ACCREDITATION CANADA

Driving Quality Health Services

Accreditation Report

St. Joseph's Healthcare Hamilton

Hamilton, ON

On-site survey dates: May 4, 2015 - May 8, 2015

Report issued: July 14, 2015

ACCREDITATION CANADA
AGRÉMENT CANADA

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

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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 2015. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

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

Confidentiality

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

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

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

A Message from Accreditation Canada's President and CEO

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

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

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

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

We look forward to our continued partnership.

Sincerely,

Wendy Nicklin
President and Chief Executive Officer

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Section 1 Executive Summary

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.

1.1 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.

1.2 About the On-site Survey

- **On-site survey dates: May 4, 2015 to May 8, 2015**

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

  Service Excellence Standards

  5 Reprocessing and Sterilization of Reusable Medical Devices
  6 Organ and Tissue Donation Standards for Deceased Donors
  7 Organ and Tissue Transplant Standards
  8 Critical Care
  9 Point-of-Care Testing
  10 Ambulatory Care Services
  11 Diagnostic Imaging Services
  12 Medicine Services
  13 Rehabilitation Services
  14 Organ Donation Standards for Living Donors
  15 Obstetrics Services
  16 Mental Health Services
  17 Transfusion Services
  18 Biomedical Laboratory Services
  19 Perioperative Services and Invasive Procedures Standards
  20 Long-Term Care Services

21 Emergency Department

- **Instruments**

  The organization administered:

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

1.3 Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
 Population Focus (Work with my community to anticipate and meet our needs)	75	0	0	75
 Accessibility (Give me timely and equitable services)	96	0	1	97
 Safety (Keep me safe)	714	7	21	742
 Worklife (Take care of those who take care of me)	157	3	1	161
 Client-centred Services (Partner with me and my family in our care)	308	1	2	311
 Continuity of Services (Coordinate my care across the continuum)	78	0	2	80
 Appropriateness (Do the right thing to achieve the best results)	1144	11	6	1161
 Efficiency (Make the best use of resources)	87	1	1	89
Total	**2659**	**23**	**34**	**2716**

1.4 Overview by Standards

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

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

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

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

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	42 (100.0%)	0 (0.0%)	0	32 (100.0%)	0 (0.0%)	0	74 (100.0%)	0 (0.0%)	0
Leadership	43 (93.5%)	3 (6.5%)	0	82 (96.5%)	3 (3.5%)	0	125 (95.4%)	6 (4.6%)	0
Infection Prevention and Control Standards	41 (100.0%)	0 (0.0%)	0	31 (100.0%)	0 (0.0%)	0	72 (100.0%)	0 (0.0%)	0
Medication Management Standards	68 (93.2%)	5 (6.8%)	5	61 (96.8%)	2 (3.2%)	1	129 (94.9%)	7 (5.1%)	6
Ambulatory Care Services	39 (100.0%)	0 (0.0%)	3	72 (100.0%)	0 (0.0%)	5	111 (100.0%)	0 (0.0%)	8
Biomedical Laboratory Services **	71 (100.0%)	0 (0.0%)	0	103 (100.0%)	0 (0.0%)	0	174 (100.0%)	0 (0.0%)	0
Critical Care	34 (100.0%)	0 (0.0%)	0	95 (100.0%)	0 (0.0%)	0	129 (100.0%)	0 (0.0%)	0
Diagnostic Imaging Services	65 (98.5%)	1 (1.5%)	1	66 (98.5%)	1 (1.5%)	1	131 (98.5%)	2 (1.5%)	2
Emergency Department	47 (100.0%)	0 (0.0%)	0	79 (98.8%)	1 (1.3%)	0	126 (99.2%)	1 (0.8%)	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
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Long-Term Care Services	38 (100.0%)	0 (0.0%)	2	93 (98.9%)	1 (1.1%)	0	131 (99.2%)	1 (0.8%)	2
Medicine Services	31 (100.0%)	0 (0.0%)	0	70 (98.6%)	1 (1.4%)	0	101 (99.0%)	1 (1.0%)	0
Mental Health Services	36 (100.0%)	0 (0.0%)	0	88 (100.0%)	0 (0.0%)	0	124 (100.0%)	0 (0.0%)	0
Obstetrics Services	61 (98.4%)	1 (1.6%)	2	77 (96.3%)	3 (3.8%)	0	138 (97.2%)	4 (2.8%)	2
Organ and Tissue Donation Standards for Deceased Donors	39 (100.0%)	0 (0.0%)	0	79 (100.0%)	0 (0.0%)	1	118 (100.0%)	0 (0.0%)	1
Organ and Tissue Transplant Standards	62 (100.0%)	0 (0.0%)	1	80 (100.0%)	0 (0.0%)	0	142 (100.0%)	0 (0.0%)	1
Organ Donation Standards for Living Donors	42 (100.0%)	0 (0.0%)	0	78 (100.0%)	0 (0.0%)	0	120 (100.0%)	0 (0.0%)	0
Perioperative Services and Invasive Procedures Standards	98 (100.0%)	0 (0.0%)	2	88 (100.0%)	0 (0.0%)	0	186 (100.0%)	0 (0.0%)	2
Point-of-Care Testing **	38 (100.0%)	0 (0.0%)	0	48 (100.0%)	0 (0.0%)	0	86 (100.0%)	0 (0.0%)	0
Rehabilitation Services	31 (100.0%)	0 (0.0%)	0	70 (100.0%)	0 (0.0%)	0	101 (100.0%)	0 (0.0%)	0
Reprocessing and Sterilization of Reusable Medical Devices	51 (100.0%)	0 (0.0%)	2	61 (100.0%)	0 (0.0%)	2	112 (100.0%)	0 (0.0%)	4
Transfusion Services **	70 (100.0%)	0 (0.0%)	5	66 (100.0%)	0 (0.0%)	1	136 (100.0%)	0 (0.0%)	6
Total	**1047 (99.1%)**	10 (0.9%)	23	1519 (99.2%)	12 (0.8%)	11	2566 (99.1%)	22 (0.9%)	34

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

1.5 Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client And Family Role In Safety (Obstetrics Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Perioperative Services and Invasive Procedures Standards)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Rehabilitation Services)	Met	2 of 2	0 of 0
Dangerous Abbreviations (Medication Management Standards)	Met	4 of 4	3 of 3
Information Transfer (Ambulatory Care Services)	Met	2 of 2	0 of 0
Information Transfer (Critical Care)	Met	2 of 2	0 of 0
Information Transfer (Emergency Department)	Met	2 of 2	0 of 0
Information Transfer (Long-Term Care Services)	Met	2 of 2	0 of 0
Information Transfer (Medicine Services)	Met	2 of 2	0 of 0
Information Transfer (Mental Health Services)	Met	2 of 2	0 of 0
Information Transfer (Obstetrics Services)	Met	2 of 2	0 of 0
Information Transfer (Perioperative Services and Invasive Procedures Standards)	Met	2 of 2	0 of 0
Information Transfer (Rehabilitation Services)	Met	2 of 2	0 of 0
Medication reconciliation as a strategic priority (Leadership)	Met	4 of 4	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Ambulatory Care Services)	Met	7 of 7	0 of 0
Medication reconciliation at care transitions (Critical Care)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Emergency Department)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Long-Term Care Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Medicine Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Mental Health Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Unmet	2 of 5	0 of 0
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures Standards)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Rehabilitation Services)	Met	5 of 5	0 of 0
Safe Surgery Checklist (Obstetrics Services)	Met	3 of 3	2 of 2
Safe Surgery Checklist (Organ and Tissue Transplant Standards)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Safe Surgery Checklist (Organ Donation Standards for Living Donors)	Met	3 of 3	2 of 2
Safe Surgery Checklist (Perioperative Services and Invasive Procedures Standards)	Met	3 of 3	2 of 2
Two Client Identifiers (Ambulatory Care Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Biomedical Laboratory Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Critical Care)	Met	1 of 1	0 of 0
Two Client Identifiers (Diagnostic Imaging Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Emergency Department)	Met	1 of 1	0 of 0
Two Client Identifiers (Long-Term Care Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Medicine Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Mental Health Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Obstetrics Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Perioperative Services and Invasive Procedures Standards)	Met	1 of 1	0 of 0
Two Client Identifiers (Point-of-Care Testing)	Met	1 of 1	0 of 0
Two Client Identifiers (Rehabilitation Services)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Two Client Identifiers (Transfusion Services)	Met	1 of 1	0 of 0
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management Standards)	Met	4 of 4	1 of 1
Concentrated Electrolytes (Medication Management Standards)	Met	3 of 3	0 of 0
Heparin Safety (Medication Management Standards)	Met	4 of 4	0 of 0
High-Alert Medications (Medication Management Standards)	Met	5 of 5	3 of 3
Infusion Pumps Training (Ambulatory Care Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Critical Care)	Met	1 of 1	0 of 0
Infusion Pumps Training (Emergency Department)	Met	1 of 1	0 of 0
Infusion Pumps Training (Long-Term Care Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Medicine Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Mental Health Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Obstetrics Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Perioperative Services and Invasive Procedures Standards)	Met	1 of 1	0 of 0
Infusion Pumps Training (Rehabilitation Services)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Narcotics Safety (Medication Management Standards)	Met	3 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Client Flow (Leadership)	Met	7 of 7	1 of 1
Client Safety Plan (Leadership)	Met	2 of 2	2 of 2
Client Safety: Education And Training (Leadership)	Met	1 of 1	0 of 0
Preventive Maintenance Program (Leadership)	Met	3 of 3	1 of 1
Workplace Violence Prevention (Leadership)	Met	5 of 5	3 of 3
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Compliance (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Hand-Hygiene Education and Training (Infection Prevention and Control Standards)	Met	1 of 1	0 of 0
Infection Rates (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Pneumococcal Vaccine (Long-Term Care Services)	Met	2 of 2	0 of 0
Patient Safety Goal Area: Falls Prevention			
Falls Prevention Strategy (Ambulatory Care Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Diagnostic Imaging Services)	Met	3 of 3	2 of 2

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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Venous Thromboembolism Prophylaxis (Critical Care)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Medicine Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Organ and Tissue Transplant Standards)	Met	2 of 2	2 of 2
Venous Thromboembolism Prophylaxis (Organ Donation Standards for Living Donors)	Met	2 of 2	2 of 2
Venous Thromboembolism Prophylaxis (Perioperative Services and Invasive Procedures Standards)	Met	3 of 3	2 of 2

1.6 Summary of Surveyor Team Observations

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

The organization, St. Joseph's Healthcare Hamilton is commended on preparing for and participating in the Qmentum survey program. The joint board of the organization is a high-performing, governance focused board. Clear direction is set for the organization and leadership is appropriately held accountable to deliver. The board understands the important distinction between governance and leadership and is much focused on ensuring the success of the organization within the broader health care reality. In reviewing areas of strength with the board, there is a strong commitment to ensuring a skills-based board that reflects the diverse make-up of the community. By way of its leadership in the strategic plan development process, the board reaffirmed the organization's commitment to quality and safety, transformation, diversity, engaging people and research and education. This focus supports a cultural transformation across the organization that reinforces ongoing efforts to engage patients and families in their care and to ensure a viable, strong future for the organization. The board has a strong oversight infrastructure, with all meetings focused on specific areas such as quality, access, safety or strategy.

Few communities are as aware of the health care needs of the populations served than Hamilton and by thoughtful reviews of the health status of the population the organization has been able to identify service priorities, as well as gaps. There is a strong awareness across all community partners of the importance of working together and, through dialogue with community partners, it is clear that partnerships and integration are a priority. Three areas are highlighted as necessary for ongoing discussion, specifically mental health services across the broader community spectrum, acute care service alignment across the Local Health Integration Network, and bundled payment initiatives aimed at ensuring the right patient receives the right care by the right provider at the right location. All community partners spoken with during the survey mentioned specifically St. Joseph's Healthcare Hamilton (SJHH's) commitment to being a strong partner. There is a clear willingness across all sectors to work collaboratively in the best interests of the people served.

One of the keys to the success of SJHH is its leadership. There is a strong connection between the organization's leadership and all key stakeholders, most notable the staff members across the organization. In developing plans, goals and objectives there is a strong commitment to ensuring input from across all levels of the organization and community. This commitment is reflected in strong alignment with SJHH and across the broader healthcare community. The challenge facing the leadership of the organization is ensuring that the capacity exists, particularly at the front-line management level, to implement the vision of the organization. There are currently numerous pressures facing the organization and it is considered key that the right tools and supports are implemented to enable success. One of these tools will be focusing the organization on key priority areas, and the appropriate resources.

The organization is committed to supporting a positive environment for its staff, and provides a number of tools via its workplace wellness program to support this fact. New facilities have come on line, and there is a commitment to ensuring that the tools necessary to provide quality care are available. The key in ensuring a positive work-life culture is to promote and support a "just" culture that values the individual contributions of all team members while holding all accountable for delivering on the goals and objectives of the organization. Staff members, physicians and volunteer surveys have highlighted this fact and the organization has focused significant energy on accomplishing this. The environment in which hospitals operate is challenging from a number of perspectives and this in turn impacts on work-life quality and staff. St. Joseph's Healthcare Hamilton's (SJHH) ongoing willingness to address these challenges are noted as key to maintaining current momentum in staff engagement.

All the care and service delivery Priority Processes reviewed during the survey were assessed to be meeting and exceeding expectations. By way of effective planning, the organizations' services are aligned with the broader needs of the community. The surveyor team is impressed with the front-line commitment to quality and innovation. The organization's revised strategic plan that focuses on quality, transformation and engagement has positioned SJHH well to continue to deliver quality, accessible services. A number of program innovations are in place and the organization can be proud of the creative approaches being implemented across all areas of the organization.

The organization is committed to engaging patients and families in decisions around both their specific care needs and the broader planning needs of the organization. Currently, 40 patients/family members are involved in committees across the organization. The organization is commended for this commitment and is urged to continue to expand patient/family involvement in organizational operations. Surveys are conducted across the organization and the organization is urged to ensure that the feedback provided continues to be shared as appropriate and continues to influence decision making.

Section 2 Detailed Required Organizational Practices Results

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

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

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

Section 3 Detailed On-site Survey Results

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

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

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

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

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

See Appendix B for a list of priority processes.

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

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

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

3.1 Priority Process Results for System-wide Standards

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

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

3.1.1 Priority Process: Governance

Meeting the demands for excellence in governance practice.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The surveyor team met with members of the joint board. The discussion focussed on board operation, strategic planning, quality oversight and fiscal oversight. The board of directors is commended for the passion and commitment brought to the table on behalf of the population serviced by St. Joseph's Healthcare Hamilton (SJHH). There is clear understanding and appreciation of the role of governance in setting the tone for the organization, along with a keen awareness of the demarcation between governance and management.

The functioning of the board is supported by bylaws, terms of reference and an array of comprehensive policies. These policies are current, with regular reviews by appropriate committees. The board has a good process in place to ensure strong, diverse representation. The skills assessment used during nominations ensures that the right mix of board members exists and the ability to appoint community members to board committees further strengthens the diversity of the board. The board is committed to ongoing evaluation, both individually and as a board, with feedback provided via these processes which serves to continually improve board functioning.

The surveyor team is impressed with the leadership exhibited by the board during the 2012 strategic planning process. It is clear that the plan's development was very much led by the board, with the final product being a reflection of the expectations the board had, both of leadership and of the organization as a whole. The revitalized focus on quality, engagement, transformation, research/education and diversity is serving to redefine the culture of the organization, and will put it in a strong position to advance and innovate in the health care reality in which it operates.

The oversight provided by the board is noted with approval. Clearly, discussions are dynamic and respectful and board expectations of the organization are clear. Reports received by the board provide the detailed information necessary to support its decision-making responsibilities. These reports also ensure that members have opportunities to probe issues to obtain a good understanding and awareness of the governance implications of decisions being made. While clearly focused on governance, it is evident that the board understood the importance of visibility across the organization and makes every effort to ensure strong connections with staff members at various events and the executive "walk-abouts."

Looking ahead, the responsibilities of governance in health care are going to have to evolve. A restrictive fiscal reality, enhanced emphasis on patient engagement, the relentless pursuit of quality, the need to integrate and innovate, the requirement for strong education and research, and the ongoing need to engage with communities around changing health care needs are all going to require resilience and strategic thinking. The commitment of the SJHH board to look outward and to create innovative partnerships such as with The Niagara Health System is going to be a continued requirement if systems are to advance. The position the board has placed itself in, specifically as a leader in integration and partnerships will be an important underpinning of SJHH's continued success. Balancing competing demands and continually refining and sharpening the focus of the organization will also be a governance requirement, greatly enabled by the relationships developed across the Hamilton region.

The board of directors can be proud of the position held by SJHH within the local and provincial health care system. Continued leadership will be required however, to ensure that the advances currently underway continue. Fortunately, the board is well positioned to ensure that this occurs.

3.1.2 Priority Process: Planning and Service Design

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
4.11	The organization's policies and procedures for all key functions, operations, and systems in the organization are documented, authorized, implemented, and up to date.	
6.5	The organization's leaders develop and implement a process to manage change.	

Surveyor comments on the priority process(es)

The organization is commended for the approach taken to overall planning and service design. The strategic plan entitled: "Mapping Our Future" is a well thought out, and is a clear plan that highlights the focus of the organization until 2017. The process followed in developing the plan was inclusive and it appears both internally and externally that stakeholders had an opportunity to engage in the plan's development. Like any plan, it is only as effective as it impacts decisions and directions and it appears as though the key platforms of: quality and safety; transforming work; research and education; engaging people and breaking down barriers are being used across the organization to advance the mission, vision and values of St. Joseph's Healthcare Hamilton (SJHH). A number of status report documents were reviewed during the survey and the organization is commended for the advances it is making in all the priority areas.

Supporting the big-dot directions of the plan are more granular initiatives, including 12 strategic projects. All initiatives are being tracked appropriately and the organization is making good progress on most. By way of discussions and tours during the survey it is gratifying to see alignment where the corporate directions were driving program-specific goals and objectives. One of the noted keys for the organization will be to continue to review progress, and remove goals and objectives that are complete, and identify additional areas of focus. In doing this, focusing on maintaining the gains will be important, as will ensuring alignment and organizational capacity in whatever additional areas of focus are chosen as the plan evolves.

The continued adoption of the mission, vision and values is noted with approval. In discussing the process it was shared that initial consideration had been given to developing a separate mission, vision and values however, in the final analysis, broader alignment was supported. It is interesting to note that in some of the discussions and on documents reviewed the potential creative tension that this decision generates. It is evident that SJHH views itself at somewhat of a crossroads and is re-committing in areas such as research to ensure ongoing "differentiation" of the organization from others in the region. A strong research platform is viewed as a key strategic imperative in the organization's growth and development. In this, and all areas, the significant key for SJHH will be to link with all partners in the system to clearly outline and define roles and responsibilities. A good platform for this already exists across Hamilton as previous decisions around service consolidation between hospitals have been made. Furthermore, the new relationship with Niagara Health System is going to allow these discussions to have a broader impact resulting in potentially more integration and innovation.

The organization is commended for the relationships it develops across the system and for proactively engaging with the Local Health Integrated Network (LHIN) in all clinical service planning areas. The recent "bundled payment" initiative is noted with approval. The SJHH is well-positioned to work locally and provincially to identify and address barriers that exist across the system preventing it from truly providing integrated care.

3.1.3 Priority Process: Resource Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization has thorough operating and capital budget processes. Driven by the board of directors which clearly establishes financial expectations for the organization, St. Joseph's Healthcare Hamilton (SJHH) manages a process that engages people and programs from across the organization. The fiscal environment faced by hospitals in Ontario is tenuous at best, with zero growth revenue often the best case scenario for organizations located in no-growth (population) regions of the province. In the case of SJHH, the funding reality has required the organization to identify savings resulting from an annual funding gap, something that will continue into the future. Depreciation funding is preserved for capital allocation, a practice that is supported.

There are comprehensive processes for both capital and operating, and capital priorities are identified appropriately across the organization for information technology (IT), equipment and facilities, with all programs having the opportunity to present and justify proposed investments. The process used to set priorities is comprehensive and ensures that the resources spent are for maximum value for the organization. Contingency dollars are available and the organization needs to remain vigilant in ensuring that contingency dollars are allocated with the same rigour as for the regular process.

The identification of operating costs in the process is noted with approval and it appears as though the organization's process ensures "fully loaded" costs are included in all recommendations. The challenge for capital is the massive IT investment looming for the organization as a result of needing to migrate away from the McKesson System operating across the organization. Decisions around acquisition and financing, as well as ongoing additional operating impacts will be the key "resource" issue for the next three years, as this is a significant risk for SJHH. A secondary risk for the organization is post construction operating plan (PCOP) funding reconciliation. It will be considered key that regular dialogue around expectations occurs with funders to prevent "reconciliation surprises" as the project moves forward.

The process of developing and equally important monitoring of the operating budget is strong. Good decision support information is available and programs and services appear to receive adequate information to plan and implement annual operating plans. Reporting structures have good integrity and issues are flagged and addressed appropriately. All levels of the organization are engaged as required, including the board of directors. The challenge for the organization will be priority setting for the next few years as revenues continue to shrink relative to expense increases. Developing a "lean" thinking culture will be key, to assure the organization that all processes are as efficient as possible. Continuing to leverage partnerships across the continuum will also be key, to ensure that the right care is provided to the right patient/client at the right time. Efforts led by SJHH in this area are noted with approval, and the strong relationships that exist with all partners provide a good springboard to further advance in this area.

3.1.4 Priority Process: Human Capital

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
10.10	The organization's leaders implement policies and procedures to monitor staff performance that align with the organization's mission, vision, and values.	!

Surveyor comments on the priority process(es)

St. Joseph's Healthcare Hamilton (SJHH) is committed to the people and community of SJHH. The departments of human resources, talent solutions, volunteer and retail services, education resources, and occupational and environmental safety and health collaborate with the vice president of people and organization effectiveness to create and implement the people and organization effectiveness strategy for SJHH.

As part of the people and organization effectiveness strategy, SJHH has undertaken a review of its processes to identify gaps. Standardized metrics are in place across the organization to measure the progress of the strategy. The recent introduction of a talent solutions director will help SJHH revise its performance appraisal forms. The organization also hopes to introduce a new position to oversee technological improvements such as a paperless hiring process and automated time-keeping and scheduling. St. Joseph's Healthcare Hamilton (SJHH) maintains a policy to monitor staff performance. Encouragement is offered to continue with the goal to improve the performance appraisals process to ensure consistency in completion of performance appraisals across the organization.
The organization offers a range of wellness programs for staff. Programs include new options like zumba, boot camp, and massage chairs. These programs are monitored and adapted depending on staff utilization and feedback. One strategy to promote psychological well-being of staff members is the introduction of mindfulness based stress reduction (MBSR) exercises at the beginning of monthly management forums, and training is available for interested staff. An employee assistance program is available for staff.

There is a comprehensive general orientation and nursing competency-based orientation program, along with continuing education in-services, online learning modules, and rounds that are offered for staff. Education is also provided to volunteers via an orientation program. There are workplace safety and health policies to support staff members, including a workplace violence prevention program to promote safety for all. The members of the joint health and safety committee encourage staff members to report incidents of violence. The organization plans an annual leadership convention with keynote speakers that focus on client safety.

The organization monitors levels of staff engagement via surveys and face to face meetings. St. Joseph's Healthcare Hamilton is commended for the innovative way it solicits questions and feedback from staff. Specifically, this is via the "Ask David" page of the MyStJoes intranet site. This organization has been listed as one of Canada's Top 100 Employers 2011-2014. It conducts exit and stay interviews. The organization supports leaders and emerging leaders to attend a comprehensive leadership program.

3.1.5 Priority Process: Integrated Quality Management

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
12.4	The organization's leaders disseminate the risk management approach and contingency plans throughout the organization.	!
12.5	The organization's leaders evaluate the effectiveness of the integrated risk management approach and make improvements as necessary.	

Surveyor comments on the priority process(es)

St. Joseph's Healthcare Hamilton (SJHH) is commended for its commitment to integrated quality management. Not only are there clear goals and objectives set corporately, these transcend the organization and are reflected in areas of focus at the front line.

There is clear commitment to quality as a strategic priority and the organization's most recent strategic plan clearly articulates quality and safety as a primary focus. Interestingly, the strategic plan can also be viewed as a cultural transformation plan as it very much focuses on how the organization succeeds, not specifically what it will do programmatically. The specific goals are endorsed at the board level, with the board spending more and more of its time on quality as a discussion priority. There is an appreciation across the organization that continued focus on quality improvement, safety and risk minimization is fundamental to the organization's success.

The framework and supports in place from the board through to quality councils, quality boards and patient safety superheroes are noted with approval. The organization has a good "triaging" system in place for identifying priorities for the quality program and with a clear work plan, is able to ensure the needed advances in all areas. The organization's quality improvement plan aligns nicely with internal efforts and will help drive advances in this area. The focus on "Standardized Safety Briefings" is noted as key as one of the greatest challenges in advancing a quality agenda, and for maintaining focus on priorities and ensuring supports and expectations are clearly articulated. The re-focusing on patient safety during huddles therefore is noted with approval, as is the awareness of the importance of data in advancing change.

