” abbreviation list at the top of the form to increase awareness and decrease the use of abbreviations when ordering medications.

A NHS-wide pharmacy and therapeutics committee is in place. For requests to add medications to the formulary, departments are able to provide a presentation outlining the rationale for the request.

There is a secure, scheduled courier service which provides timely delivery of medications to the NHS sites, with appropriate safeguards that are required for the transportation of medication including hazardous medications.

Medications are stored appropriately in both the pharmacies and the client service areas however, some pharmacies and medication areas on units are crowded and potentially distracting in the hub of activity.

A large number of standard order sets have been created across the NHS, and these are approved by a central committee. This is commendable as it will help decrease variation and improve safety for patients. The increase in nurse practitioners (NPs) has helped support thorough reviews of medications with patients and their families. The NPs have made significant contributions to the programs especially on the complex care units.

The safe handling of medications is critical and there is concern that some intravenous (IV) preparation areas are in poor condition and require upgrading in the “non-St. Catharine” sites. If improvements are made, it would be valuable to increase capacity to allow the preparation of sterile IV admixtures to reduce potential errors when IV medications are prepared on the nursing units.

Labelling has been standardized however, the size of labels may need to be adjusted to ensure safety when multiple labels are used on small mini-bags.

Unit-dose packaged products provide important safety information and opportunities when the intact package is brought to the bedside. The package provides information that supports the nurse in the provision of patient education and the patient's right to refuse a medication. The organization is encouraged to reinforce best medication administration techniques with staff.

The organization has approved a high-alert and an independent double check (IDC) policy. While staff members correctly indicated when an IDC was necessary, the process that they described was a second check, not an independently conducted check. Additional education to increase awareness may contribute to successfully sustaining these two policies.

During the on-site survey, it was identified that there was no policy or process for self-administered medications. The original vaccine consent form included a location for health care providers to document the lot number and expiry date. A recent revision of the form has removed this location/prompt. In addition, the pharmacy does not document 'lot and expiry' when dispensing. The organization is encouraged to explore a mechanism that will allow for identification of patients impacted in the event of a recall or Health Canada notification. Ideally, the mechanism should allow for centralized collection of this information.

3.2.10 Standards Set: Medicine Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
7.6	With the involvement of the client, family, or caregiver (as appropriate), the team generates a Best Possible Medication History (BPMH) and uses it to reconcile client medications at transitions of care.	ROP
7.6.4	The prescriber uses the Best Possible Medication History (BPMH) and the current medication orders to generate transfer or discharge medication orders.	**MAJOR**
7.6.5	The team provides the client, community-based health care provider, and community pharmacy (as appropriate) with a complete list of medications the client should be taking following discharge.	**MAJOR**
Priority Process: Decision Support		
13.1	The team identifies its needs for new technology and information systems.	
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The medicine/nephrology teams are engaged and committed to the services they provide to the patients in the region. Consolidation of specialized programs such as stroke care has resulted in standardized best practice care for this patient group. The team meets and reviews the needs for this population and makes appropriate changes when required.

The medical/nephrology nursing and physician leadership work together to improve metrics and have experienced a significant reduction in fall rates across all medicine units at all sites visited during the survey. The nephrology team has experienced a significant increase in home dialysis rates and is meeting the Ontario Renal Network provincial target for this important indicator.

All teams at all sites are committed to daily huddles that enable alignment of goals to improve service. The goals are visible and staff members are clearly able to articulate change and improvements for this patient group.

Priority Process: Competency

The interdisciplinary team is made up of a variety of disciplines including occupational therapy and physiotherapy and members work closely with nursing staff members to enhance the care of this complex medical group of patients. The team members understand their roles and responsibilities and are effective in the coordination of services for this patient group.

The interdisciplinary team is well-established and engaged in daily bullet rounds and safety huddles with a comprehensive goal to improve quality, safety and ensure safe and effective discharge of patients.

Intravenous (IV) pump infusion training is provided during orientation and during ongoing education sessions.

The medicine teams are active participants and leaders in the implementation of Inter-professional education rounds in partnership with the local colleges and universities. Performance reviews are completed regularly, with input from team leaders when required.

Priority Process: Episode of Care

Medicine/nephrology staff members complete comprehensive assessments in a timely manner and communicate overall care needs to colleagues at daily bullet rounds. There is dedicated hourly rounding with a focus on the four "Ps", which ensures timely and appropriate assessment throughout the hospital stay. Standardized transfer of accountability is evident in all medicine and nephrology units at all sites.

The interdisciplinary team is committed to daily huddles and bullet rounds where important safety, quality and risk information is reviewed. Indicators are altered based on importance and staff ideas for improvement. Real-time data are available and meaningful to staff. There has been a significant reduction in fall rates for this patient group. Use of patient whiteboards ensures that information is shared with patients and their families. The focus on patient goals was evident during the on-site interviews related to the care experience.

Venous thrombo-embolism (VTE) prophylaxis is consistently implemented and part of all general admission order sets. Systems are in place to ensure audits and compliance with feedback to the team. There is a structured best practice approach using order sets, clinical pathways and benchmarking data for this complex patient group. There is a patient centric-approach to medical care which includes patients and family members in all aspects of care.

During the survey some aspects of the best possible medication history (BPMH) was evident on discharge, and the team is encouraged to continue implementation of all aspects of this required organizational practice (ROP).

Priority Process: Decision Support

Physician order entry is undergoing a trial on the medical units of the Niagara Health System. Order sets are well ingrained for certain conditions and in addition, orders are being entered into the electronic environment for patient-specific needs.

Paper-based charting forms have been updated and will ensure seamless transition to the electronic chart when available. Nephrology is moving forward with clinical documentation that will support both the in-patient and out-patient aspects of the nephrology program. Plans for medical units to move to the electronic chart were unclear at the time of the on-site survey.

Priority Process: Impact on Outcomes

Fall prevention programs are ingrained into daily practice and changes have been made based on improving this metric significantly for all medical units and nephrology out-patient units.

Patient whiteboards ensure that information is shared with patents and their families and goals of care were evident in all sites visited during the survey.

The interdisciplinary team is committed to daily huddles and safety briefings where important safety, quality and risk information is discussed. Indicators are altered based on their importance for the patient population and staff ideas. Real-time data are meaningful to all staff members working in this area.

The medicine and nephrology teams are encouraged to continue to develop written safety information that patients can take with them following discharge.

3.2.11 Standards Set: Mental Health Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The mental health program is led by a team of truly committed individuals with a clear vision of what mental health services should be and could be, and they are both true advocates and leaders for clients that are suffering with mental illness. The forming of numerous partnerships internally and externally has created fluidity and a seamless continuum of care for clients and their families. The team is continually reviewing its services versus the identified needs of its clients and is recognized for their creative approach.

Priority Process: Competency

There is a firm belief and commitment on the part of the leadership team of the mental health program to ensure that services are rendered by a team of competent professionals. Their passion for the care of clients presenting with mental illness is well demonstrated in their practice and in their response to the needs of patients. During the survey staff members readily identified the resources and training available to them to ensure that they are current in their practice.

Leadership is responsive to the comments expressed by staff members regarding the staffing needs necessary to address complex situations as well as their safety in the delivering of such care. The team has created a Team Let's Chat (TLC) group with a group of volunteer nurse professionals to provide support such as compassion fatigue to their fellow colleagues. The group members have been specifically trained to be able to provide such support.

Priority Process: Episode of Care

The psychiatric emergency response team (PERT) is particularly proud of the pivotal role it plays in the care of patients presenting to the emergency department (ED) with a compromised condition. The importance of communication with the numerous community and internal partners is considered key to a good assessment of the client.

As a result of adjustments made in the handover of clients arriving in the ED accompanied by the police, the delay in handover has been cut drastically. This has resulted in improved and collaborative working relationships with the police services.

Comprehensive transfer of information at all transition points is key to a successful episode of care for the client. The team has also instituted what it describes as 'warm' transfers to ensure safe transition to the next level of care. The team is commended for the numerous programs it has implemented to address the multitude of needs ranging from the pediatric population with the school program to the support groups for the adult population.

The team is particularly proud of its transition to independent living program (TIL) which eases the return to independent living and helping in the success of the transition after a long hospitalization period.

The team is commended for its successful implementation of the medication reconciliation process.

Priority Process: Decision Support

The team is commended for its rigorous approach when implementing new programs or services. The approach ensures that programs/services are evidence-based and recognized as best practice. The team is engaged in research and is working in close collaboration with other partners to advance practice and to ensure patient/client needs are addressed. The nurse educator plays a key role in ensuring that practice is current.

Priority Process: Impact on Outcomes

In identifying and implementing the numerous programs, a focus on process or clinical outcomes is at the centre of the discussion. The programs implemented are evidence based. The team is proud of its research project on nurses' perception of pod nursing which is led by the nurse educator.

3.2.12 Standards Set: Obstetrics Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
9.6	With the involvement of the client, family, or caregiver (as appropriate), the team generates a Best Possible Medication History (BPMH) and uses it to reconcile client medications at transitions of care.	ROP
9.6.4	The prescriber uses the Best Possible Medication History (BPMH) and the current medication orders to generate transfer or discharge medication orders.	**MAJOR**
9.6.5	The team provides the client, community-based health care provider, and community pharmacy (as appropriate) with a complete list of medications the client should be taking following discharge.	**MAJOR**
Priority Process: Decision Support		
16.1	The team identifies its needs for new technology and information systems.	
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

A merger of three community hospital pediatric/obstetrics departments led to an established regional amalgamation at the St.Catharines site. This has led to a strong culture of improvement and patient safety for both services. The obstetrics service sees more than 2700 newborn deliveries per year by midwives and obstetricians. The medical leadership is strong and recruitment for obstetricians continues. There are now 10 pediatricians, with the successful recruitment of three recently. There is regional chief and chair, department of pediatrics.

The medical and nursing leadership work together to improve metrics and are below the provincial average in many areas of practice. The team is committed to daily huddles that enable alignment of goals to improve service. The goals are visible and staff members are clearly able to articulate improvements made since implementation of this change.

Priority Process: Competency

Since 2013, pregnant women planning to give birth at the Niagara Health System have had their babies at the new St. Catharines site. The obstetrics service has a team that provides care which crosses to cover triage, labour and delivery and cesarean section deliveries and post-partum care in a new unit.

Leadership has worked diligently to ensure appropriate orientation and training to this specialized environment. A partnership with a local college ensured appropriate training for the nurses working in the two operating suites for cesarean sections. All nurses are certified in pediatric advanced life support and neonatal respiratory care. The pediatric unit has a part-time child life specialist that provides teaching and therapy for the children. The pediatric unit has a clinical pharmacist available two days per week, with participation in rounds and provision of medication management support.

There are a large number of trainees and students in both areas such as family practice residents, physician assistants, pediatric residents and fellows, as well as nursing students. The collaboration with McMaster University and bringing academic pediatrics to the St. Catharines site has been perceived very positively.

Patients are cared for in a state-of-the-art facility by health care providers that are experts in maternity, newborn and women's health care.

Priority Process: Episode of Care

Since 2013, pregnant women planning to give birth at the Niagara Health System have had their babies at the new St. Catharines site. Care is provided in a state-of-the-art facility by health care providers that are experts in maternity, newborn and women's health care. Birthing suites offer safe new mother and baby care and are a model for other hospitals.

The interdisciplinary team is committed to daily huddles and bullet rounds where important safety, quality and risk information is reviewed. Indicators are altered based on importance and staff ideas for improvement. Real-time data are available and meaningful to staff. All team members readily identify barriers and make changes to improve patient care.

There is a structured best practice approach to ensuring maternal and fetal health assessments from the time of admission until labour and delivery. There is a patient centric-approach to mother and child care that includes parent and family members in all aspects of care. Discharge follow-up telephone calls take place and discharge arrangements include public health to determine high risk or high needs patients for follow-up in the community.

The Infant Loss team has done significant work to ensure maximum support for those undergoing loss. The team has a variety of interdisciplinary staff members and the forget-me-not program is very patient centred.

In pediatrics, it is a challenge to have four mental health beds as part of the unit, as there is risk in the mix of patients/ages/conditions. As well, there are considerations regarding patient watch and security requirements in terms of resource use. A pediatric rapid assessment clinic has been established to provide an alternative to hospital admissions. There is a perinatal bereavement committee and infant loss team available in the special care nursery. Quality improvements have been made in hyper bilirubinemia in term and late pre-term infants during the past year.

Some aspects of best possible medication history (BPMH) is evident on discharge and the team is encouraged to continue implementation of all aspects of this required organizational practice (ROP).

Priority Process: Decision Support

For obstetrics, pediatrics and the special care nursery, single rooms create more privacy and confidentiality for patients and their families. There are a number of best practice guidelines in place in all areas of the program. Order sets have been developed for a number of common conditions to standardize care. Transfer of accountability (TOA) is used to ensure safety in patient transfers. A pediatric procedural sedation record is currently in development.

Paper-based charting forms have been updated, and will ensure seamless transition to the electronic chart when it is available. Plans to the electronic chart in this environment were unclear at the time of the on-site survey.

Priority Process: Impact on Outcomes

The team reports and tracks various indicators required for the Local Health Integrated Network (LHIN) and Better Outcomes Registry and Network (BORN). Significant improvements have been achieved for numerous indicators. As a member of the managing obstetrical risk efficiently (MORE ob) program the team has done significant education with the team on high-risk activities in the past three years.

For pediatrics and special care nursery, best practice information and education are supported with the increase in pediatricians and expectations of the staff. Based on evaluation and feedback, the falls prevention strategy has been customized for the pediatric and special care nursery populations.

All units utilize huddle boards and patient room white boards to improve quality and safety related to key indicators such as patient falls, medication errors and obstetric-specific performance measures.

3.2.13 Standards Set: Organ and Tissue Donation Standards for Deceased Donors - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

An organ and tissue committee is in place which meets quarterly. The cases are reviewed and any recommendations or improvements are forwarded to the respective committees. The organization has a donation physician identified, and this physician co-chairs the committee. The committee members are enthusiastic and engaged. There is representation from many allied and primary health disciplines. A transplant coordinator is available 24/7.

Priority Process: Competency

Many of the policies and procedures have been developed by Trillium Gift of Life physicians and staff. These resources are readily available via the transplant coordinator. The interdisciplinary team functions collaboratively to provide a seamless process for initiating the organ procurement process.

Priority Process: Episode of Care

Information collection has become standardized and is consistently updated.

Priority Process: Decision Support

A unique identifier is assigned to all donors. This is available via the Trillium portal, with access restricted to the transplant coordinator.

Priority Process: Impact on Outcomes

No specific comments are identified.

Priority Process: Organ and Tissue Donation

The organization is actively involved in the transplant process. There is active collaboration with Trillium Gift of Life Network. A transplant coordinator is available in the organization. All processes and steps are managed by Trillium. The organization's role is simply to identify the potential donors.

Noted strengths are: engaged, enthusiastic, and extremely well-trained staff members committed to patient well being; excellent patient documentation and strong commitment to identifying potential donors, and strong leadership.

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

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

The organization has met all criteria for this priority process.

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

Point-of-care testing (POCT) is done in collaboration with nursing and laboratories, and it assures timely intervention, and has significantly reduced wait times in obtaining results for specific tests in the smaller centres that offer urgent care. The on-site conversation with staff members that perform POCT revealed the benefit of POCT, especially at times of increased occupancy.

3.2.15 Standards Set: Substance Abuse and Problem Gambling Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Based on the changing needs of the clients presenting with both mental illness and issues with substance abuse, the leadership team has implemented a concurrent program, which is based on leading practices in other jurisdictions and in partnership with the withdrawal management program.

The team is responsive to demand, and to urgent situations, and will open surge beds on an as needs basis. As was evidenced in the mental health program, the team is responsive to the needs of the clients in its immediate community, but also stretches province wide. Despite receiving insufficient funding coming from a different source the required professionals and workers needed to meet the client needs are nonetheless provided.

Clinicians with a particular passion and interest in Hepatitis C and eating disorders have spearheaded the creation of specific programs and activities for these clients.

Priority Process: Competency

Services and programs for clients are provided by a dedicated team of highly competent staff. The leadership team is attentive to the expressed training and safety needs and concerns of staff. Evidence of this is seen in the recent changes made to the coverage of the intake area, from a sole person completing this function on a permanent basis to a rotational basis which involves several nurses.

Priority Process: Episode of Care

Meeting the needs of the clients is the over arching concern of the team and it will do what needs to be done to ensure that these are met and that there are no gaps in the continuity of care. Staff flexibility in providing services is evident in as much as client and staff safety is assured.

Priority Process: Decision Support

There is a culture of evidence-based practice in the substance abuse program. Client and disorder-specific programs such as the one for women as well as the one for eating disorders is based on literature review and best practice.

Priority Process: Impact on Outcomes

Quality performance and identification and monitoring of quality indicators is well-understood and implemented by the team. The team is encouraged to pursue its work in the monitoring of identified indicators in its goal of ensuring services provided and programs running meet the identified goals.

3.2.16 Standards Set: Transfusion Services - Direct Service Provision

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

Surveyor comments on the priority process(es)
Priority Process: Transfusion Services
The on-site opportunity to observe the transfusion process from start to finish confirms there is strict adherence to all standards related to the transfusion process, and in an efficient, safe and timely manner. The continued collaborative work of the transfusion committee has provided a forum for reviewing all aspects of transfusion services including education for clients and nursing staff. The team ensures that practice is the most current practice, and that all team members comply with all standard operating procedures.

3.2.17 Priority Process: Surgical Procedures

Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge

Unmet Criteria		High Priority Criteria
Standards Set: Perioperative Services and Invasive Procedures Standards		
8.7	The preoperative assessment includes a discussion with the client about postoperative pain management options and preferences.	
8.8	The preoperative assessment includes processes to evaluate risk of postoperative nausea and vomiting (PONV).	

Surveyor comments on the priority process(es)

Currently, the surgical program is spread over three sites. Corporate chiefs for surgery and anesthesia are in place. A corporate nursing director is in place with site leaders. Both regulated and non-regulated professionals work in this area. Nurses and registered practical nurses (RPNs) are required to have appropriate post secondary education. They undergo a comprehensive orientation program. Education programs occur monthly for all staff. Skills days are organized on a yearly basis and all appropriate staff members are expected to attend. Registered nurse first-assists are utilized.

Currently, the St Catharines staff members are working in a new facility, and they had input to the design of the surgical area. The design has improved patient flow and safety. The dirty and clean areas are now separated. Clean storage is now enhanced. This has resulted in improved communication with central sterile reprocessing (CSR), improved patient flow and safety. Privacy has now improved. At the Niagara Falls site all deficiencies identified in the last Accreditation survey report have been rectified. There now are separate areas for storage of clean supplies. This initiative was done in co-operation with infection prevention and control (IPAC) staff.

Consolidation of some services has occurred. All cataracts are now done at the Welland site. On call for orthopedics consolidates call to either Welland or Niagara on weekends. Care for orthopedic patients has been standardized. Efficiency and care have improved. This has allowed significant savings which are reinvested into the program.

The surgical program has developed its own huddle board with quality initiatives specific to the program. Each of the sites has developed their own indicators, with some being common to all sites. These are in line with the corporate strategic plan. The indicators are measurable and provide useful information to allow changes to be implemented.

A comprehensive pre-operative package has been developed. All patients scheduled for elective surgery are expected to attend the pre-operative assessment clinic. The broncho pulmonary malformations (BPMs) is generated here, and the patients general medical health and status documented. Any additional investigations and consultations are done at this time. The consent is verified and any education regarding the procedure is undertaken. An on-site review of charts showed that assessment for post operative nausea and vomiting (PONV), and post-op pain was not being documented. Transfer of information throughout the

patient surgical journey remains standardized and verifiable. It is suggested that the patient post-op pain management and PONV assessment be done and documented at some point in their surgical journey. The pre-operative package has been standardized for all sites.

It was observed that pre-op antibiotics were prepared and mixed by staff members in the operating room (OR) or in day surgery. Pre-mixed antibiotics are available commercially or could be prepared under sterile conditions by pharmacy. Having this ability would eliminate errors and problems related with mixing. Patient safety would be improved.

Patients are prepped in the surgical unit. All patients are expected to wash with a disinfectant pre-operatively. The IV is started and a warming blanket applied to patients undergoing major procedures. The assessment from the pre-op clinic is reviewed.

Care pathways and standardized order sets have been developed for some of the quality-based practice (QBP) procedures. This has allowed for standardization of care to occur. Currently, standardized order sets and care pathways are being developed for other procedures.

The PICIS smart tracker allows family members to track their family member's journey in the surgical process.

Cancellations rarely occur. All day surgery patients are contacted the day after surgery. Any concerns or questions are answered and the patient experience is documented.

The St. Catharines surgical area is currently implementing an evidence-based staffing model. This is being done in collaboration with other centres. This will help to prevent burnout and stress of the nursing staff. At the other sites, patient assignments are done on the basis of patient complexity. New hires undergo a comprehensive orientation program on arrival to the surgical area. Regular staff education programs are organized, and staff members are encouraged to proceed with additional education.

Patient satisfaction surveys have not been carried out specific to the surgical in-patient unit. Opportunities for improvement include the need to continue the work to develop new standardized order sets; develop clear documentation for venous thrombo embolism (VTE) prophylaxis, and to look at having pre-operative antibiotics pre-mixed by pharmacy or supplied by an external provider.

Section 4 Instrument Results

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

4.1 Governance Functioning Tool

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

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

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

- **Data collection period: March 19, 2015 to April 6, 2015**
- **Number of responses: 10**

Governance Functioning Tool Results

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1 We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations.	0	0	100	93
2 Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	0	0	100	96
3 We have sub-committees that have clearly-defined roles and responsibilities.	0	0	100	97
4 Our roles and responsibilities are clearly identified and distinguished from those delegated to the CEO and/or senior management. We do not become overly involved in management issues.	0	0	100	94
5 We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decisionmaking.	0	0	100	93

		% Disagree	% Neutral	% Agree	%Agree * Canadian Average
		Organization	Organization	Organization	
6	Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	95
7	Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	97
8	Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	0	0	100	97
9	Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	0	10	90	94
10	Our governance processes make sure that everyone participates in decision-making.	0	20	80	95
11	Individual members are actively involved in policy-making and strategic planning.	0	20	80	90
12	The composition of our governing body contributes to high governance and leadership performance.	0	0	100	93
13	Our governing body’s dynamics enable group dialogue and discussion. Individual members ask for and listen to one another’s ideas and input.	0	0	100	96
14	Our ongoing education and professional development is encouraged.	0	0	100	90
15	Working relationships among individual members and committees are positive.	0	0	100	97
16	We have a process to set bylaws and corporate policies.	0	0	100	96
17	Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	98
18	We formally evaluate our own performance on a regular basis.	0	0	100	83
19	We benchmark our performance against other similar organizations and/or national standards.	0	13	88	71
20	Contributions of individual members are reviewed regularly.	0	10	90	66

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
21 As a team, we regularly review how we function together and how our governance processes could be improved.	0	0	100	79
22 There is a process for improving individual effectiveness when non-performance is an issue.	0	30	70	62
23 We regularly identify areas for improvement and engage in our own quality improvement activities.	0	10	90	79
24 As a governing body, we annually release a formal statement of our achievements that is shared with the organization's staff as well as external partners and the community.	0	29	71	81
25 As individual members, we receive adequate feedback about our contribution to the governing body.	0	11	89	69
26 Our chair has clear roles and responsibilities and runs the governing body effectively.	0	0	100	96
27 We receive ongoing education on how to interpret information on quality and patient safety performance.	0	0	100	90
28 As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	96
29 As a governing body, we hear stories about clients that experienced harm during care.	20	0	80	88
30 The performance measures we track as a governing body give us a good understanding of organizational performance.	0	0	100	95
31 We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	0	0	100	91
32 We have explicit criteria to recruit and select new members.	0	0	100	87
33 Our renewal cycle is appropriately managed to ensure continuity on the governing body.	0	0	100	94

		% Disagree	% Neutral	% Agree	%Agree * Canadian Average
		Organization	Organization	Organization	
34	The composition of our governing body allows us to meet stakeholder and community needs.	0	0	100	93
35	Clear written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	95
36	We review our own structure, including size and subcommittee structure.	0	0	100	91
37	We have a process to elect or appoint our chair.	0	11	89	93

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2015 and agreed with the instrument items.

4.2 Canadian Patient Safety Culture Survey Tool

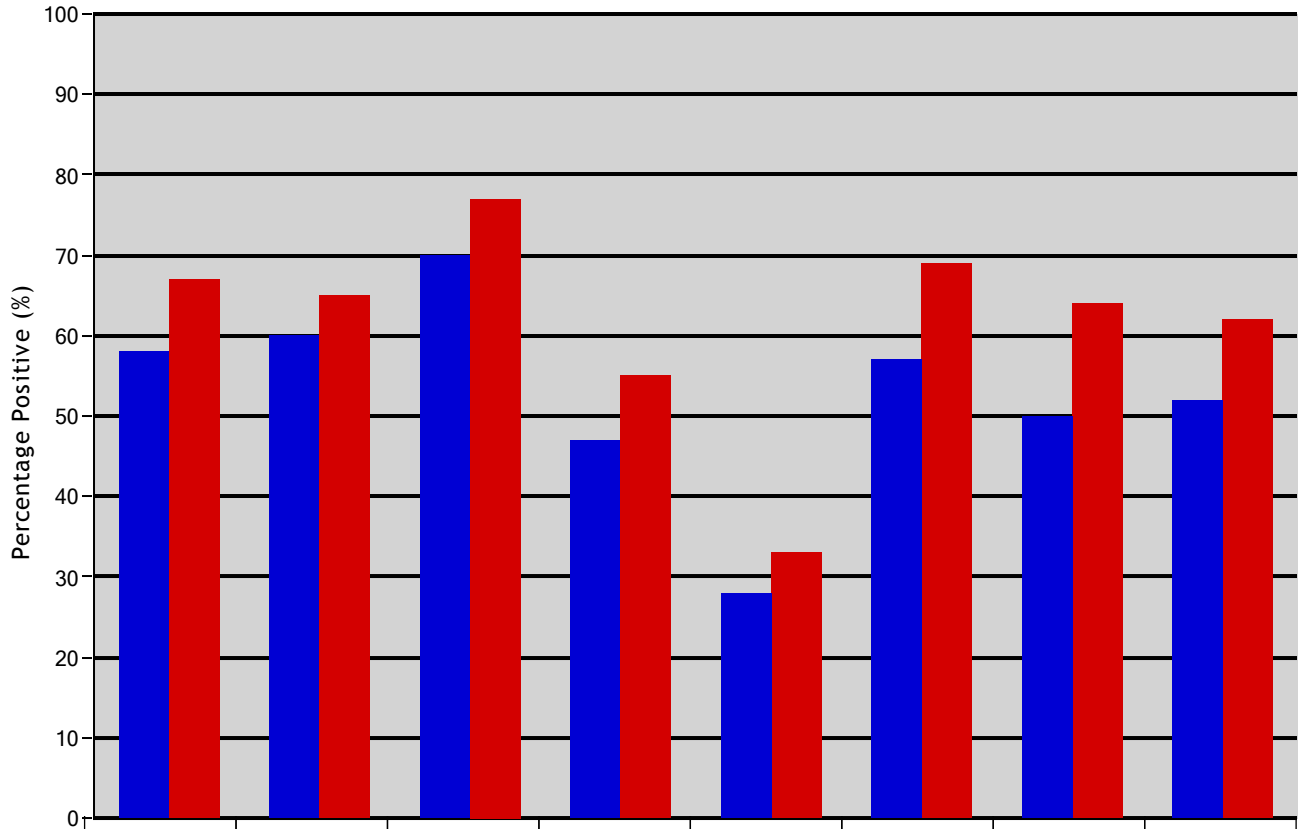
Organizational culture is widely recognized as a significant driver in changing behavior and expectations in order to increase safety within organizations. A key step in this process is the ability to measure the presence and degree of safety culture. This is why Accreditation Canada provides organizations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

Results from the Patient Safety Culture Tool allow the organization to identify strengths and areas for improvement in a number of areas related to patient safety and worklife.

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

- **Data collection period: May 26, 2014 to July 20, 2014**
- **Minimum responses rate (based on the number of eligible employees): 342**
- **Number of responses: 954**

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



	Organizational (senior) leadership support for safety	Supervisory leadership for safety	Unit learning culture	Enabling Open Communication I: judgment-free environment	Enabling Open Communication II: job repercussions of error	Incident follow up	Stand-alone items	Overall Perceptions of Client Safety
	58%	60%	70%	47%	28%	57%	50%	52%
	67%	65%	77%	55%	33%	69%	64%	62%

Legend

Niagara Health System

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2014 and agreed with the instrument items.

4.3 Worklife Pulse

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

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

The organization used an approved substitute tool for measuring quality of Worklife. The organization has provided Accreditation Canada with results from its substitute tool and had the opportunity to identify strengths and address areas for improvement. During the on-site survey, surveyors reviewed actions the organization has taken.

4.4 Client Experience Tool

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

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

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

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

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

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

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

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

Appendix A Qmentum

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

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

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

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

Action Planning

Following the on-site survey, the organization uses the information in its Accreditation Report and Quality Performance Roadmap to develop action plans to address areas identified as needing improvement. The organization provides Accreditation Canada with evidence of the actions it has taken to address these required follow ups.

Evidence Review and Ongoing Improvement

Five months after the on-site survey, Accreditation Canada evaluates the evidence submitted by the organization. If the evidence shows that a sufficient percentage of previously unmet criteria are now met, a new accreditation decision that reflects the organization's progress may be issued.

Appendix B Priority Processes

Priority processes associated with system-wide standards

Priority Process	Description
Communication	Communicating effectively at all levels of the organization and with external stakeholders.
Emergency Preparedness	Planning for and managing emergencies, disasters, or other aspects of public safety.
Governance	Meeting the demands for excellence in governance practice.
Human Capital	Developing the human resource capacity to deliver safe, high quality services.
Integrated Quality Management	Using a proactive, systematic, and ongoing process to manage and integrate quality and achieve organizational goals and objectives.
Medical Devices and Equipment	Obtaining and maintaining machinery and technologies used to diagnose and treat health problems.
Patient Flow	Assessing the smooth and timely movement of clients and families through service settings.
Physical Environment	Providing appropriate and safe structures and facilities to achieve the organization's mission, vision, and goals.
Planning and Service Design	Developing and implementing infrastructure, programs, and services to meet the needs of the populations and communities served.
Principle-based Care and Decision Making	Identifying and making decisions about ethical dilemmas and problems.
Resource Management	Monitoring, administering, and integrating activities related to the allocation and use of resources.

Priority processes associated with population-specific standards

Priority Process	Description
Chronic Disease Management	Integrating and coordinating services across the continuum of care for populations with chronic conditions
Population Health and Wellness	Promoting and protecting the health of the populations and communities served through leadership, partnership, and innovation.

Priority processes associated with service excellence standards

Priority Process	Description
Blood Services	Handling blood and blood components safely, including donor selection, blood collection, and transfusions
Clinical Leadership	Providing leadership and direction to teams providing services.
Competency	Developing a skilled, knowledgeable, interdisciplinary team that can manage and deliver effective programs and services.
Decision Support	Maintaining efficient, secure information systems to support effective service delivery.
Diagnostic Services: Imaging	Ensuring the availability of diagnostic imaging services to assist medical professionals in diagnosing and monitoring health conditions
Diagnostic Services: Laboratory	Ensuring the availability of laboratory services to assist medical professionals in diagnosing and monitoring health conditions
Episode of Care	Partnering with clients and families to provide client-centred services throughout the health care encounter.
Impact on Outcomes	Using evidence and quality improvement measures to evaluate and improve safety and quality of services.
Infection Prevention and Control	Implementing measures to prevent and reduce the acquisition and transmission of infection among staff, service providers, clients, and families
Living Organ Donation	Living organ donation services provided by supporting potential living donors in making informed decisions, to donor suitability testing, and carrying out living organ donation procedures.
Medication Management	Using interdisciplinary teams to manage the provision of medication to clients
Organ and Tissue Donation	Providing organ and/or tissue donation services, from identifying and managing potential donors to recovery.
Organ and Tissue Transplant	Providing organ and/or tissue transplant service from initial assessment to follow-up.
Point-of-care Testing Services	Using non-laboratory tests delivered at the point of care to determine the presence of health problems
Primary Care Clinical Encounter	Providing primary care in the clinical setting, including making primary care services accessible, completing the encounter, and coordinating services

Priority Process	Description
Public Health	Maintaining and improving the health of the population by supporting and implementing policies and practices to prevent disease, and to assess, protect, and promote health.
Surgical Procedures	Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge