ACCREDITATION
AGRÉMENT
CANADA
Qmentum

Accreditation Report

St. Joseph's Healthcare Hamilton

Hamilton, ON

On-site survey dates: May 12, 2019 - May 16, 2019

Report issued: June 12, 2019

About the Accreditation Report

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

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

Confidentiality

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

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

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

A Message from Accreditation Canada

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

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

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

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

We look forward to our continued partnership.

Sincerely,

Leslee Thompson
Chief Executive Officer

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Executive Summary

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

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

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

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

Accreditation Decision

St. Joseph's Healthcare Hamilton's accreditation decision is:

Accredited with Exemplary Standing

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

About the On-site Survey

- **On-site survey dates: May 12, 2019 to May 16, 2019**

- **Locations**

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

  1. St. Joseph's Healthcare Hamilton, Charlton Campus
  2. St. Joseph's Healthcare Hamilton, King St. Campus
  3. St. Joseph's Healthcare Hamilton, West 5th Campus

- **Standards**

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

  System-Wide Standards

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

  Service Excellence Standards

  5. Ambulatory Care Services - Service Excellence Standards
  6. Biomedical Laboratory Services - Service Excellence Standards
  7. Critical Care Services - Service Excellence Standards
  8. Diagnostic Imaging Services - Service Excellence Standards
  9. Emergency Department - Service Excellence Standards
  10. Inpatient Services - Service Excellence Standards
  11. Mental Health Services - Service Excellence Standards
  12. Obstetrics Services - Service Excellence Standards
  13. Organ and Tissue Donation Standards for Deceased Donors - Service Excellence Standards
      - includes Organ Donation Standards for Living Donors and Organ and Tissue Transplantation Services
  14. Perioperative Services and Invasive Procedures - Service Excellence Standards
  15. Point-of-Care Testing - Service Excellence Standards
  16. Rehabilitation Services - Service Excellence Standards
  17. Reprocessing of Reusable Medical Devices - Service Excellence Standards
  18. Transfusion Services - Service Excellence Standards

- **Instruments**

  The organization administered:

  1. Worklife Pulse
  2. Canadian Patient Safety Culture Survey Tool
  3. Client Experience Tool

Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
 Population Focus (Work with my community to anticipate and meet our needs)	53	0	0	53
 Accessibility (Give me timely and equitable services)	96	0	0	96
 Safety (Keep me safe)	667	4	5	676
 Worklife (Take care of those who take care of me)	143	0	0	143
 Client-centred Services (Partner with me and my family in our care)	393	3	3	399
 Continuity (Coordinate my care across the continuum)	75	0	0	75
 Appropriateness (Do the right thing to achieve the best results)	1093	0	3	1096
 Efficiency (Make the best use of resources)	67	0	1	68
Total	**2587**	**7**	**12**	**2606**

Overview by Standards

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

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

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

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

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	50 (100.0%)	0 (0.0%)	0	36 (100.0%)	0 (0.0%)	0	86 (100.0%)	0 (0.0%)	0
Leadership	50 (100.0%)	0 (0.0%)	0	96 (100.0%)	0 (0.0%)	0	146 (100.0%)	0 (0.0%)	0
Infection Prevention and Control Standards	40 (100.0%)	0 (0.0%)	0	30 (96.8%)	1 (3.2%)	0	70 (98.6%)	1 (1.4%)	0
Medication Management Standards	76 (97.4%)	2 (2.6%)	0	59 (96.7%)	2 (3.3%)	3	135 (97.1%)	4 (2.9%)	3
Ambulatory Care Services	45 (100.0%)	0 (0.0%)	2	77 (100.0%)	0 (0.0%)	1	122 (100.0%)	0 (0.0%)	3
Biomedical Laboratory Services **	72 (100.0%)	0 (0.0%)	0	105 (100.0%)	0 (0.0%)	0	177 (100.0%)	0 (0.0%)	0
Critical Care Services	60 (100.0%)	0 (0.0%)	0	105 (100.0%)	0 (0.0%)	0	165 (100.0%)	0 (0.0%)	0
Diagnostic Imaging Services	68 (100.0%)	0 (0.0%)	0	69 (100.0%)	0 (0.0%)	0	137 (100.0%)	0 (0.0%)	0

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	71 (98.6%)	1 (1.4%)	0	107 (100.0%)	0 (0.0%)	0	178 (99.4%)	1 (0.6%)	0
Inpatient Services	59 (100.0%)	0 (0.0%)	1	84 (100.0%)	0 (0.0%)	1	143 (100.0%)	0 (0.0%)	2
Mental Health Services	50 (100.0%)	0 (0.0%)	0	92 (100.0%)	0 (0.0%)	0	142 (100.0%)	0 (0.0%)	0
Obstetrics Services	71 (100.0%)	0 (0.0%)	2	88 (100.0%)	0 (0.0%)	0	159 (100.0%)	0 (0.0%)	2
Organ and Tissue Donation Standards for Deceased Donors	54 (100.0%)	0 (0.0%)	0	96 (100.0%)	0 (0.0%)	0	150 (100.0%)	0 (0.0%)	0
Perioperative Services and Invasive Procedures	115 (100.0%)	0 (0.0%)	0	109 (100.0%)	0 (0.0%)	0	224 (100.0%)	0 (0.0%)	0
Point-of-Care Testing **	38 (100.0%)	0 (0.0%)	0	46 (100.0%)	0 (0.0%)	2	84 (100.0%)	0 (0.0%)	2
Rehabilitation Services	45 (100.0%)	0 (0.0%)	0	80 (100.0%)	0 (0.0%)	0	125 (100.0%)	0 (0.0%)	0
Reprocessing of Reusable Medical Devices	87 (98.9%)	1 (1.1%)	0	40 (100.0%)	0 (0.0%)	0	127 (99.2%)	1 (0.8%)	0
Transfusion Services **	76 (100.0%)	0 (0.0%)	0	69 (100.0%)	0 (0.0%)	0	145 (100.0%)	0 (0.0%)	0
Total	**1127 (99.6%)**	4 (0.4%)	5	1388 (99.8%)	3 (0.2%)	7	2515 (99.7%)	7 (0.3%)	12

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

Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client Identification (Inpatient Services)	Met	1 of 1	0 of 0
Client Identification (Mental Health Services)	Met	1 of 1	0 of 0
Client Identification (Obstetrics Services)	Met	1 of 1	0 of 0
Client Identification (Perioperative Services and Invasive Procedures)	Met	1 of 1	0 of 0
Client Identification (Point-of-Care Testing)	Met	1 of 1	0 of 0
Client Identification (Rehabilitation Services)	Met	1 of 1	0 of 0
Client Identification (Transfusion Services)	Met	1 of 1	0 of 0
Information transfer at care transitions (Ambulatory Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Critical Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Emergency Department)	Met	4 of 4	1 of 1
Information transfer at care transitions (Inpatient Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Mental Health Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Obstetrics Services)	Met	4 of 4	1 of 1

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

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

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

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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Pressure Ulcer Prevention (Rehabilitation Services)	Met	3 of 3	2 of 2
Suicide Prevention (Emergency Department)	Met	5 of 5	0 of 0
Suicide Prevention (Mental Health Services)	Met	5 of 5	0 of 0
Venous Thromboembolism Prophylaxis (Critical Care Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Inpatient Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2

Summary of Surveyor Team Observations

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

St. Joseph's Healthcare Hamilton (SJHH) is commended for its commitment to quality improvement and patient safety. A strong culture of engagement is widespread throughout the organization. Leaders, staff, and physicians are committed to accreditation and were open and engaging with the on-site survey team.

SJHH emphasizes the patient experience and has an excellent understanding of ethics and decision making. Its proximity to McMaster University supports key research projects. The organization is commended for using traditional and non-traditional university programs to advance health care.

The leadership team is engaged, dedicated, and most members have a long tenure with the organization. They work well together and are respectful of each other and passionate about patient safety. The president is new to the organization and has a good understanding of SJHH's successes and challenges. She has made the effort to connect with staff throughout the organization and many staff indicate that they have met with her.

The board provides oversight to the organization. Many members have been on the board for more than five years in various roles. The board is an engaged group that demonstrates a good understanding of health care issues in Ontario and shows a clear commitment to quality and safety.

The leadership and board made an intentional decision to delay the development and implementation of a new strategic plan to focus on the implementation of the new electronic health record called Dovetale electronic health record. Work has now begun on the new strategic plan with a planned release of September 2019, and programs will work to ensure staff and patient involvement. SJHH has 80 front-line staff ambassadors whose role is to help staff understand key organizational initiatives and priorities.

The organization is being used by the Ministry of Health and Long-term Care as a model for integration for the upcoming changes to health care in Ontario. The team prides itself on not being afraid to be first and sees this as an excellent opportunity.

The integrated comprehensive care model has shown success through bundles of care for the management of chronic diseases such as chronic obstructive pulmonary disease. The model is being expanded and SJHH sees this as an opportunity to provide integrated, meaningful, respectful patient care that addresses specific needs. Other key initiatives that have been implemented since the last on-site survey include baby-friendly initiatives, violence prevention, and Connect which is the centralized intake program for mental health.

The upcoming changes to health care will put additional pressure and stress on the organization. It will be important to manage and sustain its achievements. Many staff have a long tenure with the organization and succession planning in key areas is critical. The board and leaders understand the risks facing the organization

and have plans in place to mitigate key issues.

SJHH is a learning organization that is committed to quality and safety. Staff speak positively of the support they receive from managers and leaders. The leadership team is accessible and listens to staff at all levels.

Detailed On-site Survey Results

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

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

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

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

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

See Appendix B for a list of priority processes.

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

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

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

Priority Process Results for System-wide Standards

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

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

Priority Process: Governance

Meeting the demands for excellence in governance practice.

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

SJHH is governed by the St. Joseph's Hamilton Joint Boards of Governors. Four of the fifteen board members support SJHH exclusively, in addition to the three executive members. The board committees also have community members and the Quality Committee has two patient representatives.

The board has a mix of seasoned and newer members with a diverse set of backgrounds, experiences, and competencies. When recruiting new members, a skills mix tool and process is used to identify the backgrounds, experiences, and competencies that are required to meet the needs of the community. The recruitment process is robust and has resulted in a board that functions well together. New board members follow an orientation process and are buddied with a more experienced member as a mentor.

YODA is the ethics framework that is used across the organization and by the board to guide decision making. The services of a bioethicist are also used when the organization is confronted with particularly challenging issues. In addition to the ethics framework, the board is guided by the mission and values, often starting the meetings by hearing stories from staff about how staff use the values in their day-to-day work.

The board has processes to support its role in governance, while remaining focused on the patient as the centre and preserving the culture established by the founding Sisters'. The board may wish to consider how it will measure the impact of the patient advisors and full implementation of patient- and family-centred care.

A significant challenge facing the board is the uncertainty with the budget as the new Ontario government implements changes to health care structures. There are also concerns about reputational risk following recent media reports about emergency mental health services.

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 mission, vision, and values, along with goals and objectives, have been adopted and embedded into everyday practice. The values are dignity, respect, service, justice, responsibility, and enquiry and they are visible across the organization, not just on posters or in words but also in action. The values are used in everyday conversation with staff at all levels. Board members take the opportunity to have staff talk about how their work relates to one of the values at various meetings.

Broad internal and external stakeholder engagement meetings have taken place to put forward a new strategic operational plan for 2019–2024 that incorporates community, patient, and family voices. Compassionate care, listening, empathy, dignity, access to care, cutting edge technology, community partnerships, and innovation were the directions provided and these are seen as defining SJHH from the rest of the province. SJHH is seen as one of Canada's top 40 research hospitals and it thrives on being a pioneer. The strategic plan will be disseminated to the broader organization using board, leadership, patient and family advisors, and employee and strategy ambassadors. Goals and objectives will need to be created and aligned to strategic plan, with input sought from patient and family advisory teams during key decision-making processes.

SJHH is a highly data-driven organization. For example, it uses data from patient demographics, Canadian Institute for Health Information abstracts, socioeconomics through postal codes, and code red studies. It is a nimble organization and adjusts easily to government mandates, pressure, and fast-paced changing environments and community needs and growth. There is a strong alignment among SJHH, Niagara Health, and the broader health care community.

Community partners see SJHH as an enabler and an active participant in community health care support, being the first to reach out and fill gaps in health disparity, housing, and care where needed.

Priority Process: Resource Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

SJHH ensures that the organization has an equal opportunity to voice program needs for operational and capital planning annually. Engagement is done in many forms, including connecting one-on-one with program directors, walkabouts, and aligning needs with strategic priorities.

There are many variables that may influence the leadership and board in financial allocation and decision making, particularly in times of government changes, fluctuations, and priority changes. The finance team conducts comprehensive planning assumption modelling on a four-year cycle to forecast changes in inflation in a changing environment and changes in community needs. Funds are allocated with great rigour using a fair and equitable process across the organization.

The Operational Planning and Performance Committee, which includes physicians, makes decisions collectively and builds strategies to capitalize on and maximize funding. SJHH financials are stable due to high fiscal accountability and monitoring, always finding ways to do more with less, and being an innovator in considering how to enhance cost structures. SJHH is highly respected for its continuous effort and work with its decision support teams to review data and leverage opportunities as they arise. It has positive relationships with Local Health Integrated Networks (LHINs), unions, and government.

Resource allocation and succession planning are two areas of risk. With an aging workforce, recruitment and retention challenges, and an unknown funding allocation, SJHH will need to set priorities that align with its strategic plan. Its strengths are its ability to be nimble, use data for decision making, and leverage internal and external opportunities and partnerships to redesign how health care services are offered. With an aging infrastructure, particular attention to structural deficits will be required to accommodate the growing needs of the community.

Priority Process: Human Capital

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Leadership at all levels is acting on the employee engagement survey results through targeted action plans focused on three corporate priorities along with attention to key and unique departmental drivers. Successful strategies have enhanced response rates year over year and the commitment to achieve even higher response rates includes defined action plans.

Comprehensive onboarding and orientation programs have been developed at the organizational level for all staff and volunteers, along with complementary role- or department-specific programs. All orientation and continuing development programs appear to be updated regularly based on program evaluation and analysis of the match with the organizational mission, vision, and values. As one example, a recent update in programming expanded the time allotted to patient- and family-centred care as a core value.

Mandatory training requirements, including annual patient safety training, are well defined and there are processes to track and report adherence. Multimodal learning opportunities have been thoughtfully developed based on balancing effective learning methods with access and resource intensity. There will be opportunities to further evaluate and possibly update programs following the operational planning resulting from the SJHH new strategic plan.

Organizational development initiatives are supported by a change management framework, and recent organizational changes have been deployed by engaging more than 90 ambassadors. This approach and degree of engagement among staff demonstrates a thoughtful, effective, and collaborative approach to change. The ambassador role also aligns intentionally with the aim of better engaging staff in change, which is one of the priorities revealed by the employee engagement survey results.

A comprehensive approach to measuring, analyzing, and preventing workplace violence is well planned and in progress. The violence prevention strategy consists of a variety of complementary initiatives that are clearly defined in an excellent toolkit that was developed for leaders to use with their teams. The Support to Report component of the strategy has significantly increased reporting of events, providing a better data source to more confidently target resources and improvement initiatives. Significant progress is being made with the overall strategy. The implementation of an online reporting tool (HIR) makes reporting easier and better enables data management and analysis.

A wellness program centred primarily on five modifiable risk factors framed to address mind, body, and spirit is in place for staff, learners, physicians, and volunteers. An innovative pilot program addressing compassion fatigue demonstrates continued efforts to sensitively adapt to needs.

While there are several valued recognition and award events and mechanisms, the human resources leadership team recognizes that there are opportunities to develop peer-to-peer recognition processes.

With respect to recruitment and retention of individuals with the skills to meet patient care needs, careful analysis of hard-to-fill roles is ongoing and succession planning is an important focus, particularly for leadership roles given the large percentage of staff who are eligible for or nearing retirement.

Priority Process: Integrated Quality Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization is commended for its safety culture framework and dedication to following up on recommendations and learnings. SJHH has a culture of caring and commitment all at all levels. Surveys conducted by the organization show that concerns about repercussions when errors are committed have improved; however, staff and physicians stated the opposite during on-site survey discussions. It was mentioned that the organization, team, and leaders provide psychological safety to report, support a just culture, and promote learnings for quality improvement opportunities.

Significant gains have been made to mitigate risks and physician disclosure of harm with the new 24-hour teleconference calls for critical incidents (level 5 and 6 incidents). The organization is strongly encouraged to monitor compliance and apply learnings to further the quality and safety agenda.

There is a documented approach to disclosing patient safety incidents. It is suggested that the current 2017 policy be reviewed and updated. Although it is due for review in 2020, changes in practice merit adding content around critical incident event calls to further explore disclosure with the patient and family. The need to report in the enterprise risk management system and to follow up to close the loop with staff and build risk awareness could be reinforced.

A success since the last on-site survey is the enterprise risk management system. The risk pillars, heat maps, and priority-setting classifications are visually easy to understand, relatable, and easy to disseminate at all levels. The new Quality Priority Indicators Dashboard is another tool used by the leadership team in many areas, making it easier to evaluate, prioritize, and monitor progress.

Six quality improvement priorities were adopted, and these are visible at the corporate and leadership levels but are not fully adopted at all unit levels. The organization is encouraged to continue this process for all units. Significant gains have been made with medication reconciliation and the implementation of Dovetale electronic health record.

The organization is commended for adding additional safety measures in the discharge summary to include best possible medication history medications identified on admission, including what was given, what was discontinued, and the current medication regime.

The governance team is highly engaged and passionate about quality improvement. Senior executive medical and clinical leadership review the data at Quality Committees and track actions against the organization’s goals and objectives.

Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The YODA ethics framework has been successfully implemented with extensive consultation and input from stakeholders. The framework includes a code of conduct and guidelines and processes to support decision making across the organization.

The Ethics Advisory Committee is responsible for disseminating and revising the framework. Trends in ethical issues are identified and analyzed to facilitate quality improvement. A bioethicist is available 24/7 to support teams and patients and also provides education, training, and consultation. Reports describing committee activities and the role of the bioethicist are provided to leadership, the Medical Advisory Committee, and the board of directors. The information is used to improve the quality of service across the organization.

Teams and individuals across the organization report using the framework and benefiting from consultation with the bioethicist. Staff are able to bring ethical concerns forward confidentially through an established process and whistle blower and escalation policies are in place to provide an additional layer of support and protection.

The Research Ethics Board meets monthly to assess the merits and risks of research proposals. The board is also available for consultation, as needed.

Despite being challenged by issues including workplace pressures, diverse cultural needs, and very complex and complicated ethical issues, ethics and ethical decision-making is embedded in the culture. The team is commended for its investment in and commitment to principle-based care and for the leadership and support it provides to community partners. It is encouraged to continue with its efforts to build capacity and provide ongoing orientation to and review of the framework.

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)

During discussions with the chief information officer, chief privacy officer, and the director of public affairs, the corporate strategic communication plan was highlighted. The plan had many inputs and was informed by audits of previous communication initiatives. Purposeful attention was paid to restructuring internal communication. For example, emails to leaders are now consolidated into weekly updates including reports on key projects such as Dovetale electronic health record. The internal and external websites were revamped to ensure consistent messaging. Management forum meetings occur where leaders interact directly with the executive. Staff speak positively about these changes.

The website will be undergoing a consultation process to identify improvements. There is a portal for patient and family advisors with key information that is important to their role at SJHH.

Different strategies are used to address issues and crisis management. An area of focus has been increasing leadership visibility. Staff can speak directly to executives by checking a box when they report a safety incident.

The organization has made great strides in the implementation of Dovetale electronic health record. While it has not been without its challenges, most of the organization went live at the same time. Purposeful attention was paid to the culture of engagement, partnerships with physicians, and ensuring that staff were well informed and supported. Guiding principles and decision-making principles were key to success.

A Data Governance Committee has been established to oversee the management of information. There is mandatory reporting of privacy breaches. Annual training has been adapted to reflect the new system. The organization is encouraged to continue to monitor its systems to ensure they remain safe and secure. It will be important to work with partners and patients to ensure that policies are updated and reflect the current system.

Some patient groups are able to access their personal health records through MyDovetale (Patient Accessed Electronic Health Record). Selected programs have undergone a privacy impact assessment and engagement with patient and family advisors to ensure success. The organization is purposefully spreading access to the integrated comprehensive care patient population and there will be no charge for patients in the programs. SJHH is encouraged to continue with this rollout.

Social media is managed through policies and staff education. The organization is encouraged to continue to listen to the voices of its patients and advisors as social media opportunities unfold.

As part of SJHH's story-telling approach, it is encouraged to tap into the wisdom and experience of the patient and family advisors and the staff who have been working together, to share the challenges they face, learn from their peers, and promote engagement.

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)

SJHH is a multi-site hospital that provides ambulatory, acute, and mental health care to the Hamilton region and the Hamilton Niagara Haldimand Brant LHIN. It is the largest acute care hospital in the St. Joseph's Health System, comprising the Charlton Campus, the West 5th Campus, and the King Campus as an outpatient facility.

The physical environment covers over 2 million square feet and varies from newer facilities (diagnostic imaging, surgical centre, dialysis which is still under construction, West 5th Campus) to some areas that are older. Nevertheless, space is optimized and the facilities are well maintained. Several redevelopment projects are underway.

The management team has developed a multi-year health infrastructure renewal plan and has implemented several initiatives for cost containment and savings. For example, internal building services staff have been trained to perform minor repairs rather than contracting this work out. A program that subsidizes 80 percent of the salary of a worker was used to hire an environmental engineer to help with the energy plan to reduce consumption. Over 4,000 light fixtures were replaced with LED technology that reduces costs and improves safety; for example, lighting in the parking lots has been improved significantly and staff say they feel safer. A computerized maintenance management system has been implemented and the organization is 100 percent compliant with it. A protocol for code aqua has been developed following a serious flood and monthly drills are practiced.

Several projects and renovations have been completed to improve accessibility and meet new standards, such as barrier-free showers on patient units, automatic door openers, and signage for better wayfinding. The team is encouraged to continue its work to improve wayfinding, especially in some of the older areas of the hospital.

All renovation projects require inspection and sign-off by infection prevention and control (IPAC), and infection control measures and standards are part of all contracts. Signed-off documentation is posted at each area under construction.

The Charlton Campus has a small laundry facility as most laundry services are contracted out. There is good separation of soiled and clean linens and the kitchen meets all food handling, hygiene, and cleaning standards, although the physical environment itself is showing its age.

Building services has made renovations to improve staff spaces, such as repurposing an old operating room into a Wellness Centre for staff where they can attend on-site fitness classes, redesigning the staff

lounge for the surgeons in the operating room, and creating a nice spiritual space for staff and patients.

SJHH has aging facilities but there is a long-term infrastructure vision and plan.

Priority Process: Emergency Preparedness

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Emergency preparedness has a strong visual and actual presence throughout the organization. Codes of the month are practised throughout the facility and are highlighted on the intranet. There are regular tabletop and other exercises with partnering agencies such as Hamilton Health Sciences, the municipality of Hamilton, fire department, police services, and ambulance services. There are also strong internal partnerships with departments such as IPAC, building maintenance, housekeeping, and clinical services to ensure policies are relevant and reflect current realities such as with the code silver (active attacker/active shooter) policy and procedure.

The incident command process is seen as an effective way to manage a variety of situations and was used to facilitate the implementation of the electronic health record.

A commitment to staff and patient safety and continuous development of partnerships to facilitate learning and improvement are evident.

Priority Process: People-Centred Care

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

SJHH is congratulated on the evolution and strength of its dedication to people-centred care. There is a culture of caring and engagement at the bedside, in the community, and in organizational decision making. The value and importance of people-centred care is evident in conversations with patients, families, staff and physician leaders, front-line staff, and patient and family advisors.

Several noteworthy people-centred care initiatives include the patient liaison program, the "made with patient and family involvement" seal of approval, the inclusion of patient and family advisors on interview panels, the online resource portal for patient and family advisors, the AVS discharge summary, and the Youth Wellness Centre. These are just some examples that honour the legacy of the Sisters of St. Joseph's.

The organizational Patient and Family Advisory Council has matured well. Advisors comment that they no longer have to push their way into being of service and are invited into more priority-setting and decision-making opportunities. They report that board members and other leaders have a clear understanding and appreciation of the advisors' roles and potential, but that front-line staff seem to be less aware.

Some advisors have been on the council since its inception in 2011. The council may want to consider reviewing its terms of reference and developing a succession planning strategy to include new perspectives. Patient and family advisors are interested in exploring the possibility of collaborating with local universities to build medical students' knowledge of people-centred care.

Evaluating the experience of patient and family advisors and incorporating their feedback is a strength. The organization is encouraged to evaluate the engagement process of the various Patient and Family Councils to determine the impact and effectiveness of the feedback received.

Departmental- or service-level committees that include patient and family advisors are in various stages of maturity. Committees with one advisor are encouraged to have a minimum of two in order to align with engagement best practices. The organization is encouraged to optimize the wisdom and learning of the more experienced committees. Staff and patient and family advisors could offer advice on challenges and the factors for successful and meaningful engagement.

A continued, intentional, and strategic focus on seeking feedback from patients and families is suggested. While Patient and Family Advisory Councils can be a valuable way to seek and incorporate feedback, they tend to be resource intensive and need appropriate support.

SJHH has been working diligently to recruit more patient and family advisors and these efforts have been quite productive. Continued attention on recruiting for diversity that represents the community is suggested.

As the patient and family advisor program grows, there is a possibility that more staff resources will be required to support the needs of the organization. The current staff member (.8 FTE) is very dedicated and eager to continue to learn how to implement engagement best practices into this work.

SJHH values the benefits of collaborating with community partners to provide the best care possible. There are many examples across the organization and the collaborative relationship with the Six Nations community is specifically acknowledged.

There is an evident culture of caring throughout SJHH. Patients say they feel well cared for and are comfortable asking questions. They are encouraged to be actively engaged in their own care to the extent they are able. Family members report that they are confident in the care their loved ones receive. Staff recognize that “family” is defined by the patient.

The intensive care unit is commended for the Footprints initiative that brings greater humanity to the patient experience, and the Three Wishes program that brings joy to critically ill patients and their loved ones.

Communication boards are effective tools that are used to communicate with patients and families; however, the boards are not in all patient rooms. It is suggested that this worthwhile patient- and family-centred care tool be implemented in all areas.

There are many challenges in meeting the diverse needs of a variety of patient populations. The organization has opportunities to improve the ease of transition for youth mental health patients to adult mental health services. In addition, patients and families have concerns with the experience of the mental health emergency room. However, once they are able to access mental health services, they are very pleased with the support available.

SJHH has clearly created a culture of meaningful, patient- and family-centred care.

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)

Bed meetings to coordinate and improve patient flow occur twice a day, with participation from all units. The leadership team measures specific goals, as required by the province, and these are monitored and shared at the corporate improving Access Steering Committee. Examples include improving transfer times from the emergency department (ED) to the intensive care unit and the medical step-down unit, reducing emergency length of stay for admitted mental health patients and reducing re-visits from these patients, reducing ambulance off-load time, and reducing acute length of stay for alternate level of care patients in general medicine.

The implementation of Dovetale electronic health record has allowed staff to access data more readily and has improved tracking and reporting. This in turn facilitates the implementation of some improvement plans.

The leadership team also has access to several dashboards to trigger surge protocols or plans depending on the level of risk identified. Leadership reviews on a biannual basis the bed map of the entire organization to help determine the appropriateness of bed occupancy and identify new needs or opportunities.

The organization has many partnerships and works with community resources as well as with its many outpatient clinics to manage patient flow. Some local initiatives include the Home-to-OR program that allows stable patients awaiting semi-urgent day surgery to be discharged home so they can wait there for an opening, as well as the ED's admission avoidance initiative that has in the last year avoided 1,200 admissions to hospital.

Priority Process: Medical Devices and Equipment

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

Unmet Criteria	High Priority Criteria
Standards Set: Reprocessing of Reusable Medical Devices	
14.3 All sterilized items in storage, or transported to patient service areas or other organizations, can be tracked.	!

Surveyor comments on the priority process(es)

Medical device reprocessing and equipment leadership teams are knowledgeable and experts in their field, which is a significant asset to the organization. The biomedical engineering department works closely with its respective stakeholders and remains connected to the growing needs of the organization. It is innovative and continuously looks for ways to improve care, minimize risks, be fiscally responsible, and monitor response times as a measure of quality.

The 3D printer is one of many ways the team addresses equipment and clinical needs in a timely manner. The team's computer maintenance management system addresses manufacturing requirements and preventive maintenance programs for equipment that the team supports. Mechanisms to monitor risks are linked to the enterprise risk management system for ratings.

Equipment is vetted through the biomedical engineering department with added checkpoints to ensure compliance for new or replacement equipment. Staff in the biomedical department take pride in the work and service they provide and are keen to keep learning and growing with technological advancement and complexity. Due to the effective preventive maintenance program and skilled task force, a lot of equipment has exceeded its lifespan, reducing costs and down time and supporting patient care needs.

The medical device reprocessing teams have had time to settle into their new environment since the last on-site survey. The layout of the unit is well designed and forward thinking. The leadership team is exceptionally driven to create positive collaborative relationships with the staff by empowering them and by recognizing the excellent service they provide. They are inclusive in their decision-making process and promote the visibility of the teams.

With regard to transporting equipment externally, there is no evidence in the standard operating procedure or the policy to show that items can be tracked in other organizations. The policy needs to be refined and updated to include more details about the type of containers used for transport, minimum and maximum exposure to temperature variations, and how clean and dirty containers need to be identified and differentiated during transport.

The department is commended for its focus on the team and being a leader in best practice guidelines, research, support, and elevating training to another level. The quality that the unit provides is admirable.

Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Point-of-care Testing Services

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

Clinical Leadership

- Providing leadership and direction to teams providing services.

Competency

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

Episode of Care

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

Decision Support

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

Impact on Outcomes

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

Medication Management

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

Organ and Tissue Donation

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

Infection Prevention and Control

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

Diagnostic Services: Imaging

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

Diagnostic Services: Laboratory

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

Transfusion Services

- Transfusion Services

Standards Set: Ambulatory Care Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
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 ambulatory care programs at the Charlton Avenue and King St sites are comprehensive. Programs are interdisciplinary and cover many clinical areas.

Priority Process: Competency

Staff report that they have ongoing education and professional development opportunities and that there is positive team functioning.

Performance reviews are up to date.

Leadership support is identified as an enabler in many of the programs.

Priority Process: Episode of Care

There are numerous diverse ambulatory care clinics, all of which function on an interdisciplinary team model. Dovetale electronic health record has been implemented in some clinics, while other have a hybrid charting system, and still others are waiting for Dovetale electronic health record. The organization is encouraged to move to full implementation of Dovetale electronic health record and reduce the risk of duplicate or hybrid charting. MyDovetale (Patient Accessed Electronic Health Record) will be implemented in some of the ambulatory care programs and the organization is encouraged to continue to provide access to patients.

Many programs have staff ambassadors who support key organizational initiatives. All staff are passionate about and committed to their work and speak highly of the organization.

The hemodialysis clinics at Charlton Avenue and King St. provide hemodialysis, peritoneal dialysis, and home dialysis training. Both clinics function similarly and use registered nurses and kidney technicians. Ontario Renal Network data are used to help plan capacity and predict growth.

Partnerships are key to the success of the programs. Satellite clinics are supported by SJHH staff. Clinic staff support dialysis in the home through a specific education program. A Modality Education Nurse is involved with patients before dialysis begins. The program is aiming to increase home dialysis from 23 percent to 28 percent. Patients feel well supported through the process.

The Patient and Family Advisory Council has just begun and the plan is to include patients at the quality meetings. There is no timeline and the organization is encouraged to develop a plan that includes timelines. The clinics cite numerous quality improvement projects that are in place. It will be a challenge to meet the increasing demands of patients transferring from dialysis to conservative care as they come off dialysis.

The Firestone Ambulatory Clinic is the regional referral centre for chest medicine and thoracic surgery. Patients spoke of the meticulous approach to care with shared information and coordinated appointments. One of the keys to the clinic is Integrated Comprehensive Care (ICC) for COPD patients. Care is wrapped around the patient. Some of the notable successes is the reduction in inappropriate emergency visits and readmissions and self-management component. Staff work within a full scope of practice in a model of collaboration. Technology enables their work. The ICC model is spreading to all booked surgical patients. The team is encouraged to continue to look at what could be better for the patients by including patients and families in the future decision-making.

Staff work to their full scope of practice in a collaborative model, and technology enables their work. This model is now being spread for use with all surgical patients. The team is encouraged to continue to look at what could be made better for the patients by including patients and families in future decision-making.

The adult pain management program follows an interdisciplinary, psychosocial model of care. Patient satisfaction surveys have helped reshape the program content. The program primarily sees patients with

back pain, neck pain, and post-surgical pain. Palliative care patients are now referred to the program. The team continues to look at other population groups that could benefit from these services. The space where team consultation takes place is very small.

The diabetes clinic and the bariatric clinic welcome and encourage input from patients and families to help them continue to improve services by ensuring they meet patients' needs. The bariatric clinic has identified some improvement opportunities through its most recent patient satisfaction survey and work on these will begin in the next several weeks. The team is encouraged to consider engaging patient and family advisors in this improvement work in a more formal way.

The organization will need to address human resources planning as a number of retirements are expected in the next few years.

Priority Process: Decision Support

Evidence-based guidelines are used. Dovetale electronic health record has provided a new format for documentation. Not all areas of ambulatory care are on the system and the organization is encouraged to complete the implementation of Dovetale electronic health record to avoid hybrid and duplicate documentation.

Priority Process: Impact on Outcomes

Teams track performance indicators and have good sense of where they need to focus attention. Evidence-based guidelines are used.

Safety incidents are followed up and feedback is provided to staff.

Standards Set: Biomedical Laboratory Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Episode of Care

Universal falls precautions are in place.

Priority Process: Diagnostic Services: Laboratory

Laboratory services completed an ISO 15189 surveillance with the Institute for Quality Management in Healthcare in April 2018. The peer review is scheduled for April 2020. The model is an integrated laboratory service with Hamilton Health Sciences (the Hamilton regional laboratory medicine program) that operates under a single management structure. There is a strong link with McMaster University.

Strategically, services have been consolidated to improve efficiency and avoid duplication. The upcoming strategic plan will consider further efficiencies such as the consolidation of pathology and the repurposing of the King Street lab to a point-of-care site. Leadership works closely with their partners to ensure that consolidations and expansions meet the needs of the population.

Volumes are reviewed monthly. Choosing Wisely has had an impact and growth has occurred in molecular, virology, and genetics specialties. There is digital technology, such as Cellavision instruments, at all sites. This technology has helped to address skill mix, expertise, and safety. Standard operating procedures are updated regularly and staff ensure that the information is communicated.

Succession planning is a challenge as many long-term staff will be retiring in the coming years. The organization has increased automation and medical laboratory assistant positions, but there will still be a need for medical laboratory technologists. The organization partners with five training programs for medical laboratory assistant and medical laboratory technician students.

The team has numerous quality improvement projects underway. The Theta Care approach has shown improvements using huddles and regular status updates. A pilot project in the ED to reduce the time to report flu results has enabled care disposition decisions to be made faster. Turnaround time for patients in the pilots was reduced from five to two hours.

Standards Set: Critical Care Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The program is interdisciplinary. The team works well together to address the needs of the patients.

Each room as the required equipment to ensure that patient needs can be met.

Priority Process: Competency

Staff receive ongoing education and professional development and there are opportunities provided to them.

Staff indicate that they are supported by the leadership team.

Performance reviews are up to date.

Priority Process: Episode of Care

The critical care program consists of a 22-bed closed level 3 intensive care unit, a critical care response team, and a 12-bed medical step-down unit. There is a dedicated physician leader and manager. Care is provided by an interdisciplinary team.

The team works closely with Critical Care Services Ontario and accepts patients from the LHIN and other designated communities. Primary diagnosis' of patients include respiratory, renal, and drug overdoses. A surge capacity plan has been developed to address capacity. Beds were added and the unit has now reached its physical capacity.

The unit has three strategic plan ambassadors who help the front-line staff understand their role in operationalizing the strategic plan for critical care.

Dovetale electronic health record has been implemented on the unit. Documentation can be done in real time. Staff speak positively about the system.

Families are encouraged to participate, if they wish, in all aspects of care. If they wish, they are supported to remain while the patient is undergoing a challenging procedure such as a code.

Whiteboards are used in each room.

The Footprints program has a form that can be filled out to help staff understand who the patient is. The Three Wishes program is used for terminally ill patients. There is a proactive relationship with Trillium Gift of Life Network and clear processes are in place.

Antimicrobial stewardship rounds take place twice weekly. A daily safety briefing highlights issues and concerns for staff. The intensive care unit will be a pilot site for the provincial rollout of the electronic family satisfaction survey.

The medical step-down unit has not incorporated whiteboards in patient rooms and it is encouraged to do so.

Dovetale electronic health record has been implemented and staff speak positively about it. They find it is easy to identify key assessments and subsequent documentation for patients.

Priority Process: Decision Support

The implementation of Dovetale electronic health record is complete and staff identify the benefits of it. There are many checkpoints where two patient-specific identifiers are used.

Priority Process: Impact on Outcomes

Numerous indicators are tracked as per provincial mandatory requirements.

Staff are aware of potential risks and discussion takes place at daily safety briefings.

Priority Process: Organ and Tissue Donation

The team follows Trillium Gift of Life Network protocols and processes.

Standards Set: Diagnostic Imaging Services - Direct Service Provision

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

The organization has met all criteria for this priority process.

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

The diagnostic imaging department offers a wide range of comprehensive services. The department in the main Charlton Campus is fairly new and was developed with input from patients and families. It is spacious and comfortable, and respects patient privacy. There are separate entrances for outpatients and inpatients and these two populations never cross paths which increases privacy for inpatients.

Staff have access to refresher training through GE Tips that offers a wide variety of courses that range from technical refreshers to leadership development courses. Staff working in critical areas, where sedation is required for example, have the required resuscitation courses. Many improvements have been implemented with patient and family input. Staff of the department and of the hospital have very good support from the radiologists and their residents.

The ED has its own on-site general radiography that is supported by two residents. The implementation of Dovetale electronic health record has greatly improved turnaround time for results, as staff get notification through the electronic health record of completion of tests. Physicians in the ED can also communicate with the on-call radiologists by putting provisional diagnoses on “sticky notes” in the electronic health record.

Departmental staff are well versed in patient safety issues and are aware of and participate in quality improvement plans and initiatives.

Service utilization reviews are done and radiologists protocol requests and provide feedback to requesting clinicians.

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	
9.15 Clients and families are provided with information about how to file a complaint or report violations of their rights.	!
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 leadership team is highly engaged and collaborative and includes a patient and family advisor. The team knows the population well and works collaboratively to make improvements.

The ED serves a high volume of patients yearly and has worked on many initiatives to improve ED flow. In particular, a physician has been added in the waiting room who does an assessment following triage and can order diagnostic tests or handle the problem and discharge the patient. This has improved flow and reduced the dissatisfaction of patients who need to be seen by the on-call physician in the ED.

Priority Process: Competency

There is a high level of collaboration and respect among all team members. Staff run simulations on a weekly basis as learning opportunities and often involve other services in the hospital. Emergency medical services is also invited to participate in the simulations.

Staff express satisfaction with the training for Dovetale electronic health record. They receive ongoing refresher training on patient safety topics and specifically on infusion pumps. All staff have been trained in workplace violence prevention.

Priority Process: Episode of Care

SJHH uses the electronic Canadian Triage and Acuity Scale (eCTAS), an electronic triage decision support tool that standardizes the application of the CTAS national triage guidelines. The initial assessment done by a physician at the beginning of the process in the waiting room allows for rapid triage, ordering of diagnostic tests, and discharge of some patients, and has improved satisfaction among patients. Also, the implementation of the admission avoidance team, consisting of an occupational therapist, a physiotherapist, and a registered nurse in the ED, identifies patients who can safely return home with support and avoids admission to hospital.

Dovetale electronic health record's discharge summary function (After Visit Summary) provides clear instructions to the patient on discharge and also provides the attending physician with fast and accurate information on their ED visit.

Priority Process: Decision Support

Dovetale electronic health record has greatly improved documentation and access to information, specifically with respect to transfer, and the discharge summary and medication reconciliation features have improved work flow.

Standard order sets are easily accessible through dropdown menus.

Priority Process: Impact on Outcomes

The team has a quality improvement plan that incorporates metrics that must be reported provincially. It is able to benchmark against similar organizations. The metrics are closely monitored and reviewed. The team also uses information from incident reports to make improvements.

Evidence-based protocols are used in the ED.

Priority Process: Organ and Tissue Donation

The team follows Trillium Gift of Life Network protocols and processes.

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

Unmet Criteria	High Priority Criteria
Priority Process: Infection Prevention and Control	
8.4 Team members, and volunteers have access to dedicated hand-washing sinks.	
Surveyor comments on the priority process(es)	
Priority Process: Infection Prevention and Control	

The IPAC team is high functioning and well integrated into clinical and non-clinical services at all three SJHH sites. A wide range of staff and physicians referenced a past outbreak of C. difficile that resulted in a renewed focus on IPAC practices; this is an example of SJHH's strong safety culture and commitment to learning. This strength is apparent in an exceptional hand-hygiene program based on effective audit and feedback processes combined with departmental accountability and a keen engagement to drive continuous improvement. Corporate safety metrics feature hand hygiene, well-targeted infection/colonization rates, and measures of effective environmental cleaning. These metrics are visible on clinical units and appear to be sources of celebration and inspiration for improvement.

The IPAC team's support from and access to senior management is further evidence of the organization's commitment to infection prevention and control.

The IPAC team includes strong integration and collaboration with infectious diseases and microbiology/laboratory services along with other departments like patient support services. Collectively, risks and prevention strategies are analyzed and continuously adjusted based on data from an effective surveillance program in combination with the application of evidence-informed guidelines and practices.

The team recently collaborated with internal and external stakeholders to evaluate the appropriate duration of additional precautions, resulting in reduced isolation requirements. As a result, patient experience and patient flow have been improved without compromising patient or staff safety. The team has engaged in research to better understand effective teaching methods for patients with C. difficile infections and initiated a quality improvement project to learn about and improve patients' understanding of the reasons for their isolation in hospital. These are both important areas of focus to expand knowledge in the IPAC community, and the team intends to publish and present its findings. There is strong evidence of a commitment to professional development that is necessary to developing and sustaining specialized IPAC knowledge.

Standards Set: Inpatient Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
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 inpatient general internal medicine program is a large program encompassing several specialty services. Careful thought into resource allocation and care delivery models is evident. The introduction of the geographical care model, replacing the former team-based model, is an example of designing care delivery to improve the consistency of care, communication with patients and families, and safety through stronger teamwork and fewer handovers. Implemented in July 2018, it is showing positive results toward all improvement aims.

The alternate level of care unit demonstrates an awareness of specialized care required for patients who perhaps would be better served outside of the hospital environment but who cannot be discharged for a variety of reasons. Team members are extraordinarily committed to providing excellent, personalized, and compassionate care for patients with complex health conditions and social circumstances. They have created a unique environment that suits the needs of this population.

The fifth floor flex unit that can accommodate surges in patient census, to optimize flow and ensure care is provided in the right place by the right staff, is an excellent example of clinical leadership.

There is a high degree of effective collaboration among the general internal medicine program team, and also with other departments in SJHH and with external agencies.

Priority Process: Competency

There is a strong commitment to continuing education across the general internal medicine team.

Learning needs are largely met through a variety of mechanisms including full-day, in-person learning sessions, weekly and ad hoc targeted 30- to 60-minute sessions, and daily safety huddle discussions. There is a sense among staff that their professional development needs are being addressed. A variety of iLearn programs and other resources and references are readily available to staff. Mandatory training programs on, for example, patient safety and infusion pump safety, are provided, evaluated, and tracked.

Two patient and family advisors are members of the Quality Council and help enhance competencies in people-centred care. The strategic ambassador role provides additional capacity to deliver education and also enhances communication, education, and leadership skills of the participants.

Priority Process: Episode of Care

The general internal medicine program is a large program that provides care to a diverse and complex patient population that includes several clinical subspecialties. The team consistently engages patients and families in developing care plans that are grounded in appropriate clinical care pathways while incorporating individual needs.

With many aging patients, team members focus on paying attention to geriatric needs and the development of associated skills. It is a high-functioning team that effectively collaborates with other teams such as the ED to optimize patient flow and appropriate patient placement. It collaborates with external services to facilitate discharge planning and to connect patients with specialized services such as those provided by another hospital in the integrated stroke care program.

Safety priorities such as medication reconciliation, pressure injury, falls, and venous thromboembolism prevention are a consistent focus, with well-established and reliable assessment, documentation, and prevention strategies in place.

A number of mechanisms are in place to support strong communication with patients and families, including communication boards in all patient rooms, standardized discharge and other information material, and information from Dovetale electronic health record. Staff show genuine commitment and skill in listening to patients and trying to accommodate requests. Two patient and family advisors are members of the Quality Council and they are respected and valued team members.

Exceptional attention to the needs of this complex and diverse patient population along with innovative care designs have resulted in noteworthy initiatives. The geographical care model contributes to stronger teamwork, more consistent patient care, and fewer opportunities for error by reducing the frequency of handovers. It has also likely contributed to improving patient flow.

The alternate level of care and flex units are creative and effective solutions to providing appropriate,

compassionate care to patients who might be seen by other organizations as “bed blockers.” The flex beds make additional surge capacity available on short notice.

The palliative care room on one of the teaching units, made possible through philanthropy, was highly valued by the patient and family occupying it during the on-site survey. Staff recognize it as an important but scarce resource.

The limitations imposed by an aging facility are known by staff and they have created effective workarounds, such as enhancing access to hand sanitizer in areas where dedicated hand-hygiene sinks are not available. Despite the age of some units, they appear well maintained and clean. Facility improvements that are possible are well targeted, such as the recent renovation of a medication room to improve its functionality and enhance safe practices.

Priority Process: Decision Support

A number of staff report that access to consistent patient information has improved following the implementation of Dovetale electronic health record. In particular, they see improvements in medication reconciliation, quality of handover information, standardized processes for admission, and ongoing assessment of safety risks such as falls, venous thromboembolism, and behavioural triggers.

It is suggested that the MyDovetale (Patient Accessed Electronic Health Record) functionality be expanded to patient groups who request it and to targeted populations where clear benefits are known.

Priority Process: Impact on Outcomes

Close attention is paid to improvement priorities in part through the reporting, analysis, and team engagement processes in quality and safety metrics. All staff readily know of and are engaged in improvement initiatives. It is striking how many individuals are focused on corporate- and unit-level priorities and are proud of and empowered to make individual suggestions and improvements.

Data from Dovetale electronic health record reports are being used to improve medication reconciliation and barcode medication administration, to name just two. There is an enormous opportunity for SJHH and the general internal medicine program to measure and improve outcomes by optimizing this data source.

Standards Set: Medication Management Standards - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Medication Management		
13.3	Chemotherapy medications are stored in a separate negative pressure room with adequate ventilation, and are segregated from other supplies.	!
16.3	There is a separate negative pressure area with a 100 percent externally vented biohazard hood for preparing chemotherapy medications.	!
22.1	There are criteria for determining which medications can be self-administered by clients.	
22.2	Established criteria are used to assess whether a client is able to self-administer medications.	
Surveyor comments on the priority process(es)		
Priority Process: Medication Management		

The team has much of which to be proud. Two high-functioning interdisciplinary committees, the Medication Management Quality Council and the Pharmacy and Therapeutics Committee, review all policies, procedures, quality reports, and formulary changes before these are submitted to the Medical Advisory Committee.

Since the last on-site survey the team has implemented closed loop medication management, accomplishing this in far less time than in other hospitals provincially and nationally. The implementation of Dovetale electronic health record has streamlined order verification, dispensing workflows, barcoding, medication reconciliation processes, and inventory controls.

This team has implemented other innovative patient safety improvements such as the hospital-wide insulin pen project, and proactive best possible medication history documentation by pharmacy technicians in the ED.

Two areas for improvement are noted.

The first the physical environment at the Charlton Campus in the rooms where chemotherapy medications and biohazards are stored. While the ventilation is adequate there is insufficient negative pressure to meet provincial standards. The team is aware of this and the capital submission process is currently in progress with the Ministry of Health and LongTerm Care.

The second relates to self-administration of medications for designated patient populations. Draft policies

and processes have been developed for self-administration of medication for patients in rehabilitation services, mental health and addictions services, and geriatric services. An earlier version of the program was paused as the current version of Dovetale electronic health record is unable to support it. It is anticipated that updates to Dovetale electronic health record will support this implementation. This will be an important component of patient care in those clinical areas.

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 services and programs are recovery oriented. Patients and families report that they are active participants and are supported throughout the process to exercise control over their care. Patients and families are involved in service design, space decisions, and program evaluation. Each program has important connections to the community and these partnerships support the quality and continuity of care.

Teams report that management supports their day-to-day work and note that relationships have improved.

SJHH works tirelessly to reduce the stigma of mental illness. Staff, patients, and families are proud of this work and grateful to the leadership for its support and commitment.

Priority Process: Competency

Teams work collaboratively with patients and families and care planning decisions are shared. Dovetale electronic health record provides timely access to details of patient care and processes such as situation-background-assessment-recommendation (SBAR) are used to promote patient safety¢

[ŜI·ŘŜ№ăKλLJ ădzLJLJ2№ůă LJ№2ŦŜăăλ2yl·f ŘŜØŜf2LJYŜyű I·yŘ ŜŘdzÕI·ůλ2y I·yŘ ű№I·λyλyΞ 2LJLJ2№ůdzyλůλŜă I·№Ŝ LJ№2ØλŘŜŘ 2y I·y 2yΞ2λyΞ ōI·ăλă¢ ¢№I·λyλyΞ λyÕfdzŘŜă λŘŜyűλŦèλyΞΣ №ŜŘdzÕλyΞΣ I·yŘ Y I·yl·ΞλyΞ №λă⌊ă ů2 LJI·ůλŜyű I·yŘ ůŜI·Y ăI·ŦŜűè I·yŘ λă ălJŜÕλŦλÕ ů2 ůKŜ ăŜ№ØλÕŜ I·yŘ LJ№2Ξ№I·Y¢ ¢ŜI·Y YŜYōŜ№ă №ŜLJ2№ű ůKI·ů LJŜ№Ŧ2№YI·yÕŜ №ŜØλŜøă I·№Ŝ Õ2yŘdzÕůŜŘ I·yÿ℅I·ftèΣ I·yŘ Ξ2I·tă I·№Ŝ ăŜű I·ÕÕ2№ŘλyΞ ú2 λyŘλØλŘdzI·f Ξ№2øůK I·yŘ ŘŜØŜf2LJYŜyű LJfI·yã¢

Wellness initiatives are supported, and individuals and teams are recognized for their contributions. Although the mental health teams report no issues with recruitment and retention, it is suggested that planning for human resources requirements and retention strategies be included in operational planning.

Priority Process: Episode of Care

5dzNλyЭ ΰKŜ 2yãλΰŜ ădzNØŜè ΰKŜ ₮2ff2ØλyЭ YŜyΰl·f KŜl·fΰK LJN2ƎNJl·Yă l·yŘ ăŜNØλÒŜă ØŜNŜ NŜØλŜØŜŘT ! ÕdzΰŜ tăèŎKλl·ΰNèΣ C2NŜyãλÒă tăèŎKλl·ΰNè tN2ƎNJl·Y λyLJl·ΰλŜyΰ dzyΛΰΣ /2yŷŜÕΰ óÒŜyΰNJ·fλÎŜŘ λyΰl·ʅŜ ₮2N l·YōdzfI·ΰ2Nè YŜyΰl·f KŜl·fΰK ăŜNØλÒŜăú ΰKŜ ¸2dzΰK ² ŝftyŜăă /ŜyΰNŜΣ l·yŘ {ŎKλÎ2LJKNŜyΛl· λyLJl·ΰλŜyΰ LJN2ƎNJl·Y l·yŘ 2dzΰLJl·ΰλŜyΰ Ôfλyλ Ò¢ KŜ tăèŎKλl·ΰNλÒ 9YŜNƎŜyÕè {ŜNØλÒŜă ót9{ú ΰŜl·Y ølă l·fă2 ōNλŜ₮fè ØλăλΰŜŘ ₮2N l·ydzLJŘl·ΰŜ¢

! ff LJN2ƎNJl·Yă l·yŘ ăŜNØλÒŜă l·NŜ 2₮₮ŜNŜŘ λyăl·₮ŜΣ Ò2Y₮2Nΰl·ōfŜ ŜyØλN2yYŜyΰă ΰKl·ΰ LJN2Y2ΰŜ ÔfλŜyΰ ăl·₮Ŝΰè l·yŘ NŜÒ2ØŜNè{ {2YŜ LJN2ƎNJl·Yă Kl·ØŜ LJfl·yã ΰ2 Y2ŘλfλŜŘ 2N ŜÈLJl·yŘ ΰKŜλN ălJl·ÔŜT LyLJl·ΰλŜyΰ C2NŜyãλÒă øλff ŜÈLJl·yŘ ōè π Ò2NNŜÕΰλ2yōŜŘă λyнлмф l·yŘ Kl·ă ŘλăÒdzăăŜŘ ₮dzΰdzNŜ LJfl·yã ₮2N l· ŘI·è K2ălJΛΰl·fΣ t9{ λă LJfl·yŷλyЭ ₮2N l· NŜ₮NŜăK l·yŘ ŜÈLJl·yãλ2y l·yŘ !ÕdzΰŜ tăèŎKλl·ΰNè λă Ò2yãλŘŜNλyЭ ălJl·ÔŜ LJfl·yŷλyЭ ΰ2 ădzLJLJ2Nΰ LJl·ΰλŜyΰΩă LJNλØl·Ôè¢

¢KŜ YdzfΰλŘλăÕλLJfλyl·Nè ΰŜl·Yă LJN2ØλŘλyЭ YŜyΰl·f KŜl·fΰK ăŜNØλÒŜă l·NŜ Ò2YYλΰΰ ŜŘΣ IjdzI·fλ₮λŜŘ LJN2₮Ŝăăλ2yl·fă øK2 LJN2Y2ΰŜ LJl·ΰλŜyΰ l·yŘ ₮l·YλfèπÔŜyΰŜNŜŘ Ôl·NŜ l·ΰ l·ff fŜØŜfă l·ÔN2ăă ΰKŜ ăŜNØλÒŜă l·yŘ LJN2ƎNJl·Yă¢ {ΰl·₮₮ λă ΰNJ·λySŘ ΰ2 dzăŜ ăΰl·yŘl·NŘλÎŜŘ l·ăăŜăăYŜyΰă l·yŘ Ò2yãλăΰŜyΰ Y2ŘŜfă 2₮ Ôl·NŜ¢ ¢2 NŜλy₮2NÔŜ LJl·ΰλŜyΰ l·yŘ ₮l·YλfèπÔŜyΰŜNŜŘ Ôl·NŜΣ LJl·ΰλŜyΰă l·yŘ ₮l·YλfλŜă l·NŜ λyÕfdzŘŜŘ λyŘŜÕλăλ2yYl·ʅλyЭ NŜƎl·NŘλyЭ ΰKŜλN Ôl·NŜ l·yŘ l·NŜ Ò2yãdzfΰŜŘ 2y NŜfŜØl·yΰ 2LJŜNJl·ΰλ2yl·f ÕKl·yƎŜă¢ ¢KŜ C2NŜyãλÒ ΰŜl·YΩă tl·ΰλŜyΰ {l·₮Ŝΰècl·ăʅ C2NÔŜ fŜŘ õè ÕdzNNŜyΰ λyLJl·ΰλŜyΰă l·yŘ ΰKŜ aŜyΰl·f lŜl·fΰK ΰŜl·YΩă {dzλÕλŘŜ tNŜØŜyΰλ2yY ! a2ŘŜf2₮ {dzλÕλŘŜ wλăʅ !ÕN2ăă ΰKŜ /l·NŜ /2yΰλydzdzY ØŜNŜ ō2ΰK NŜÒ2ƎyλÎŜŘ l·ă l· [Ŝl·ŘλyЭ tNJl·ÕΰλÔŜă õè lŜl·fΰK {ΰl·yŘl·NŘă hNƎl·yλÎl·ΰλ2yπ l{h óнлмфπнлнмύ¢ ¢Kλă l·ÕKλŜØŜYŜyΰ Řλăΰλy3dzλăKŜă ΰKŜ ΰŜl·YΩă fŜl·ŘŜNăKλLJ l·yŘ ŘŜŘλÒl·ΰλ2yΰ2 ŜÈÒŜ₮fŜyÕŜ¢ CdzNΰKŜNYƵ2NŜΣ YŜYōŜNă 2₮ LJl·ΰλŜyΰ l·ŘØλă2Nè Ò2YYλΰΰ ŜŜă l·ÕΰλØŜfè LJl·NΰΰλÒλLJl·ΰŜ λy aŜyΰl·f lŜl·fΰK LJN2ƎNJl·Y ŘŜØŜf2LJYŜyΰ λyλΰλl·ΰλØŜă¢

! ÕdzfΰdzNŜ 2₮ IjdzI·fΰΰè l·yŘ ăl·₮Ŝΰèλă ŜYōŜŘŘŜŘ λyΰKŜ Řl·è ΰ2 Řl·è ŘŜfλØŜNè 2₮ ăŜNØλÒŜă l·yŘ ŘλNŜÕΰă ăK2Nΰ l·yŘ f2yЭ ΰŜNY Ǝ2l·fă¢ {ΰŜøl·Nΰ λă l· Y2ŘŜf 2₮ Ôl·NŜ λyΰN2ŘdzÕŜŘ λyΰKŜ aŜyΰl·f lŜl·fΰK l·yŘ !ŘŘλÒΰλ2yă LJN2ƎNJl·Yă ΰ2 λYLJN2ØŜ ăl·₮Ŝΰèλ¢ ¢KŜ Y2ŘŜf LJN2Y2ΰŜă LJ2ăλΰλØŜ λyΰŜNJl·Õΰλ2yă ōŜΰøŜŜyˇăΰl·₮₮ l·yŘ LJl·ΰλŜyΰă ΰ2 NŜŘdzÕŜ ΰŜyΰăλ2yΣ LJNŜØŜyΰ Øλ2fŜyÕŜ l·yŘ ŜyKl·yÕŜ ăl·₮Ŝΰèλ¢ Lΰ dzăŜŘ Ò2yãλăΰŜyΰfè l·yŘ Ŝ₮₮ŜÕΰλØŜfè õè l·ff ΰKŜ ΰŜl·Yă ΰ2 Yl·yl·ƎŜ ăl·₮ŜΰèNλăʅλ¢ vdzI·fΰΰè λyŘλÒl·ΰ2Nΰăl·yŘ LJŜNƵ2NYl·yÕŜ YŜΰNλÒă l·NŜ LJ2ăΰŜŘ 2yˇŜl·ÒK dzyλΰ l·yŘ ΰKŜ NŜădzfΰă l·NŜ dzăŜŘ ΰ2 Yl·ʅŜ λYLJN2ØŜyƎŜyΰă¢ ! ăΰl·yŘl·NŘλÎŜŘ ăl·₮ŜΰèLJfl·yΣ ΰKl·ΰ λă ōdzλfΰ λyΰ2 ΰKŜ 52ØŜΰl·fŜ ŜfŜÒΰN2yλÒ KŜl·fΰK NŜÒ2NŘ λă ŘŜØŜf2LJŜŘ øλΰK l·ff LJl·ΰλŜyΰă¢ LyˇI·ŘŘλΰλ2yΣ Yl·yè ăŜNØλÒŜă l·yŘ LJN2ƎNJl·Yă Kl·ØŜ l·ŘŘλΰλ2yl·f ăl·₮ŜΰèăΰNJ·ΰŜƎλŜă ΰKl·ΰ l·ŘŘNŜăă ăLJŜÒλ₮λÒ ăl·₮ŜΰèyŜŜŘă¢ wλăʅ l·ăăŜăăYŜyΰă l·NŜ l·fă2 Ò2yŘdzÒΰŜŘ N2dzΰλySfè¢

5ŜăLJλΰŜ ă2YŜ NŜÕŜyΰ l w ÕKl·ffŜyƎŜăΣ ΰKŜ ÕfλyλÒl·f ΰŜl·Y λyˇt9{ NŜLJ2Nΰ ΰKl·ΰ NŜÒŜyΰ ăΰNJ·ΰŜƎλŜă ōŜŜyˇŜ₮₮ŜÕΰλØŜ λyˇ λYLJN2ØλyЭ ăl·₮Ŝΰèλ¢ LyˇI·ŘŘλΰλ2yΣ ΰKŜ l·ŘŘλΰλ2yˇ2₮ l·ŘŘλÒΰλ2yˇÒ2dzyăŜfλyƎΣ LJŜŜNJ ădzLJLJ2Nΰ ø2N ʅŜNă l·yŘ l·ŘŘλΰλ2yl·f LJăèŎKλl·ΰNλÒ yΛdzNăλyƎΣ ΰKŜ ₮f2ø Yl·yl·ƎŜNΣ l·yŘ Ò2ffl·ō2NJl·ΰλØŜ ø2NʅλyЭ øλΰK ΰKŜ YŜŘλÒλyŜ¢

/2yŷŜÕΰ λă l· ÕŜyΰNJ·fλÎŜŘ λyΰl·ʅŜ Y2ŘŜf Kl·ă ōŜŜyˇλyΰN2ŘdzÕŜŘ ΰ2 l·YōdzfI·ΰ2Nè YŜyΰl·f KŜl·fΰK ăŜNØλÒŜă l·yŘ LJN2ƎNJl·Yă ΰKl·ΰ øŜNŜ fl·dzyŎKŜŘ λyˇCŜōNdzl·Nè нлмф¢ Kλă ăŜNØλÒŜ Kl·ă ŘŜY2yăΰNJ·ΰŜŘ ΰKl·ΰ λΰ Kl·ă NŜŘdzÕŜŘ ŘdzLJfλÒl·ΰλ2yl·yŘ ăΰNŜl·YfλyŜŘ LJN2ÕŜăăŜă hyƎ2λyЭ ŜØl·fdzl·ΰλ2yˇl·yŘ NŜØλŜø l·NŜ LJfl·yŷŜŘ ΰ2 Ŝyădzl·NŜ LJN2ÕŜăăŜă l·NŜ l·ŎÕdzNJ·ΰŜ l·yŘ ΰλYŜfè l·yŘ NλăʅăλNŜ Yl·yl·ƎŜŘ Ŝ₮₮ŜÕΰλØŜfè¢

¢KŜ ¸ 2dzűK ² ŜftfyŜăă LJN2ƎNI·Y ʎYLJfŜYŜyűŜŘ ʎy˝нлmp KI·ă ădzŐŐŜăăŦdzffê ŐNŜI·űŜŘ I· ăI·ŦŜ I·yŘ I·ŐŐŜăăʎōfŜ NŜă2dzNŐŜ Ŧ2N ŐfʎŜyűă мтπнp¢ CŜŜŘōI·Ǒ] ŦN2Y dzăŜNă ʎă ØŜNè LJ2ăʎűʎØŜ I·yŘ űKŜ űŜI·Y Ŧdzyŏűʎ2yʎyƎ ʎă LJ2ăʎűʎØŜ¢ D2I·fă Ŧ2N Ŧdzűdz˝NŜ LJfI·yŷʎyƎ ʎyŐfdzŘŜ ŘŜØŜf2LJʎyƎ Y˝2NŜ ŘŜűI·ʎfŜŘ ŘʎăŐKI·NƎŜ LJN2ŐŜăă ű2 ădzLJLJ2Nű LJ2ăʎűʎØŜ 2dzűŐ2Y˝Ŝă¢

¢KŜ {ŐKʎÎ2LJKNŜyʎI· ŐfʎyʎŐ I·yŘ ² I·űŜNŦI·ff ʎyLJI·űʎŜyű LJN2ƎNI·Y˝ I·NŜ f2ŐI·űŜŘ ʎy˝Őf2ăŜ LJN2ÈʎY˝ʎűè I·yŘ Ő2Y˝Y˝dzyʎŐI·űŜ ŜŦŦŜŐűʎØŜfè ø ʎűK ŜI·ŐK 2űKŜN¢ ¢ŜI·Y˝ă KI·ØŜ ōŜŜy˝ŜÈLJI·yŘŜŘ ű2 ʎyŐfdzŘŜ I·ŘŘʎŐűʎ2y˝Ő2dzyŽŜfʎyƎ I·yŘ bdzNăŜ tNI·ÖűʎűʎyŜN¢ ¢KŜ ŐfʎyʎŐ KI·ă ŘŜØŜf2LJŜŘ I· ŘŜűI·ʎfŜŘ űNI·yŽʎűʎ2y˝LJN2ŐŜăă I·yŘ I·ff LJI·űʎŜyűă ʎy˝űKŜ ʎyLJI·űʎŜyű LJN2ƎNI·Y˝ KI·ØŜ Ŧ2ff2øŜŘ dzLJ 2NƎI·yʎÎŜŘ I·ű ŘʎăŐKI·NƎŜ¢

9ăűI·ōfʎăKŜŘ Ő2Y˝Y˝dzyʎűè LJI·NűyŜNăKʎLJă ădzLJLJ2Nű ûKŜ ŘŜØŜf2LJY˝Syű I·yŘ ûKŜ ăI·ŦŜ ŘŜfʎØŜNè 2Ŧ ăŜNØʎŐŜă I·yŘ ûKŜ Ő22NŘʎyI·ûʎ2y˝2Ŧ ŐI·NŜ I·yŘ ûNI·yãʎűʎ2y˝2Ŧ LJI·ûʎŜyű Ŧf2ø¢

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Priority Process: Decision Support

Dovetale electronic health record was implemented early in 2019 following detailed planning and extensive staff training. Staff report high levels of satisfaction with the system and with the improvements to communication and the flow of patient information. They have identified some areas for improvement to optimize Dovetale electronic health record's capabilities and these may be made after the upgrade scheduled for June 2019. Connect the Mental Health & Addiction Programs Central Access Program is working closely with IT as the team evaluates performance and moves forward with monitoring full implementation.

Teams also intend to continue to use technology to streamline processes and support clinical services. For example, in the Forensic Psychiatry Program, Virtual Reality is used as staff training tool and an iPAL, which is a human-like robot that moves on wheels, has been introduced improve the patient experience and enhance safety. iPAL is being oriented to the unit and to the patients by a former patient who is now an outpatient.

Priority Process: Impact on Outcomes

Clinical interventions and programs delivered by the mental health teams are developed according to evidenced-informed guidelines and are regularly reviewed and updated as needed. Processes and practices are standardized to reduce variation, enhance safety, improve team collaboration, and increase efficiency.

Feedback from patients and families is gathered formally and informally to help evaluate improvements. Daily huddles and regular team conferencing that include patient participation are standard practice.

A proactive approach to identifying and systematically managing risk is evident in all programs. Teams are oriented to a standardized patient safety incident reporting system. Daily reviews and summary reports are analyzed and shared with teams and safety improvement strategies are evaluated. This is supported by promoting a non-punitive work environment.

All the mental health teams track quality indicators and collect data to guide quality improvement activities. The results are shared with the teams and posted directly on the units.

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	
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

Leadership is highly engaged and collaborative.

The team underwent More OB certification years ago and continues to put learnings into practice. The team knows its population well and has designed services to meet the need.

There is a high volume of deliveries every year. Deliveries are performed by a team of obstetricians, family physicians, and midwives.

Priority Process: Competency

Staff undergo a comprehensive orientation and training program to work on the unit. The unit is certified in More OB and continues to incorporate a continuous leaning environment through ongoing training.

Monthly simulations are run for staff.

Staff are trained and recertified in neonatal resuscitation and are up to date on organizational patient safety training such as infusion pumps, incident reporting, and hand hygiene.

Priority Process: Episode of Care

Mothers are triaged in the birthing unit and a determination to discharge or admit is made. The unit has eleven birthing rooms with two on-site operating rooms in case of caesarean section. 2 B nursery that admits infants of at least 32 weeks gestation and infants who require more intensive care.

After delivery mothers and babies are admitted to the Mother Baby unit. The unit encourages skin-to-skin and babies co-habitate with the parents in the room. Nurses teach the parents and two registered nurses provide breastfeeding coaching.

They also run a program for women with substance use and their infants who are at risk of neonatal abstinence syndrome (NAS). It follows babies and mothers to ensure they have required support before discharge.

Priority Process: Decision Support

The implementation of Dovetale electronic health record has greatly improved documentation and access to information, specifically with respect to transfer between services, and the discharge summary and medication reconciliation features have improved work flow. Standard order sets are easily accessible through dropdown menus.

The prenatal chart is still paper as the community physicians’ and obstetricians' offices are not on the electronic health record and must be scanned into Dovetale electronic health record.

Priority Process: Impact on Outcomes

All protocols and processes are evidence based. The team has a quality improvement plan and collects data on indicators that it tracks regularly, reports on, and shares with staff, patients, and family.

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

The clinical leaders are highly engaged and knowledgeable in the field of organ donation. They are key partners and leaders in Ontario's Renal Network, in collaboration with Niagara Health. They have joint steering committees and advisory committees. The team meets the following standards; Organ and Tissue Donation Standards for Deceased Donors, Organ and Tissue Transplant Standards, Organ Donation Standards for Living Donors.

Program policies comply with standards and are continuously reviewed, with input from and in collaboration with patient advisory teams. The medical director is an active participant at the local and provincial levels and is committed to system partnerships.

There is a dedication to patient- and family-centred care and access to services. Barriers to patient access are continually reviewed and team members work to remove these and ensure that if the patient is not able to come to them, they go to the patient. They listen to what the patient needs and ensure that they

continue to grow the program as they incorporate the patient voice. An example is piloting the “one day of donor testing” to reduce the number of days donors have to take off from work to adhere to the testing requirements and reduce hospital visits.

Priority Process: Competency

Staff are recognized and state that collaboration is what defines them and that there is no hierarchy, just a big family that never stops learning.

One of the program staff just received the Human Touch award from Cancer Care Ontario through the Ontario Renal Network. This award recognizes exemplary and compassionate patient care by health care professionals, providers, and volunteers in the kidney and cancer care systems.

Priority Process: Episode of Care

All information is collected in Dovetale electronic health record.

Priority Process: Decision Support

The MyDovetale (Patient Accessed Electronic Health Record) system was implemented in 2017 in all areas of the organization. During this transition, it was noted that Dovetale electronic health record has a gap in data linkages between organ donors and organ recipients. There is a hybrid model in place to collect the data but it is suggested all information be integrated into the existing electronic record.

Priority Process: Impact on Outcomes

The kidney and urinary program at SJHH is the regional referral and renal transplantation centre in south central Ontario for patients with end-stage renal disease. The program is one of the largest regional programs in the province, supporting more than 2,000 patients and providing a spectrum of care from tertiary acute to chronic management of kidney disease. The program offers centralized services from an interdisciplinary team of experts to better support patients in two care environments, nephrology and transplant.

In partnership with McMaster University the teams are highly engaged in research and the home of Hamilton Centre for Kidney Research. The program is commended for continually pushing the boundaries of innovation by partnering with traditional and non-traditional programs, such as the School of Engineering design and technology to further its strong research platform, and leveraging the technician role to support operational needs and expertise. It livestreamed Canada’s first Facebook Live kidney transplant that had 36 million views.

Priority Process: Organ and Tissue Donation

It is suggested that an area be designated in the ED to store organs that are waiting to be transported to the operating room.

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

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The leadership team is very engaged and works collaboratively to develop services. Patient and family advisors sit on the Quality Council and their advice is incorporated into service design. The team knows the population well and offers a wide range of surgical services.

Priority Process: Competency

Staff have the required mix of skills and knowledge to deliver the services from admission, pre-op, day surgery, recovery, and the operating room block, and includes support and housekeeping staff. Training is customized for each role.

Roles and responsibilities are well defined and staff receive regular performance reviews. In addition to professional development, staff also receive training on patient safety topics such as incident reporting and workplace violence prevention.

Priority Process: Episode of Care

Twelve operating rooms are in use every day. Management of the schedule and execution of surgeries is like a well-executed choreography where all the key stakeholders play an important role. The level of collaboration and cooperation is remarkable. There is also a high level of collegiality and respect among all staff.

The briefing and the use of the surgical checklist is a model to behold. Transfer of accountability is exemplary and is enhanced by the electronic health record.

The operating room suites are well equipped and well maintained.

Discharge protocols are well defined and some patients benefit from the integrated comprehensive care program that ensures follow-up and support after discharge, for example for joint surgery (hips and knees) patients.

Simulation codes are practiced monthly.

Priority Process: Decision Support

Implementation of the electronic health record has improved the accuracy of charting and transfer of information between points of services. Medication information is more reliable as is compliance with protocols related to Required Organizational Practices, as these are incorporated into the record.

Priority Process: Impact on Outcomes

Protocols and processes are evidence based.

The team's quality improvement plan is well known by staff. The team measures indicators and reports and shares the results with staff, patients, and families.

Priority Process: Medication Management

All medications are safely stored, administered, and accounted for.

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

Oversight for point-of-care testing is the responsibility of the laboratory quality manager. Point-of-care devices are monitored by the laboratory to ensure education and quality control are in place.

Staff use barcodes to access any point-of-care device, and they are locked out if training is not up to date.

The laboratory at King Street will be repurposed to a point-of-care only site as of June 2019 and staff will be relocated to the Charlton Avenue site. This was based on equipment use reviews which were only 4 percent.

Standards Set: Rehabilitation 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 leadership team has established an integrated interprofessional team to address the complex needs of the patient populations. The clinical leadership provided by the nurse practitioner in rehabilitation and the general practitioner in complex care, supported by the medical specialists, allows for timely resolution of problems.

Patients are fully engaged in their care and describe feeling supported to achieve their goals. Staff likewise report feeling supported to learn and grow in their respective roles. All staff, physicians, leaders, and patients proudly talk about the strong team culture.

The involvement of various team members in the Rehab Alliance has led to program and service improvements such as the new bed definitions.

Priority Process: Competency

Patients in the two programs are served by a well-functioning interprofessional team. Education is available and provided in ways that support the staff in their day-to-day work.

The team would be further strengthened and better able to meet patient needs if the allied health staff

were available seven days per week and if coverage were provided for absences, especially those of a longer duration such as vacations. Medical coverage is also reduced on weekends. The admission of hip patients on the weekends, as well as the increased complexity of the patients, may provide opportunities to review staffing models for the programs.

Priority Process: Episode of Care

The programs and services are offered in safe, comfortable environments that promote patient safety and recovery.

The interdisciplinary teams are committed, qualified professionals who promote patient- and family-centred care at all levels across the services and programs. Standardized assessments are used and there is frequent communication among team members to ensure consistent approaches with individual patients.

A culture of quality and safety is embedded in the day-to-day delivery of services and is reflected in the goals. Quality indicators and performance metrics are posted on each unit and the results are used to make improvements. A standardized safety plan that is built into Dovetale electronic health record is developed with all patients.

Patients and families are included in decision making about their care and are consulted on relevant operational changes. They report that they are able to raise issues and feel confident that the issues will be addressed. They find the Dovetale electronic health record discharge tools to be very valuable.

Priority Process: Decision Support

Staff report high levels of satisfaction with Dovetale electronic health record and with the improvements to communication and the flow of patient information. They have been able to develop customized forms to further enhance its functionality.

The leadership and staff take advantage of the data that are now available to initiate and support quality improvement activities.

Priority Process: Impact on Outcomes

The clinical interventions and programs delivered by the complex care and medical rehabilitation teams are developed according to evidence-informed guidelines and are regularly reviewed and updated as needed. Processes and practices are standardized to reduce variation and enhance safety, improve team collaboration, and increase efficiency.

Formal and informal feedback from patients and families is gathered to help evaluate improvements. There are regular team huddles and care planning conferences. Teams track quality indicators and collect data to guide quality improvement activities. Results are shared with the teams and posted on the units.

Standards Set: Transfusion Services - Direct Service Provision

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

Surveyor comments on the priority process(es)
Priority Process: Episode of Care
Universal falls precautions are in place.
Priority Process: Transfusion Services
The team reviews transfusion data annually at the local and provincial levels. Service delivery, proper use, wastes, trends, and population needs are viewed. The team works collectively with other units with regard to timely access to blood and blood products and volume needs. Roles are clearly defined and reviewed regularly. There is a dedicated focus on quality and regular reviews of standard operating procedures. Quality audits are performed and the results are used to determine ongoing education needs of front-line staff with regard to safe handling and administration of blood and blood products.

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.

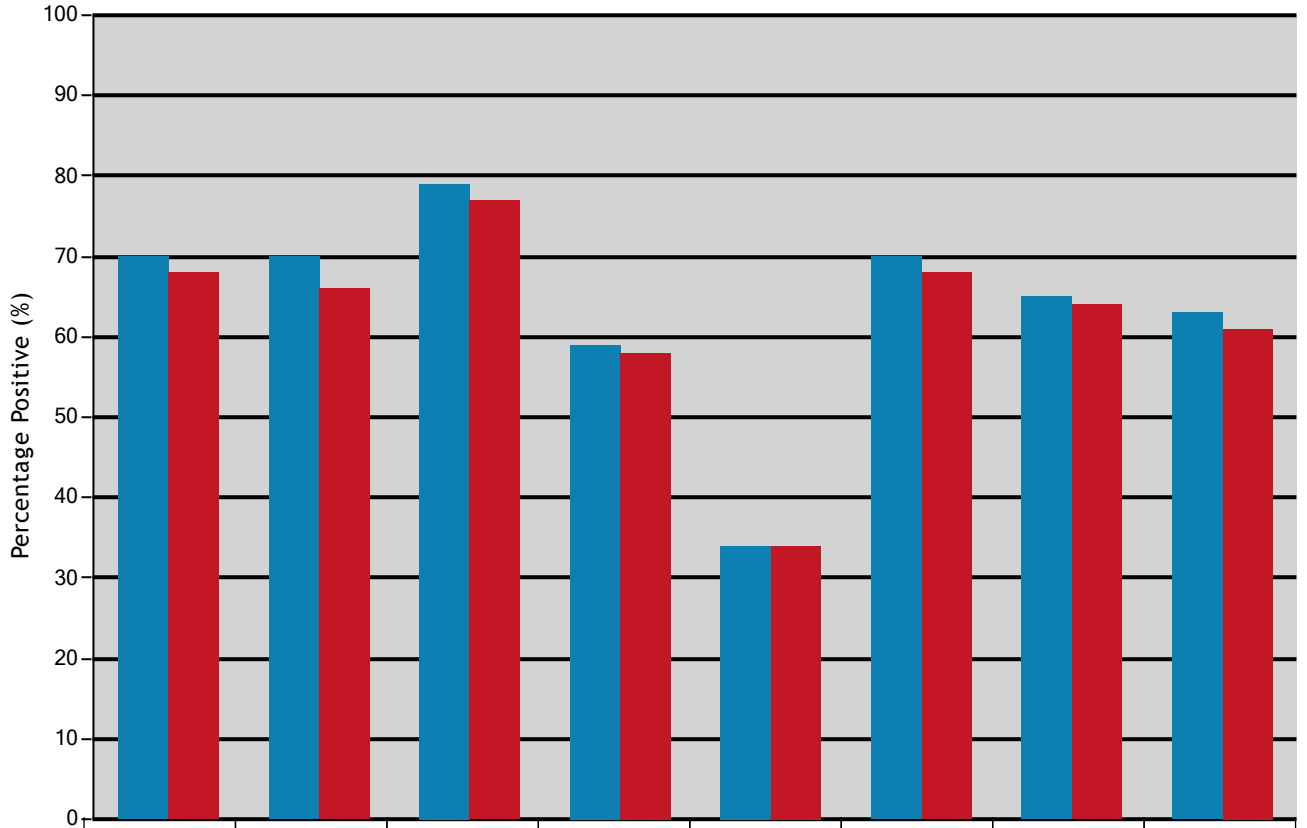
Canadian Patient Safety Culture Survey Tool

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

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

- **Data collection period: September 12, 2018 to October 10, 2018**
- **Minimum responses rate (based on the number of eligible employees): 338**
- **Number of responses: 2244**

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
	70%	70%	79%	59%	34%	70%	65%	63%
	68%	66%	77%	58%	34%	68%	64%	61%

Legend

St. Joseph's Healthcare Hamilton

* Canadian Average

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

Worklife Pulse

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

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

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.

Client Experience Tool

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

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

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

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

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

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

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

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

Appendix A - Qmentum

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

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

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

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

Action Planning

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

Appendix B - Priority Processes

Priority processes associated with system-wide standards

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