The approach taken by the organization with the safe effective accessible kind care (SEAK) scorecard is also noted with approval. By reinforcing safe, effective, accessible and kind care, SJHH is continually reinforcing the underpinnings of a strong, caring and just culture. The results of the Patient Safety Culture Tool were reviewed and discussed, specifically as they related to staffs' perception on reporting incidents. Clearly, the organization promotes a just culture and continues to reinforce this in all that it undertakes. Continuing to understand why there are perspectives from staff members of this nature will be important and the organization is commended for its focus in this area.

The enterprise risk management framework is noted with approval. It is an excellent start to clearly articulating the risks faced by the organization and also, to identify tools and plans to minimize same.

All members of the surveyor team were impressed with the commitment to quality across the organization. Maintaining the commitment and enthusiasm towards advancing the quality agenda will be important as the organization continues to evolve. Also considered key is ensuring capacity exists, particularly at the management level, to implement, support and maintaining the initiatives.

3.1.6 Priority Process: Principle-based Care and Decision Making

Identifying and decision making regarding ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

A well-established clinical ethics program is in place. The document: "Health Ethics Guide" from the Catholic Health Association of Canada is utilized as the foundation for the ethical decision-making framework. A comprehensive and extensive education program is in place to provide guidance to staff members in assessing the services offered. This is accomplished by providing unit rounds, grand rounds, and ethics-based case presentations. A strong commitment is made to honour religious and cultural beliefs. Education has also focused on training staff to utilize the YOD A ethical framework. The framework is strongly aligned to the mission, vision, values and strategic plan of the organization. The committee meets monthly. The Ethicist is available 24/7 on call for consultation and is shared with partner organizations. All members of the committee participate in regular education sessions. Legal representation and help with forensic issues is readily available.

Aligning the ethics framework to the mission, vision, values of the organization, and the strong collaboration with other Catholic health facilities are noted as strengths.

The organization has an active and busy research ethics board (REB). The board is aligned with the Hamilton Health Sciences Ethics Board. Two separate panels exist with representation from both boards to ensure that the Catholic Health Association of Canada mission is honoured in decision making. Between 20% and 25% of the research protocols are generated at St. Joseph's Healthcare Hamilton (SJHC). Many of the research protocols are first reviewed by Clinical Trials Ontario. All members of the REB participate in continuing education. A comprehensive selection process is in place to select board members.

3.1.7 Priority Process: Communication

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
11.3	The organization's leaders implement, review, and update policies and procedures to support the collection, entry, use, reporting, and retention of information.	!

Surveyor comments on the priority process(es)

The leaders of St. Joseph's Healthcare Hamilton (SJHH) demonstrate appreciation for the value of open communication, and take active steps to continuously improve the infrastructure and processes that support internal and external communication. There is engagement of patients/families, staff and credentialed clinicians, community partners and the general public. This is well-described by the board, the leadership team, staff members and patient advisors as part of the process of developing SJHH strategy, and individuals can describe how they see their input reflected in the plan and the emerging tactical steps.

The communications team plays a significant role in translating the strategy and organizational priorities into language and formats that are meaningful to the different audiences. The corporate strategic communication plan, developed in the fall 2012 is renewed annually as needed, with the most revision occurring in January 2015. The communications team works closely with the clinical programs and service support areas to develop messages and tools for patients, families and staff. There is also great pride taken in how increasingly the voice of patients and families is influencing the nature of both internal and external communications.

Communication tools include such things as videos, web pages, electronic newsletters, and policies that guide communication and media practices. Given the limited resources aligned to the communications team, there has been focus on building capacity of leaders/staff and on consistency with approach. This is occurring by way of education, which includes media training and access to online tools for planning of communication. Leaders also demonstrate awareness and willingness to turn to the communication team as a resource when need arises.

Time and resources have been invested to refresh the SJHH website, which welcomes the general public, patients, providers/staff, and guides them to information with customized questions and cues. There is an authentic effort with the organization being transparent in sharing information about the strategy and its performance with health education and with items of general public interest. The organization is encouraged to consider exploring ways to ensure that information is timely and current by dating documents and timely posting of reports and minutes.

Staff members positively describe the efforts taken to support transparency and to create dialogue. An example of how staff engagement and sharing of information is being supported is: "Ask David and the Leadership Team" that was profiled by the SJHH team, including board members and direct care and service providers. Similarly, "walk abouts" with a focus on safety or in-person response to critical incidents were described as ways for leaders and staff members to share perspectives on issues of mutual interest or concern.

There is the information and communication technologies plan to refresh technology, which creates a vision for 2018 that is guided and inspired by the corporate strategy. An information management and technology committee is overseeing the plan which includes a significant change given the need to replace the electronic health record (EHR) platform. The organization is working closely in partnership with other health care organizations/providers on this initiative. As the initiative unfolds, the organization will expand on what is currently available using the Cancer Care Ontario (CCO) portal, Clinical Connect or EPIC, to make personal, health care and/or educational information directly available to patients and community-based providers.

Timely access to current knowledge and leading evidence-based practices for staff is enabled by the services of the Sherman Library with journals, computer terminals and expert support with literature searches for care, knowledge and research. To support care planning and decision making, staff members have ready access to many applications and online resources such as the Joanne Briggs Institute for Evidence-Based Practice (EBP) database; Micromedex Drug Information; Medscape; Epocrates; and Dynamed.

The organization takes justifiable pride in being a Registered Nurses Association of Ontario (RNAO) Best Practice Spotlight Organization (BPSO) and enables transfer of leading practices to other disciplines with the goal of safe, quality patient care. The user-friendly tool "MyStJoes" supports staff members in enabling access to order sets, medical directives and policies, and online resources.

The online policy resource is extensive. While there is evidence of updates of many policies, there are also many outdated policies. This carries risk of a disconnect between policy, knowledge of leading practices and actual practice. Ensuring reliable mechanisms for review and update of policies is encouraged. In the review/update process consideration might be given to reducing the number of policies as many appear to be more procedural and could be supported with the use of other online resources. Leaders in the organization acknowledged awareness that the policy review process needs to be refreshed and are taking steps to ensure that policy and practice are aligned.

Leaders describe a purposeful emphasis on translating data into information that is made available to teams to support decision making. There is collaboration amongst those supporting health information, information technology, finance and quality and safety. This collaboration leads to generating reports that are used by clinical programs/councils, which in turn with support from performance improvement consultants, results in developing and reporting on improvement projects to the executive and ultimately to the board.

Policies and processes to support patient privacy and security of information are robust, and when tested have been met with approval of the provincial privacy office.

The team is encouraged to continue with its efforts in engaging all stakeholders, including residents/learners, and also in providing feedback on how input is used, as well as its impact on care, quality and safety.

3.1.8 Priority Process: Physical Environment

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

This team recognizes the importance of working with key partners in the organization. Team members have a good relationship with infection prevention and control (IPAC), environmental services and occupational health and safety and are members on key committees in those programs. At the time of survey, the overall physical plant located on Charlton Avenue is clean and not cluttered. There are mats in the front entrance that could be a trip hazard and some patient care areas could use a coat of paint or new furniture. There are a number of bathrooms in both the public and patient care areas of King St and Charlton Ave. that have toilet brushes left in the open, with some sitting on the floors and not in a dedicated bucket. Waste baskets are not always available at the exit of the bathroom doors for disposal of paper towels to avoid touching the door handles after handwashing has taken place.

The team has been engaging with patients to identify how signage could be improved and how the facilities could be more suited to needs of patients with disabilities. There were lessons learned from the flood in the new building. This prompted development of Code Aqua and putting processes in place that would assist in addressing a similar incident. A manual is now available for staff. An energy manager will be hired to assist proactively in becoming more energy efficient.

The facilities excellence scorecard can now be updated as a new building services manager is in place. With a good foundation of reliable equipment the team will be introducing predictive technology for equipment. All the building services staff members have received upgrading on equipment and job requirements this year. This has been done in collaboration with Mohawk College.

The organization's West 5th Campus site opened in February 2014 and is home to inpatient and outpatient mental health and addiction services, clinical and diagnostic ambulatory services, and research programs. The project was realized using a design build finance maintain (DBFM) process where St. Joseph's Healthcare Hamilton (SJHH) entered into partnership with Plenary Health Hamilton. This partnership includes Honeywell as the facilities management provider. Operating procedures are clearly identified by Honeywell and have incorporated SJHH values and protocols. The building is well-designed and provides an abundance of natural light and open space, with good signage. St. Joseph's Healthcare Hamilton (SJHH) was certified with a leadership in energy and environmental design (LEED) gold award for building an energy efficient facility. A unique design strategy was utilized to promote safety and the freedom of inpatient mental health and addiction clients. The inpatient units are separated from the public spaces via main access points, monitored by security and secure key code access doors to provide clients access to a larger space off the unit. An evaluation of the move to the 5th St. Campus is in progress and learning will be adapted for future moves.

3.1.9 Priority Process: Emergency Preparedness

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization has demonstrated the importance placed on emergency preparedness with its support to having a full-time person with accountability for corporate-wide planning, education and evaluation. Ensuring effective emergency preparedness processes for three sites of different vintages, and serving different populations is complex. Significant improvements to the emergency preparedness framework, supporting disaster preparedness and response were completed and approved in early 2015. The new framework has strong endorsement from the executive team.

Two significant events occurred since the previous survey. A widespread outbreak of Clostridium difficile infections was experienced in 2012. The team worked closely with partners, such as infection control personnel during this challenging time. In 2014 a disastrous flood occurred when a pipe burst during a cold spell. This resulted in widespread interruption of operations in critical areas such as the operating rooms and emergency department. The team and affected staff members are commended for their prompt action in minimizing the risk to patients.

The team takes tremendous pride in how all sites responded to the emergency with the flood at the Charlton site as it illustrated the organizations readiness and responsiveness to the crisis and ability to minimize the compromise to care and service delivery. Following this event, significant improvements were made to processes and procedures for the code 'Aqua'. The lessons learned have influenced practices across the organization and have been shared by the team more broadly in a recent publication of Healthcare Quarterly.

The team employs strategies such as 'code of the month' which are communicated to the front-line via staff educators, meetings and daily safety huddles. The team publishes updates on the website with a direct link to: "what's new" in emergency preparedness.

An evacuation exercise was completed in 2014 in collaboration with community partners. Table-top exercises have been undertaken to prepare for the upcoming Pan Am Games.

Building services staff members receive annual nuclear training at this site, the only one with a nuclear medicine department. Respiratory equipment has been acquired to protect staff members during hazardous events involving chemicals or pathogens such as Ebola virus.

3.1.10 Priority Process: Patient Flow

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

St. Joseph's Healthcare Hamilton (SJHH) has shown a commitment to improving patient flow with the creation of and adherence to a corporate patient flow policy. The patient flow team meets weekly to share the work being done by individual programs and strategize on ideas to enhance patient flow.

Standardized information is collected to assist SJHH to monitor and evaluate trends. As a proactive approach to managing patient flow, there are twice daily bed meetings where the entire team gathers, in addition, there are separate surgical and medical team meetings about flow mid-day. The programs engage in quality improvement projects using LEAN processes with the view of standardizing where possible and using data to inform needs. Use of software called “The Vue” captures real-time data.
Upcoming improvements to the system include bed turn around time and potential redevelopment of patient care space to increase the availability of private rooms and over capacity space. The team describes increased staff and physician engagement due to the use of transparent and objective processes. This has also helped decrease programs working in silos, as well as working with community partners to address flow into acute care, transitional beds and long-term care.

3.1.11 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: Diagnostic Imaging Services		
8.6	All diagnostic imaging reprocessing areas are physically separate from client service areas.	!

Surveyor comments on the priority process(es)

The central sterilization department (CSD) has moved into a new expanded area. Staff members had some input to the design and requirements of the area. Separate areas exist for decontamination, cleaning and tray assembly, sterilization and storage. A TDOC system has been implemented. This provides information and documentation about all steps involved in the safe sterilization of instruments and equipment. All technical manuals are available on the system. On preparing a surgical tray the pictures and the list of components is now available at each of the stations.

Goals and objectives have been established. These are in line with the strategic plan. A quality improvement plan is in place. This allows the tracking of certain quality indicators. From the results, improvements in departmental processes can be implemented. A strong liaison exists with Infection control and occupational health.

The biomedical engineering department is staffed by 10 qualified individuals. A list of all devices requiring preventive maintenance is generated monthly. For every individual the number of open and closed work orders is monitored. This allows appropriate work assignment. A process is in place to request services .Work orders are reviewed and assigned appropriate priority. An inventory of common parts that break down is kept. Most of the repairs are done in house. The department has access to external vendors.

When new equipment is requested both biomedical engineering and CSD have strong input to the process. There is strong commitment to quality and safety. Opportunities for improvement include moving towards separating the reprocessing area from the client service area in diagnostic imaging.

3.2 Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Organ and Tissue Transplant

- Providing organ transplant services, from initial assessment of transplant candidates to providing follow-up care to recipients

Organ Donation (Living)

- Providing organ donation services for living donors, including supporting potential donors to make informed decisions, conducting donor suitability testing, and carrying out donation procedures

Point-of-care Testing Services

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

Clinical Leadership

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

Competency

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

Episode of Care

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

Decision Support

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

Impact on Outcomes

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

Medication Management

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

Organ and Tissue Donation

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

Infection Prevention and Control

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

Surgical Procedures

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

Diagnostic Services: Imaging

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

Diagnostic Services: Laboratory

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

Transfusion Services

- Transfusion Services

3.2.1 Standards Set: Ambulatory Care Services

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	
There is collaboration with other stakeholders when defining priorities and ways to provides services that respond to the needs of the clients/patients. An example of this collaboration is the community advisory group at the mental health clinic as well as the partnership with the: "stay well program" at the diabetes clinic.	

Priority Process: Competency

A clear multidisciplinary approach was observed during the on-site survey, as well as a strong commitment to patient centred care. An orientation plan for new employees is in place and is usually tailored to individual needs and closely monitored for completion.

Priority Process: Episode of Care

The alignment of services with the strategic plan was evident upon the interviews during the on-site survey. Information about the priorities and strategies in place to achieve them has been widely communicated to patients and staff.

The eventual implementation of a structured medication reconciliation process would be a great benefit to the clients of the mental health clinic at the King Street Campus site.

The hemodialysis outpatient team is commended for developing a home emergency kit for their patients and also for the subsequent training of 1,200 Emergency Medical Services (EMS) staff.

The existence of an established and organized practice of informing clients and their families about the services provided and what to expect of the care process reflects on the engagement with patient-centred care, which is present at this site.

The regular analysis of no-shows and the multidisciplinary review of triaged cases at the mental health clinic are practices that contribute to improving access to care in order to be within the set waiting time targets.

Priority Process: Decision Support

Medical records are handled in a safe way and are readily available to the clinical team. Information systems are being used not only as a repository of information but also as a tool for patient safety and quality improvement. A more structured and well-documented process for selecting evidence-based guidelines in some areas could be of great benefit for the clinical staff and ultimately, for the clients.

Priority Process: Impact on Outcomes

Falls prevention and the provision of information to clients about their role in promoting safety are elements with room for improvement.

Staff members are familiar with adverse events reporting and feel confident to do so thanks to a blame-free culture and a deep engagement with patient safety and the identification of opportunities for improvement.

Evidence of work on quality improvement activities can be seen on informational white boards containing information on metrics and specific improvement initiatives as well as making clear, the organizational priorities around quality. Quality is also fostered by the use of tools such as the ones provided by the LEAN methodology, as is the case in the mental health clinic.

3.2.2 Standards Set: Biomedical Laboratory Services

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

Surveyor comments on the priority process(es)
Priority Process: Diagnostic Services: Laboratory
The organization has experienced major enhancements to their laboratory services since the previous survey. The team is commended for using the right tools, such as LEAN methodology, and new technology to streamline and improve the quality and efficiency of their operations. Significant contributions have been made to leading practices in tests for example, for Clostridium difficile and for processes such as contingency planning for potential Ebola threat. The scope of service has been increased with the addition of the human leukocyte antigen (HLA) laboratory to support the kidney transplant program. Overall, the laboratory provides specialized services that support the world class programs at St. Joseph's Healthcare Hamilton.

3.2.3 Standards Set: Critical Care

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 intensive care unit (ICU) is a comprehensive closed multidisciplinary unit providing care to high acuity and complex patients. Currently, there are 21 beds with two beds kept open to manage surge. The unit is a major referral centre accepting patients from within the Local Health Integrated Network (LHIN) and from areas outside the region. The ICU does not routinely accept trauma patients, patients with severe neurological injury or those with acute cardiac events.

In addition to the main unit there is a closed 12-bed medical step down unit and an open eight-bed surgical step down unit.

Priority Process: Competency

The interdisciplinary team conducts daily rounds on all patients. The unit is well staffed with a mix of junior and senior nurses. There is little turnover of staff. Nurses are happy with the staffing level and workload assignment. Nurses spoken with during the survey felt that their educational needs were being met.

A corporate-wide system is in place to recognize staff. There is a six month orientation to the unit. Information technology (IT) is comprehensive and under the supervision of the nurse educator. New nurses are happy with the education process. Infusion pump training is ongoing with 80% of staff completing the educational package. All staff members receive a regular performance evaluation and to date, 94% of unit staff have been evaluated.

Priority Process: Episode of Care

Families are encouraged to become involved and informed in the care of their family member at an early stage. They are informed and kept abreast when changes in patient condition or care are encountered. Rituals to recognize death, cultural practices and spiritual beliefs are respected. All staff members have access to the document: "Multi Faith Guide" for health care professionals.

A rapid response team is in place. It responds to all code blues and to urgent consultations. Patients are assessed for suitability of admission to the intensive care unit (ICU). Those felt to be stable are followed on the requesting unit. All patients discharged from the ICU are followed up for at least three days. This significantly helps prevent re-admissions.

The rooms are equipped with comprehensive monitoring available. All best practice criteria related to the care of the ICU patient are followed and electronically documented. Transfer of Information occurs both electronically and verbally.

Priority Process: Decision Support

An electronic documentation system is in place. This has greatly simplified documentation and improved safety and quality patient care. Evidence-based guidelines are utilized for patient care. Physicians are routinely involved in updating and modifying the guidelines, and have become leaders in this regard.

The unit actively participates in research activity. Two projects that staff members are proud of are the: "Early Patient Mobilization" and "Getting to know our patients."

Priority Process: Impact on Outcomes

A comprehensive quality improvement plan with goals and objectives is in place. Measurable objectives are identified. These are utilized to initiate quality improvement initiatives. Families and patients are encouraged to provide feedback. This also guides quality improvement initiatives.

Team members are regularly informed via a monthly newsletter. All activities and results of research and quality initiatives are shared. The process is transparent and all staff members have the ability to provide input to quality initiatives.

Staff members are aware of the procedure involved in reporting sentinel events or requesting help to handle challenging ethical situations.

Two client identifiers are utilized when providing care. The ventilator associated pneumonia (VAP) bundle and the central line infection (CLI) bundle have been implemented.

Priority Process: Organ and Tissue Donation

Once a potential donor is identified the Trillium Gift of Life Network is informed. All administrative issues and logistics are then undertaken by that organization.

St. Joseph's Healthcare Hamilton has become active and engaged in the philosophy and benefits of transplantations. The unit has achieved success in identifying and providing donors. The staff members have received education on tissue donation. Ethical support is always available to address concerns.

3.2.4 Standards Set: Diagnostic Imaging Services

Unmet Criteria	High Priority Criteria
Priority Process: Diagnostic Services: Imaging	
3.10 The team evaluates and documents each team member's performance in an objective, interactive, and constructive way.	
Surveyor comments on the priority process(es)	
Priority Process: Diagnostic Services: Imaging	

St. Joseph's Healthcare Hamilton (SJHH) is commended for the breadth and depth of its imaging program and for the commitment to integration of the service across the broader Hamilton community. During the survey a good opportunity was afforded to two members of the surveyor team to review imaging services across the organization, including tours and discussions with diagnostic imaging (DI) leadership.

There is a clear appreciation across the program of the need to engage clients and referring physicians around service planning. Overall, the City of Hamilton has a fairly robust method for identifying health status and community need, and SJHH utilizes this and other information in its planning for DI services. Good efforts are made to engage stakeholders in planning and the program is commended for its efforts in ensuring appropriate utilization of imaging modalities. This includes participating in the Choosing Canada Wisely program. Initiatives with referring physicians include: Decoding Diagnostics: Demystifying Diagnostics, and efforts in areas such as utilization of computerized tomography (CTs) for pulmonary emboli studies.

There is a strong commitment to quality improvement across the DI program, with efforts and examples viewed throughout. Initiatives such as centralizing interventional radiology, reducing turn around time (TAT) on lung biopsies and standardizing CT protocols city wide have all had an extremely positive impact on patient care. Of note however are the efforts to improve coordination and access to service with breast biopsies, where automatic, five-day out appointments are made with general surgeons for biopsy patients. The impact on care, including emotional well-being, is significant.

The departmental space, layout and colour schemes are all noted with approval. Patient flow was well-addressed in the design of current space and there is appropriate waiting and changing room area, including separate space for nuclear medicine. The sterilization of probes is innovative however, the requirement for separate areas for sterilization, away from patients, is noted.

Staff members are well-versed in safety protocols for the program and are able to address and speak to quality issues and initiatives with confidence. While an issue that appears to transcend all hospitals in the country, the addition of "after-the-fact" signage should be reviewed.

Due to the capital intensive nature of the program, a good discussion ensued around the acquisition and maintenance of equipment. The commitment to coordinated maintenance is noted with approval as are efforts to coordinate buying across the region. Continued emphasis on these areas will be important, particularly as service alignment continues to be addressed. With the addition of DI services at the West 5th campus site efforts to ensure appropriate utilization will need to continue across SJHH.

Efforts to continue to improve the patient experience are commendable. The comment about: "being more relevant to the patient" nicely summarized the program's commitment to providing the highest value and quality of service achievable.

3.2.5 Standards Set: Emergency Department

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
2.2 The team has the workspace it needs to deliver effective services in the emergency department.	
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 emergency program has focused on improving patient flow, access to physicians and consultants and ambulance off-load times by way of quality improvement projects. The initial assessment by the physician (IAP) allows patients to be seen by a physician within 15 to 30 minutes of arriving in the department. The quality improvement project between the emergency department (ED) and Emergency Medical Services (EMS) has significantly decreased ambulance off-load times and improved co-operation between the two services. The department has also improved access to diagnostic imaging and transfers within St. Joseph's Healthcare Hamilton.

Staff members identified that increased space is required for consultants at the Charlton Campus site and also, to support work flow at the King Street urgent care facility.

Priority Process: Competency

There is strong collaboration amongst the interdisciplinary team in the emergency department. Education is ongoing and valued within the department. Recognition of workload is evidenced with physicians and nurses offered the opportunity to rotate to the various clinical areas of the department to promote well-being.

Priority Process: Episode of Care

Process improvements like the initial assessment by the physician (IAP) and ambulance off-load times have improved the wait times for patients waiting to be assessed and treated. Consent is routinely obtained and patients and their families are included in the discussion of treatment options. Transfer of accountability is evident with the introduction of a new process and a 'faxed' report.

Priority Process: Decision Support

Evidence-based guidelines are utilized for patient care with input from various disciplines. Physician protocols like the sepsis protocol have standardized assessments and improved detection rates for patients at risk for destabilizing. There are daily bed huddles to enhance communication within the team.

Priority Process: Impact on Outcomes

No specific comments are identified. Please refer to other report sections for comments about the Emergency Department.

Priority Process: Organ and Tissue Donation

No specific comments are identified.

3.2.6 Standards Set: Infection Prevention and Control Standards

Unmet Criteria	High Priority Criteria
Priority Process: Infection Prevention and Control	
The organization has met all criteria for this priority process.	

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

The strong leadership of the physician and manager is apparent. The team has been working together for a few years and have worked to become a high performing team. The focus has been on change and innovation and specifically addressing surveillance documentation, consolidation of information technology (IT) systems and applications for auditing using iPads.

All infection control (IC) practitioners are supported to obtain their certification within three years of hire. They work closely with key stakeholders in the organization such as environmental services, occupational health and safety and patient care. The IC practitioners have a strong presence on the patient units and during the survey, the staff members spoke positively of the support they provide.
Documentation in the clinical record is clear and up to date. Patient education materials were well done and are developed with patient input. Procedures for outbreaks are clear and there are early warning detection triggers. Any unit that has more than three cases in total is identified as on high alert. This prompts additional support from environmental services called precautionary cleaners.

Communication is sent daily to all managers and the senior leadership team. Patients that are in the hospital for more than 30 days have their rooms thoroughly cleaned. Infection prevention and control staff members spoke positively of the 'Knowledge Translation' days that occur and the role they were able to play both as presenters and participants.

The new food services food delivery system is in its third week of implementation. Food services staff members spoke of their focus on client identifiers, hand hygiene and allergies. They continue to focus on ensuring that the food tray follows the patient to the right unit (one tray/one patient.)

At the King Street campus, the practice of cleaning the stretchers in the surgical area may want to be reviewed and aligned with practices at other sites.

St. Joseph's Healthcare Hamilton (SJHH) has contracted environmental services to Aramark for the King Street and West 5th sites and a collaborative partnership is evident. Aramark has incorporated SJHH infection prevention and control policies into its own protocols and orientation and ongoing education is provided for environmental services staff.

An innovative pilot on one of the general units in forensic psychiatry involves clients auditing the hand hygiene of staff. This promotes involvement of clients in their care and appears to be well-received by the staff members on that unit.

3.2.7 Standards Set: Long-Term Care Services

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
4.15 Each team member's performance is regularly evaluated and documented in an objective, interactive, and constructive way.	
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 unit leadership is part of the Local Health Integrated Network (LHIN) Complex Care Implementation project. With the changing needs of the complex care patient, the unit now accepts patients that are younger, on dialysis, ventilator dependant, medically complex, end-of-life and bariatric.

Considerable work has been done to change the focus of care and help staff members meet the changing needs. The goals and objectives are linked to those of the organization. There is monitoring of key performance indicators such as falls, hand hygiene and medication errors.

The unit is well laid out and spacious to allow for wheelchairs and other equipment. The implementation of physician to physician transfer of accountability (TOA) for weekend coverage was spoken of during survey and is seen as a positive initiative.

Priority Process: Competency

There have been significant changes to the population in the unit. To address this issue extensive education has been provided and in particular, the unit has worked to address changes to the scope of practice to registered practical nurses (RPNs). Staff members spoke positively of these sessions and how it has helped them to provide care to the changing population.

Priority Process: Episode of Care

There is a strong interdisciplinary team that provides care to this group of complex care patients. There is a standardized approach to the assessment of the patient on admission and throughout their stay. The goal is to have patients on the unit for 90 days and to come up with specific measurable goals. While not all patients leave within this time frame the length of stay overall has been reduced. The focus is one of restorative care. The organization is remodelling part of the unit to provide better services for the bariatric patient.

Priority Process: Decision Support

Charts audits are conducted to ensure that the documentation process is complete including the transfer of accountability (TOA) at shift change.

Priority Process: Impact on Outcomes

The interdisciplinary quality council meets on a regular basis. At their annual retreat the staff members identify the indicators that will be their areas of focus. Many of these indicators align with organizational goals such as falls, medication errors, patient satisfaction and hand hygiene. The manager uses the safety huddles to provide review of progress of indicators and identify opportunities for improvement. The data are readily available and were posted in a public area.

3.2.8 Standards Set: Medication Management Standards

Unmet Criteria		High Priority Criteria
Priority Process: Medication Management		
4.1	The organization provides initial and ongoing training to staff and service providers based on their roles and responsibilities for medication management within their scope of practice.	!
11.4	The organization regularly tests the limits set for soft and hard doses to make sure they are working in the smart infusion pump.	!
13.3	The organization stores chemotherapy medications in a separate negative pressure room with adequate ventilation segregated from other supplies.	!
16.3	The organization has a separate negative pressure area with a 100 percent externally-vented biohazard hood for preparing chemotherapy medications.	!
16.4	The organization has a separate area with a certified laminar air flow hood for preparing sterile products and intravenous admixtures.	!
22.3	The organization has a process for storing medications that are self-administered by clients.	
27.1	The organization provides the resources needed to support quality improvement activities for medication management.	

Surveyor comments on the priority process(es)

Priority Process: Medication Management

The St. Joseph's Healthcare Hamilton (SJHH) pharmacy staff members are dedicated to enhancing medication safety. All staff members are encouraged to work to full scope of practice and the team is well-positioned to meet the Canadian Society of Hospital Pharmacists (CSHP) Vision 2015 objectives in all patient care units. The team would benefit from establishment of metrics that measure the number of drug related problems that are resolved by clinical pharmacists that are working with healthcare teams.

The organization is commended for investing in resources dedicated to medication management and antibiotic stewardship. The antibiotic stewardship program is supported by dedicated resources, and the physician and pharmacist team make recommendations to optimize antimicrobial use. Though reports monitor the impact of the program on individual antimicrobials and metrics such as defined daily dose and costs, the team is encouraged to also evaluate and incorporate clinical outcomes and resistance rates such as Clostridium difficile rates.

Although audits of error prone abbreviations were recently completed, including follow-up with prescribers by pharmacy staff, the team would benefit from a more structured strategy with regular audit intervals, follow-up reports, and so on. The new strategy should include a process that has been endorsed and supported by the medical leadership to engage recalcitrant prescribers, identified by audits that continue to use dangerous abbreviations when writing orders.

An orientation program is in place for residents and the organization should formalize the structure of their new physician orientation program. The program needs to ensure that all medical staff members become educated about their roles and responsibilities for medication management before beginning work in the SJHH facilities. The plan should allow the organization to record and track medical staff members that have successfully completed the orientation.

A hybrid medication system exists with a blend of automated dispensing cabinets and medication carts. Two medication rooms in the intensive care unit (ICU) have optimal features for drug storage and security. Some vulnerability was observed during the survey with the medication distribution carts in other areas. Medications in anesthetic trays, found in the operating rooms (ORs), are easily accessible to unauthorized personnel. Pre-filled syringes of remifentanil and propofol were observed to be unattended and on the top of the anesthetic cart between cases in one OR theatre.

The intravenous (IV) admixture area in the pharmacy does not meet current standards. Risk assessment of the compounding practices to ensure compliance with the physical environment standards such as USP 797 would identify opportunities for strategies to address gaps. Such enhancements to processes during parenteral compounding activities will increase the safety of the IV medications prepared. The organization is encouraged to explore regular monitoring of pump key stroke data which will lead to changes that will optimize safe intravenous (IV) medication delivery. The use of observation methodology, as described by Ken Barker and colleagues (Archive Internal Medicine, September 9 2002), to accurately detect medication errors would benefit the organization in its quest to monitor and reduce medication errors.

The team is faced with the monumental task to replace the pharmacy software system. The organization is encouraged to explore the jump to computerized physician order entry (CPOE) during the next pharmacy software implementation.

3.2.9 Standards Set: Medicine Services

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
4.8 Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	
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 medicine program team is clearly committed to a collaborative and proactive leadership approach. The program's infrastructure includes operations and quality councils. These councils are inclusive of inter-professional care and service providers. The councils also include the patient perspective, either with the presence of an advisor, or by gaining patient perspective from satisfaction surveys or other means of input.

The team is deliberate in aligning time, energy and resources to support the corporate strategy, and ensuring that staff/direct care providers understand the value of their engagement and support of improvement initiatives. The patient profile, with data supported by high-volume case mix groups (CMGs), or with predictable high-need populations, influences the areas of focus in the program.

The team has demonstrated ambitious leadership with the oversight of the integrated comprehensive care (ICC) initiative for the cardiac heart failure (CHF) and congestive obstructive pulmonary disease (COPD) populations. It is launching the patient care collaborative model. This model involves introduction of the category of registered practical nurse (RPN) and entailed a change in the make-up of the staff complement, and the medical consultation unit to support patient flow. The team places importance on collaborating with local and regional partners, working closely with them to address challenges with the Community Care Access Centre (CCAC) as example in the ICC initiative, and sharing the success of the innovation at the provincial level.

Priority Process: Competency

The interdisciplinary team is a high-functioning team. The engagement of physician partners in designing and overseeing implementation of change is effective. The presence of attending physicians at rapid rounds on the inpatient units, which include residents and 'learners' models, reinforces the value of the processes of and time spent on patient care planning.

Staff members describe a supportive learning environment. There is time given to the support the orientation and successful integration of new members of staff. Education is focused, and competency based. The recent accreditation of the graduate and undergraduate medical programs speaks well to the clinical learning environment.

There are gaps in the documentation of evidence for infusion pumps training of staff working in an area where pumps are in use. The migration to an electronic learning management system (LMS) that displays the status of mandatory education will enable staff members and leaders to be aware of needs and support competency/skill training.

The process for completing individual performance feedback and development of learning plans for all staff members is recognized as important and while not yet complete, is being addressed.

The team's work on a model of care, with the introduction of registered practical nurses (RPNs) has supported quality patient care for a specific patient population, while enabling individuals to work to their full scope of professional practice in a safe and efficient manner.

While leaders and staff describe specific expectations pertaining to documentation on the patient record (charting by exception) an on-site review of records suggests that practice differs and is somewhat inconsistent. The team is encouraged to revisit the expectation and support consistent adoption of approved documentation practices.

Priority Process: Episode of Care

The inter-professional team is proactive in exploring ways to ensure safe, quality care and continuously improve the patient experience.

Patient safety is promoted by staff. This is done with use of specific protocols, aligned to the organizations priorities, and required organizational practices (ROPs) such as for assessment of skin integrity, falls risk assessment, and medication reconciliation. Patients are engaged and encouraged as partners in their care and safety, and education materials are made available in both the ambulatory and in-patient settings for patients and families. Examples are: "Welcome to General Internal Medicine" book, and "Preventing Pressure Ulcers or Bed Sores - Keeping your skin healthy in the hospital" and the "Avoiding Caregiver Burnout" brochure and which are given to appropriate patients. These materials are also prominently displayed to be picked up by families.

The team is encouraged to ensure that assessments and education are documented. The team places priority on facilitating patient flow, and has successfully created a culture where the team on the medicine program view admitted patients in the emergency department (ED) as "their patients" and takes active steps to expedite transfers/discharges as early in the day as possible and/or to create bed capacity in the inpatient units. The team is rigorous with daily care and discharge planning discussions with inter-professional Rapid Rounds and use of a red, green, yellow flag system to illustrate and message progress toward discharge. The process has resulted in earlier average discharge times, and shortened ED wait times.

The number of patients that are designated as alternate level of care (ALC) undoubtedly challenges patient flow, and the team has taken steps when possible to cohort patients with similar care needs and to support their care with protocols and staffing plans modelled after long-term care (LTC) settings.

The integrated comprehensive care (ICC) project is an innovative approach for care for targeted populations and in medicine this is the cardiac heart failure (CHF) patients and those with congestive obstructive pulmonary disease (COPD). The project includes a care coordinator based at St. Joseph's Healthcare Hamilton (SJHH). The coordinator works closely with the care team and contracted home care service providers to plan, and support the patient's transition to home/community and monitor their well-being on an ongoing basis. The approach is one that is expected to be adopted on a broader scale in the hospital setting and province.

White boards in the patient rooms are used as an additional means of support for communication between patient/family and staff. White board were described by patients as being welcomed and useful.

Also, in support of care being delivered in the best setting, in reducing length of stay and minimizing risk of readmission, patients and continuing care providers receive information at the time of transfer or discharge to support continuation of care and safe medication practices. The internal medicine rapid assessment clinic (IMRAC) serves to have higher risk/need patients that typically will benefit from being seen within 72 hours to one week of discharge to support ongoing care in the community and minimize risk of readmission. Patients are also referred from the emergency department (ED) to the IMRAC with the goal of admission avoidance. This clinic has been in place for approximately five years and by objective measurement of indicators including ED diversion, earlier hospital discharge and patient satisfaction measures, the clinic is seen as a success. A similar clinic that will support referral from community-based primary care providers has just been launched and is envisioned as having potential for even greater impact on ED diversion and avoidable admissions.

There are processes and tools to support transfer of accountability (TOA) and hand-over reports between in-patient areas. The team on the unit supporting patients designated as ALC similarly have processes to support transfer of information when patients transition to LTC homes. Given the average six-week length of stay on the unit, the team has great insight into behavioural issues and personal likes/dislikes of the patient. For this reason, the team might consider enhancing the transition of the patient, which is primarily paper-based transmission of information, with a person-to-person hand-over between members of both the sending and receiving organizations.

Priority Process: Decision Support

Planning of initiatives and assessment of change is enabled with data and information from health records and quality department program counterparts. By way of example, the medicine and emergency department (ED) data were critical in evaluating the effect of using space and resources to support a medicine consultation unit, and the impact on patient flow and wait times in the ED.

The staff members have access to online resources and tools such as order sets to support decision making.

The team participates in research and this activity is enabled by processes of engaging team members as appropriate with endorsement of the proposal, ethics review, support of the conduct of the research, and/or sharing of findings.

Priority Process: Impact on Outcomes

The team monitors a number of indicators for quality, safety and experience of patients. There is transparency about the performance with staff members, patients and families by posting results with trending information on a quality board on the unit. This board is used to trigger discussion of reasons for current performance and opportunities to make improvement. Staff members also actively participate in daily rounds, where in addition to care and discharge planning, there is focus on risks associated with falls or skin integrity. Visual, colour-coded flags are placed on patient charts, on white boards at the central care station and on the white boards in patient rooms, and these serve as additional cues about high risks,

The team, in co-operation with the quality council meeting, monitors performance measures aligned to inpatient and ambulatory settings in the program, and utilizes the data to identify gaps and further opportunities for improvement.

Patients and family members are complimentary of the care in all settings, and describe feeling respected, heard and involved in an authentic way with being part of the planning of care.

The team has been ambitious with the number of initiatives undertaken in the past year or more. Leaders have been purposeful with engaging staff members and building capacity in the team to support change. The team appears responsive and receptive to the magnitude of change and describes being energized by the opportunities to learn and contribute to the organization goals. It will remain important for there to be ongoing monitoring of the resiliency of the leaders and the team, and to sustaining the gains that have been made with the many excellent initiatives.

3.2.10 Standards Set: Mental Health Services

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	

St. Joseph's Healthcare Hamilton (SJHH) has a strong commitment to adult mental health services. The mental health program has grown substantially during the last year with the introduction of the Youth Wellness Centre and expanded forensic psychiatry program. The opening of the new West 5th Campus facility provides amenities to promote wellness, safety, and recovery in a well-designed expansive space.

Innovative services offered by the interdisciplinary team are person-centred, recovery-oriented, and trauma-informed. The Youth Wellness Centre accepts self or family referrals and the team shows a genuine interest in providing services that are tailored for the youth. The forensic psychiatry program actively engages clients by involving them on the quality council, staff interviews, handwashing initiative, and other client-centred projects.

The concurrent disorder program has integrated addiction workers and mental health nurses to provide services to individuals with mental health and substance use issues. The acute psychiatry and mood disorders program offer various treatment modalities and opportunities for clients, including a patient-initiated medication program.

The mental health program continues to expand seclusion reduction tools with the introduction of debriefings following seclusion episodes. The inclusion of a mental health nurse in the initial assessment by physician (IAP) of the emergency department (ED) and the psychiatric emergency service (PES) enhances assessment and treatment of individuals in the ED.

There is a commitment to evidence-based care evidenced by the use of validated assessment tools and a variety of research projects to evaluate the effectiveness of programs. The overall program has introduced technology to promote transfer of accountability and patient flow processes.

Leadership promotes open communication with staff members and a commitment to quality improvement initiatives. St. Joseph's Healthcare Hamilton (SJHH) maintains a policy to monitor staff performance. Leadership is encouraged to continue with its goal to improve the performance appraisals process as this is not consistently done across the program. Increasing collaboration with community partners has been identified by the program to promote patient flow and reduce stigma.

Priority Process: Competency

No specific comments are identified. Please refer to other report sections for comments about Mental Health Services.

Priority Process: Episode of Care

No specific comments are identified. Please refer to other report sections for comments about Mental Health Services.

Priority Process: Decision Support

No specific comments are identified. Please refer to other report sections for comments about Mental Health Services.

Priority Process: Impact on Outcomes

No specific comments are identified. Please refer to other report sections for comments about Mental Health Services.

3.2.11 Standards Set: Obstetrics Services

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
The organization has met all criteria for this priority process.			
Priority Process: Competency			
3.7	The organization provides sufficient workspace to support interdisciplinary team functioning and interaction.		
Priority Process: Episode of Care			
9.6	With the involvement of the client, family, or caregiver (as appropriate), the team generates a Best Possible Medication History (BPMH) and uses it to reconcile client medications at transitions of care.		ROP
	9.6.1	Upon or prior to admission, the team generates and documents a Best Possible Medication History (BPMH), with the involvement of the client, family, or caregiver (and others, as appropriate).	**MAJOR**
	9.6.2	The team uses the BPMH to generate admission medication orders OR compares the Best Possible Medication History (BPMH) with current medication orders and identifies, resolves, and documents any medication discrepancies.	**MAJOR**
	9.6.4	The prescriber uses the Best Possible Medication History (BPMH) and the current medication orders to generate transfer or discharge medication orders.	**MAJOR**
10.11	The team follows the organization's established policies on handling, storing, labelling, and disposing of medications and breast milk safely and securely.		!
12.5	Following transition or end of service, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end-of-service planning.		
Priority Process: Decision Support			
15.1	The team maintains an accurate and up-to-date record for each client.		
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

Obstetrics services are embedded in the women's and infants' program at St. Joseph's Healthcare Hamilton (SJHH) and as such partners with pediatrics and family medicine which includes midwifery. This program team is highly collaborative and thoroughly engaged in providing the best care to women and infants, with approximately 3300 deliveries and 3340 newborns annually. Leaders openly share perspectives and appear committed to partnering to exploring opportunities for improvement.

The infrastructures supporting service planning include an inter-professional women's and infants' steering committee as well as a quality council. Each has a broad composition with community-based service providers, and the quality council includes a patient advisor.

A portion of the credentialed staff members providing obstetrics services have offices at SJHH and run on-site clinics, while others run community-based practices and attend patients when they are admitted.

The team's priorities are aligned to the corporate strategy. Informal feedback and available information from a variety of sources including internal data and Better Outcomes Registry Network (BORN), an Ontario database, is used to understand issues and concerns, to conduct gap analysis and to design options to address issues.

The team in collaboration with public health and family medicine has conducted a recent pilot of a baby assessment clinic (BAC) focused on safely discharging families to the community. The innovative pilot, which is showing early positive impact on patient outcomes, patient satisfaction and length of hospital stay, will soon be presented to the board of directors. The goal of presenting the pilot is to seek support for expansion in the organization in the short-term, with continued evaluation to be further expanded potentially in the community in the longer term.

Priority Process: Competency

The team is proactive in supporting knowledge and skill acquisition. Team members are involved with the managing obstetrical risk efficiently (MORE ob) program, which is an inter-professional program that includes theory and simulation exercises. Additionally, there has been implementation of regular simulation sessions that enable staff groups to work through clinical scenarios and discuss potential improvement opportunities. There is also full engagement of the appropriate members of teams following clinical and/or critical incident debriefs with sharing of recommended actions at safety rounds/huddles.

The clinical educator role supports orientation of new staff members and ongoing education with updates. The nurse practitioner works with the entire inter-professional team to support adoption and integration of a leading practice and Cue Based Feeding is one example. The entire team collaborates in creating a learning environment that supports resident rotations and learner placements.

While there is evidence of documentation of education on infusion pumps for the majority of staff members, there are gaps in the evidence for those working with infusion pumps. The migration to a fully implemented electronic learning management system (LMS) with merging of databases will help to have a reliable source of information about the status of mandatory education. It will also enable staff members and leaders to know when education needs must be addressed to ensure patient safety and support professional practice.

The team is encouraged to consider an inconsistency in practice in terms of midwives as credentialed members of staff and service providers receiving training in infusion pumps, with documentation, while

credentialed physicians that also use pumps such as in anesthesiology do not. While it appears that physicians may in fact receive some information education about devices, it is not with a consistent curriculum and it is not documented.

The physical environment supporting the care of Level 2B newborns is constrained and presents challenges in terms of space and infection control standards. As well, workspace for the clinical team in the antepartum/postpartum unit has been identified as an opportunity for improvement. Planning for modified space is underway for the neonatal intensive care unit (NICU) and is imminent in the postpartum unit. The team is encouraged to continue with these space redevelopments.

Priority Process: Episode of Care

The team is extremely engaged in ensuring a focus on patient and family experience. Staff members are highly sensitized to the demographic profile of its patient population, take the appropriate steps to provide for the unique needs of the patients and families, and display great respect and care to the patients and families.

As a Level 2B centre, the team supports care for a targeted maternal and newborn population and has ensured that criteria, protocols and processes are in place to support the safe transfer of care to the tertiary maternal/newborn centre when appropriate. Given the multicultural make-up of the community, systems are in place to give support to staff members with patient care should there be language or cultural or faith-based considerations. The socio-economic profile and recognized incidence of homelessness and/or substance use, has triggered general anti-stigma education and specific supports for newborn abstinence. Staff members are able to identify who they would access for support and guidance should they encounter a difficult situation.

The team takes pride in St. Joseph's Healthcare Hamilton being one of three hospitals in Ontario designated as Baby Friendly, and for having a high rate of exclusive breastfeeding at discharge. The breastfeeding and newborn assessment clinic (BANA) provides lactation support with approximately 3000 visits per year to support sustained breastfeeding.

At this time the team does not have a process for direct contact with the patient or provider post discharge. There is some confidence taken in the fact that Public Health is engaged pre-discharge and with follow-up care. The baby assessment clinic being proposed by the team is a strategy that will support an integrated and comprehensive model to support safety and quality care in the days immediately following discharge.

There are many patient education materials available with some provided at the point of admission, and others during the episode of hospitalization as appropriate. These assist patients in understanding what to expect, how to be engaged in their own safety, and to share knowledge regarding self and newborn care. While there is attention given to both understanding the medication profile of obstetrics patients at the time of admission and ensuring patients are discharged with information about medications, the medication reconciliation process has yet to be fully implemented for obstetrics patients.

The security on the units, with controlled access and video surveillance, respects the potential risks associate with newborn care.

The team is currently supporting the installation and implementation of the new medication storage/delivery system in labour and delivery. As part of this process, the team is encouraged to review and address the current practice of nurses withdrawing controlled substances and then providing directly to physicians (anesthesiology).

Priority Process: Decision Support

The team uses a provincial database to monitor their performance again predictable maternal newborn indicators such as cesarean section, induction, epidural, gestational age, birth weight, and breastfeeding rates. The team also looks at peer comparators, and works with regional and provincial counterparts to gain understanding of options for change. Evidence-based practices are reviewed, implemented as possible, and monitored to drive improvement.

To the extent possible the team does maintain an up-to-date record. Antenatal records are generated and updated by obstetrics service providers on a regular and increasingly frequent basis nearer the expected delivery date. The forms are generated by obstetrics service providers in the organization and in the community. In the absence of an electronic medical record, the providers need to 'fax' or ensure personal delivery of paper copies of the records to the birthing unit. As a result, when an obstetrics patient presents to the unit, the staff members may not have the most recent antenatal assessment and plan to best inform the next steps in care planning and delivery.

Laboratory results and diagnostic findings are available electronically. The team is encouraged to continue to explore ways of mitigating risk from absence of information, and to remain actively engaged with the corporate planning aligned to the information technology and communication.

Priority Process: Impact on Outcomes

Clinical debriefs and critical incident reviews occur and findings or recommendations arising from the analysis are shared with the team.

Staff members are aware of the corporate priorities and the program initiatives aligned to support the strategy. Corporate and program goals/targets have been developed using a process of engagement with leaders and staff, and performance metrics are transparent to staff members and patients/families on the quality boards. Although performance on some measures may be below organizational or benchmarks, the team is transparent about performance and the steps being taken to make improvement.

It is clearly evident that staff members have a quality improvement mindset and were observed as being professional and caring in their interactions with patients, families and colleagues. Patients interviewed spoke highly of the care received, and of the welcoming environment, and the staff.

3.2.12 Standards Set: Organ and Tissue Donation Standards for Deceased Donors

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	

St. Joseph's Healthcare Hamilton (SJHH) has made a strategic commitment to be a leader and champion in support of organ donation and retrieval. An organ and tissue donation steering committee is charged with maximizing organ and tissue donation for the purpose of saving and enhancing lives in Ontario. The committee has effectively overseen a corporate-wide approach to educate clinical teams and engage all units at the Charlton site to work in partnership with the Trillium Gift of Life Network (TGLN). This has involved adoption of best practices with donation standards and policies and procedures. As a result, and within the span of approximately three years TGLN is predictably notified of all deaths less than 79 years old unless exemptions apply.

There is great collaboration amongst key stakeholders to facilitate processes associated with organ and tissue donation, particularly in the emergency department, the intensive care unit and the operating room. While fully respecting all obligations for separate and confidential organ donation and kidney transplantation processes, the medical and operational leaders of the regional renal program which has oversight for living donation and kidney transplantation support TGLN goals, and are resources on issues pertaining to policies, standard operating procedures and expertise as needed.

Priority Process: Competency

An inter-professional team works closely with the Trillium Gift of Life Network (TGLN) hospital development coordinator in having policies, defined accountabilities, and standard operating procedures in place to guide practice related to organ and tissue donation with deceased donors. These include processes for notification of a TGLN donation coordinator in the event of an imminent death or a deceased donor.

Staff members across the organization are provided with education appropriate to their area of work that details the processes that support communication of opportunity for organ and tissue donation. All areas have resources such as manuals, pocket cards immediately available to support staff members with decision-making and with communication internally and with TGLN.

Priority Process: Episode of Care

The team works with closely with the Trillium Gift of Life Network (TGLN) and complies with national standards in obtaining information about potential cadaveric donors.

Priority Process: Decision Support

The team, in conjunction with the Trillium Gift of Life Network (TGLN) ensures the adoption of provincial and national standards with documentation, record keeping and reporting. The organ and tissue donation steering committee receives reports with the organization's performance and trends related to organ and tissue donation, as well as provincial benchmarking data. Data are used to identify opportunities and to engage staff members in designing improvements, such as timing of notification to TLGN.

Priority Process: Impact on Outcomes

The team has focused on the organization-wide adoption of the practices associated with notifying Trillium Gift of Life Network (TGLN) of all imminent or actual deaths of less than 79 years of age. What began just over three years ago with the emergency department and the intensive care unit implementing the requirements of TGLN, has successfully extended to all inpatient units, with mental health unit still exempt. Of note is the high adoption of notification practices by the staff.

Acknowledging that donation numbers are small, the team is focusing on TGLN performance targets including the conversion rates, and is working with TGLN on processes such as earliest notification. As part of continuous improvement, consideration might be given to establishing an internal process or outcome measure for ongoing performance monitoring.

Priority Process: Organ and Tissue Donation

The processes that support organ and tissue donation are strongly influenced by provincial and national guidelines, and are implemented in collaboration with the Trillium Gift of Life Network (TGLN) coordinator. As appropriate, the clinical teams in the intensive care unit and operating room and the renal program, should there be subsequent kidney transplantation, respectfully work together to ensure there is confidentiality and separation of processes. The teams are fully committed to providing compassionate care and support for the needs of the patients, families and staff members that are directly involved in the organ and tissue donation process.

3.2.13 Standards Set: Organ and Tissue Transplant Standards

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

Surveyor comments on the priority process(es)

Priority Process: Organ and Tissue Transplant

St. Joseph's Healthcare Hamilton (SJHH) is committed to leadership and excellence in kidney transplantation as a strategic priority. The regional renal program has roles and committees/councils in place, with distinct accountabilities to oversee the integrity of processes that support organ donation and kidney transplantation.

Effective partnerships have been put in place with the Ontario Renal Network (ORN) and Trillium Gift of Life Network (TGLN) and leaders work within the provincial systems to support achievement of goals and targets. The program adheres to provincial and national policies/guidelines with practices related to determining suitability, supporting all aspects of decision-making, and documenting and reporting. The program works in collaboration with ORN, TGLN and provincial counterparts in monitoring quality and outcomes and ensuring targets are met.

Priority Process: Clinical Leadership

The organization and the renal program have demonstrated great commitment and leadership with putting in place the infrastructure and processes needed to support kidney transplant. Over the past three years there has been an annual growth of between 5% and 10% in the number of transplants. This speaks to the vision of becoming a centre of excellence for transplantation, and also to the dedication of time, energy and resources to achieve that goal.

St. Joseph's Healthcare Hamilton and specifically the regional renal program actively partners with the Ontario Renal Network (ORN), as well as with the Trillium Gift of Life Network (TGLN) to support having organ procurement and renal transplant policies and protocols in place and congruent with Ontario and Canadian Standards. Medical and operational leaders and program staff members are active participants on provincial and national bodies that establish care guidelines and professional practices.

The leadership team is highly collaborative and cohesive. Team members proactively engage with key stakeholders from services such as critical care, emergency and the operating room in conjunction with TGLN to ensure understanding of the pertinent roles, responsibilities and protocols in order to respond to all opportunities for organ donation, and for renal transplant. Similarly, processes have been put in place to ensure readiness of potential recipients and living donors.

All policies specific to transplant are current. With the next review, or as opportunity presents, there should be consideration of whether all policies are required or if some might be converted to standard operating procedures (SOPs) or protocols.

Given recent changes with program personnel and with the continual growth of the program, the team is encouraged to monitor activities such as documentation, data capture and upkeep of the SOPs as these are critical to sustaining the quality of the service. As necessary, both organizational and ORN processes need to be used for decision-making about the need for realignment of resources and sustainability and continued growth of the program.

Priority Process: Competency

The St. Joseph's Healthcare Hamilton (SJHH) team undertakes a thoughtful review of the provincial and national standards for organ transplant, and customizes standard operating procedures as appropriate to the setting. Tools such as algorithms and checklists guide consistency with the management of the wait-list for transplant, as well as with pre and post transplant care.

Experts and educational resources are available to support integration of new staff members and to support regular training and updates.

There has been an informal and voluntary process put in place with the London Health Science Centre (LHSC) whereby the LHSC team comes to audit the policies and process at SJHH for pre and post transplant care, and with living donor processes. In turn, the SJHH goes to LHSC for the same purpose. This arrangement builds a strong network with program counterparts and creates the opportunity for knowledge exchange and continuous improvement.

The fact that the organization has a performance that can support a transplant fellowship program speaks to the calibre of the team as well as the resources and processes that have been put in place.

Priority Process: Decision Support

A comprehensive patient history and clinical profile is gathered, recorded and readily available on an ongoing basis to be used by the inter-professional team. This team works closely with the patient to support consideration of all options with renal care or with decision-making regarding renal transplantation.

Transplant guidelines and protocols are evidence-based and their content is informed and influenced by provincial and national bodies. It is noteworthy that the St. Joseph's Healthcare Hamilton (SJHH) team has been instrumental in sharing leading practices that have been adopted at a national level.

The reporting on organization-specific performance is enabled with data capture and validation in the organization, and reporting to the Ontario Renal Network (ORN). This sharing of information is considered key to benchmarking and with performance management. With a spirit of transparency and continuous improvement, the team monitors and shares their performance/trending along with that of peer comparators, and explores ways to improve processes and/or outcomes. In addition to renal-specific metrics, the team also focuses on quality and performance measures that are aligned to corporate priorities such for hand hygiene, patient satisfaction and operational efficiencies, among others.

Priority Process: Impact on Outcomes

The team is clear about the importance placed on the care and safety of patients in the renal program and as such has been able to deliver on operational efficiencies and budget imperatives without any compromise to quality. The team appreciates that there is opportunity to become more vocal about the accomplishments of the program, including the contribution of leaders to practice and policy at a provincial and national levels.

There is value placed on the standardization of processes using provincial and national standards, particularly as a means of ensuring greater predictability and consistency with planning care and monitoring quality and outcomes, and performance is comparable to leading renal programs.

The team collaborates in conducting a regular review, typically on a quarterly basis, with the Ontario Renal Network (ORN) leadership team, with a focus on performance relative to ORN transplant targets.

The team seeks out and is responsive to patient feedback. Based on recent patient feedback, changes were designed with patient input, and have resulted in improved hand hygiene upon entering the clinic room, and also to an improved model of patient flow with the patient, nurse and physician meeting and collaborating at the beginning and end of every visit.

With infrastructure, protocols and processes in place, the team appropriately focuses on quality planning and monitoring. A robust set of metrics have been developed for fiscal 2015/16, covering the pre-transplant, transplant and post transplant phases of kidney transplant. For each phase there is data source, methodology, target, reporting frequency and accountability for review and action. This continuous improvement mindset is encouraged and should be supported as it will enable the team's commitment to improving quality and safety of patients and excellence in the program.

All observed interactions between the team members and the patients during the survey affirm that strong, respectful and caring relationships have been fostered. Patient feedback is highly complimentary of the team and the focus on care, quality and patient experience. Based on patient feedback for ways to further improve their experience, the team and organization might explore opportunities to make improvements with laboratory services.

3.2.14 Standards Set: Organ Donation Standards for Living Donors

Unmet Criteria	High Priority Criteria
Priority Process: Organ Donation (Living)	
The organization has met all criteria for this priority process.	
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	
Surveyor comments on the priority process(es)	
Priority Process: Organ Donation (Living)	
There is strong leadership presence, collaboration with stakeholders and commitment to the use of processes that support living organ donation. Policies and standard operating procedures are informed by provincial and national guidelines.	
Priority Process: Clinical Leadership	
St. Joseph's Healthcare Hamilton (SJHH) and the renal program have demonstrated great commitment and leadership by putting in place the infrastructure and processes necessary to support a living donation program and a renal transplantation program. In the past three years there has been expansion of awareness and support for organ donation and retrieval across the Charlton site campus, as well as growth in the number of living donations and kidney transplants, both cadaveric and living donor. This speaks to the vision of becoming a centre of excellence and the dedication of time, energy and resources to achieve that goal. The organization and specifically, the regional program is an active member of the Ontario Renal Network (ORN), and partners with the Trillium Gift of Life Network (TGLN) to have organ donation and renal transplant policies and protocols in place and that are congruent with Ontario and Canadian standards. Leaders of the renal program, both medical and operational are active representatives on provincial and national bodies that establish care guidelines and professional practices.	

The leadership team is highly collaborative and cohesive. Team members proactively engage with key stakeholders at SJHH from services such as critical care, emergency and the operating room and work in conjunction with TGLN to ensure understanding of the pertinent roles, responsibilities and protocols in order to respond to all opportunities for organ donation, and for renal transplant. Similarly within the renal program, processes have been put in place to ensure readiness of potential recipients and living donors.

All policies specific to transplant are current. With the next review of all policies or as opportunity presents, there should be consideration of whether all policies are required or if some might be converted to standard operating procedures (SOPs) or protocols.

Given recent changes with program personnel, along with the continual growth of the program of between 5% and 10% per year, the team is encouraged to monitor activities such as documentation, data capture and upkeep of the SOPs as these are critical to sustaining the quality of the service. The team describes the challenge and mixed blessing of becoming a centre of excellence and resource to others when this calls upon the program's increasingly limited time, energy and resource. As necessary, organizational processes need to be used for decision making about realignment of resources and sustainability/growth of the program, and the ORN should be engaged in supporting a business case.

Priority Process: Competency

The St. Joseph's Healthcare Hamilton (SJHH) team undertakes a thoughtful review of the provincial and national standards for organ transplant, and customizes standard operating procedures as appropriate to the setting. Tools such as algorithms and checklists guide consistency with the management of the wait-list for transplant, as well as with pre and post transplant care.

There has been an informal and voluntary process put in place with the London Health Science Centre (LHSC) whereby the LHSC team comes to audit the policies and process at SJHH for pre and post transplant care, and with living donor processes. In turn, the SJHH goes to LHSC for the same purpose. This arrangement builds a strong network with program counterparts and creates the opportunity for knowledge exchange and continuous improvement.

The fact that the organization has a performance that can support a transplant fellowship program speaks to the calibre of the team as well as the resources and processes that have been put in place.

The team is broad and inter-professional in its makeup to ensure that every clinical, psychosocial and spiritual need of the patient can be considered and addressed. Experts and educational resources are available to support integration of new staff members and to support regular training and updates.

Priority Process: Decision Support

A comprehensive patient history and clinical profile is gathered, recorded and readily available for use by the inter-professional team. The team works closely with the patient to support consideration and decision-making regarding kidney donation.

Transplant guidelines and protocols are evidence-based and their content is informed and influenced by provincial and national bodies.

The reporting on organization-specific performance is enabled with data capture and validation in the organization, and reporting to the Ontario Renal Network (ORN). This sharing of information is considered key to benchmarking and with performance management. With a spirit of transparency and continuous

improvement, the team monitors and shares their performance/trending along with that of peer comparators, and explores ways to improve processes and/or outcomes. In addition to renal-specific metrics, the team also focuses on quality and performance measures that are aligned to corporate priorities such for hand hygiene, patient satisfaction and operational efficiencies, among others.

Priority Process: Impact on Outcomes

There is value placed on the standardization of processes using provincial and national standards, particularly as a means of guiding counselling and decision making; ensuring greater predictability and consistency in planning care and monitoring quality and outcomes.

The feedback received during the on-site tracer from a patient that as the recipient of a kidney from a family member was highly complimentary of the approach taken by the team to support the different and unique needs of both individuals. There was good appreciation for the complexity of the process and gratitude expressed on behalf the family.

3.2.15 Standards Set: Point-of-Care Testing

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
Staff members were observed to use good technique that met these standards when using Point-of-Care Testing.

3.2.16 Standards Set: Rehabilitation Services

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 program's focus is medical and respiratory rehabilitation. There is a shared blended service model with a physiatrist, internist and nurse practitioner. The goals and objectives align with those of the organization. A strong interdisciplinary team provides care to the patient. Length of stay (LOS) for the program has decreased to less than 23 days and less in some instances, which is less than peer hospitals.

Priority Process: Competency

A review of the skill mix on the unit has taken place and changes have been implemented. This has been done to align with other rehabilitation units in the province.

Priority Process: Episode of Care

There is a standardized assessment for all patients and it is carried out by the nurse clinician. Nurses have their own assessment requirements that are also completed on admission. Hip fracture patients are pulled to the unit once medically stable rather than having to undergo an assessment/referral process. This allows patients to be on the unit in a timelier manner. Respiratory patients have a fixed length of stay of six weeks. The team is part of a patient engagement project (PEP) with the Canadian Foundation for Healthcare Improvement (CFHI) where the teach-back method is being used for falls, medications and discharge planning. This project is helping staff members' understanding, via patient advisors, of how to prepare patients for discharge.

Priority Process: Decision Support

No specific comments are identified. Please refer to other report sections for comments about Rehabilitation Services.

Priority Process: Impact on Outcomes

During the survey the nurse practitioner role was spoken of as a positive addition to the unit. This role has helped to improve the quality of service by implementing a standardized assessment and has worked to coordinate planning. Patients have spoken positively about having better information about their discharge planning.

The interdisciplinary quality council reviews key indicators to determine if goals and objectives are being met. The team holds safety briefings on a regular basis. This provides the opportunity to review adverse events, hand-hygiene audits and other data key to their performance.

Patient satisfaction results are also reviewed and communicated.

3.2.17 Standards Set: Transfusion Services

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

Surveyor comments on the priority process(es)
Priority Process: Transfusion Services
The team in the blood bank continues to enhance the safety and accuracy of its services. The use of bar code technology reduces the likelihood of dispensing blood products to the wrong patient. The acquisition of a new blood dispensing cabinet (HemoSafe) will greatly decrease the time for operating room staff to obtain blood.

3.2.18 Priority Process: Surgical Procedures

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Since the previous survey the surgical program has moved into a new expanded building. This has significantly improved patient flow, patient satisfaction and privacy. The King Street Campus site is also a newer facility.

Many types of surgical procedures are performed, and these are spread over two campuses. The program has elected to maintain excellence in several disciplines, and is a leader in orthopedic, bariatric, renal transplant surgery and ophthalmology procedures. The program also is a pioneer in Robotic surgery.

There is a comprehensive educational and assessment program in place, encompassing all aspects of care from admission to discharge. This involves the multidisciplinary team. Patients interviewed during the survey are pleased with the processes in place and were well informed.

The surgical program has a strong commitment to quality and patient safety. The quality council has developed a strong action plan with goals and initiatives. There are several matrixes which are followed and include median length of stay, rate of readmission, first case starts, cancellation rate among other things.

Being an academic centre students and medical personnel in various stages of training are present and involved in the care of patients.

Pre-operative antibiotics are administered prior to skin incision. All documentation from admission to day surgery to operating room to post-anesthetic recovery is now done electronically. The surgical area will soon be coming on line. Patient care paths and standardized order sets have been developed and utilized to encompass best practice.

Staff members receive ongoing training in the use of surgical equipment and pumps. Educational sessions and huddles occur regularly. All new staff members undergo a comprehensive orientation to the unit. Nurses rotate in all the areas to maintain competency. Many are assigned to areas where they are leaders and experts.

Flash sterilization has been eliminated in the OR at both campus sites.

Medication reconciliation is a priority in all patients and is done with the help of the patient, family, nursing staff and a pharmacy technician.

Noted strengths are: strong commitment to patient quality and safety; patient flow and transfer of accountability (TOA), and the integrated comprehensive care project. Noted areas for improvement are: performance evaluations and anesthetic narcotic reconciliation.

Section 4 Instrument Results

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

4.1 Governance Functioning Tool

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

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

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

- **Data collection period: March 1, 2014 to December 30, 2014**
- **Number of responses: 7**

Governance Functioning Tool Results

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1 We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations.	0	0	100	93
2 Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	0	0	100	95
3 We have sub-committees that have clearly-defined roles and responsibilities.	0	0	100	97
4 Our roles and responsibilities are clearly identified and distinguished from those delegated to the CEO and/or senior management. We do not become overly involved in management issues.	0	0	100	95
5 We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decisionmaking.	0	0	100	92

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
6 Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	14	86	95
7 Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	98
8 Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	0	0	100	96
9 Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	0	0	100	94
10 Our governance processes make sure that everyone participates in decision-making.	0	0	100	94
11 Individual members are actively involved in policy-making and strategic planning.	0	14	86	89
12 The composition of our governing body contributes to high governance and leadership performance.	0	14	86	93
13 Our governing body’s dynamics enable group dialogue and discussion. Individual members ask for and listen to one another’s ideas and input.	0	0	100	96
14 Our ongoing education and professional development is encouraged.	0	0	100	88
15 Working relationships among individual members and committees are positive.	0	0	100	97
16 We have a process to set bylaws and corporate policies.	0	0	100	95
17 Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	97
18 We formally evaluate our own performance on a regular basis.	14	0	86	82
19 We benchmark our performance against other similar organizations and/or national standards.	14	43	43	72
20 Contributions of individual members are reviewed regularly.	0	71	29	64

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
21 As a team, we regularly review how we function together and how our governance processes could be improved.	0	43	57	81
22 There is a process for improving individual effectiveness when non-performance is an issue.	0	43	57	64
23 We regularly identify areas for improvement and engage in our own quality improvement activities.	0	29	71	80
24 As a governing body, we annually release a formal statement of our achievements that is shared with the organization's staff as well as external partners and the community.	29	57	14	84
25 As individual members, we receive adequate feedback about our contribution to the governing body.	0	71	29	69
26 Our chair has clear roles and responsibilities and runs the governing body effectively.	0	0	100	96
27 We receive ongoing education on how to interpret information on quality and patient safety performance.	0	29	71	84
28 As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	95
29 As a governing body, we hear stories about clients that experienced harm during care.	0	0	100	85
30 The performance measures we track as a governing body give us a good understanding of organizational performance.	0	14	86	92
31 We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	0	14	86	87
32 We have explicit criteria to recruit and select new members.	0	43	57	84
33 Our renewal cycle is appropriately managed to ensure continuity on the governing body.	0	0	100	90

		% Disagree	% Neutral	% Agree	%Agree * Canadian Average
		Organization	Organization	Organization	
34	The composition of our governing body allows us to meet stakeholder and community needs.	0	29	71	94
35	Clear written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	94
36	We review our own structure, including size and subcommittee structure.	0	0	100	89
37	We have a process to elect or appoint our chair.	0	0	100	95

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

4.2 Canadian Patient Safety Culture Survey Tool

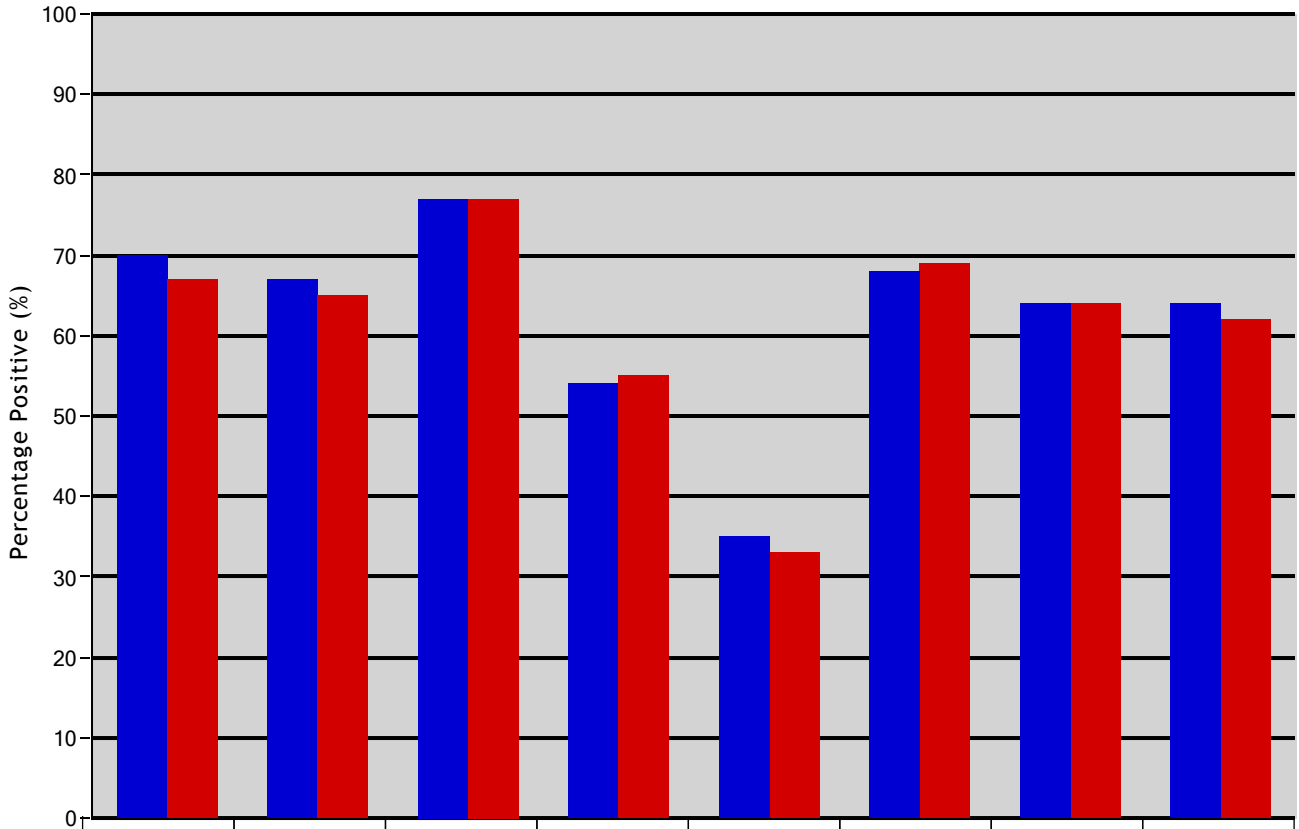
Organizational culture is widely recognized as a significant driver in changing behavior and expectations in order to increase safety within organizations. A key step in this process is the ability to measure the presence and degree of safety culture. This is why Accreditation Canada provides organizations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

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

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

- **Data collection period: June 1, 2014 to July 22, 2014**
- **Minimum responses rate (based on the number of eligible employees): 339**
- **Number of responses: 2447**

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%	67%	77%	54%	35%	68%	64%	64%
	67%	65%	77%	55%	33%	69%	64%	62%

Legend

St. Joseph's Healthcare Hamilton

* Canadian Average

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

4.3 Worklife Pulse

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

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

The organization used an approved substitute tool for measuring the quality of worklife but did not provide Accreditation Canada with results.

4.4 Client Experience Tool

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

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

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

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

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

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

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

Client Experience Program Requirement	
Conducted a client experience survey using a survey tool and approach that meets accreditation program requirements	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. The organization provides Accreditation Canada with evidence of the actions it has taken to address these required follow ups.

Evidence Review and Ongoing Improvement

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

Appendix B Priority Processes

Priority processes associated with system-wide standards

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

Priority processes associated with population-specific standards

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

Priority processes associated with service excellence standards

Priority Process	Description
Blood Services	Handling blood and blood components safely, including donor selection, blood collection, and transfusions
Clinical Leadership	Providing leadership and overall goals and direction to the team of people providing services.
Competency	Developing a skilled, knowledgeable, interdisciplinary team that can manage and deliver effective programs and services
Decision Support	Using information, research, data, and technology to support management and clinical decision making
Diagnostic Services: Imaging	Ensuring the availability of diagnostic imaging services to assist medical professionals in diagnosing and monitoring health conditions
Diagnostic Services: Laboratory	Ensuring the availability of laboratory services to assist medical professionals in diagnosing and monitoring health conditions
Episode of Care	Providing clients with coordinated services from their first encounter with a health care provider through their last contact related to their health issue
Impact on Outcomes	Identifying and monitoring process and outcome measures to evaluate and improve service quality and client outcomes
Infection Prevention and Control	Implementing measures to prevent and reduce the acquisition and transmission of infection among staff, service providers, clients, and families
Medication Management	Using interdisciplinary teams to manage the provision of medication to clients
Organ and Tissue Donation	Providing organ donation services for deceased donors and their families, including identifying potential donors, approaching families, and recovering organs
Organ and Tissue Transplant	Providing organ transplant services, from initial assessment of transplant candidates to providing follow-up care to recipients
Organ Donation (Living)	Providing organ donation services for living donors, including supporting potential donors to make informed decisions, conducting donor suitability testing, and carrying out donation procedures
Point-of-care Testing Services	Using non-laboratory tests delivered at the point of care to determine the presence of health problems

Priority Process	Description
Primary Care Clinical Encounter	Providing primary care in the clinical setting, including making primary care services accessible, completing the encounter, and coordinating services
Public Health	Maintaining and improving the health of the population by supporting and implementing policies and practices to prevent disease, and assess, protect, and promote health.
Surgical Procedures	Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge