ACCREDITATION CANADA

Driving Quality Health Services

Accreditation Report

North Bay Regional Health Centre

North Bay, ON

On-site survey dates: November 29, 2015 - December 4, 2015

Report issued: February 1, 2016

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

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

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

Confidentiality

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

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

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

A Message from Accreditation Canada's President and CEO

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

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

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

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

We look forward to our continued partnership.

Sincerely,

Wendy Nicklin
President and Chief Executive Officer

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Section 1 Executive Summary

North Bay Regional Health Centre (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

North Bay Regional Health Centre's accreditation decision is:

Accredited with Commendation

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

1.2 About the On-site Survey

- **On-site survey dates: November 29, 2015 to December 4, 2015**

- **Locations**

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

  1 Emergency Medical Services
  2 Kirkwood Place
  3 NBRHC-Main SIte
  4 North Bay Detox and Substance Abuse Center
  5 Northeast Specialised Geriatric Service (NESGS)
  6 Regional Outreach
  7 Wordplay Jeux de mots

- **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 - Service Excellence Standards
  6 Organ and Tissue Donation Standards for Deceased Donors - Service Excellence Standards
  7 Critical Care - Service Excellence Standards
  8 Point-of-Care Testing - Service Excellence Standards
  9 Ambulatory Care Services - Service Excellence Standards
  10 Community Health Services - Service Excellence Standards
  11 Diagnostic Imaging Services - Service Excellence Standards
  12 Medicine Services - Service Excellence Standards
  13 Rehabilitation Services - Service Excellence Standards
  14 Substance Abuse and Problem Gambling Services - Service Excellence Standards

15 Emergency Medical Services - Service Excellence Standards
16 Community-Based Mental Health Services and Supports Standards - Service Excellence Standards
17 Ambulatory Systemic Cancer Therapy Services - Service Excellence Standards
18 Obstetrics Services - Service Excellence Standards
19 Mental Health Services - Service Excellence Standards
20 Transfusion Services - Service Excellence Standards
21 Biomedical Laboratory Services - Service Excellence Standards
22 Perioperative Services and Invasive Procedures Standards - Service Excellence Standards
23 Emergency Department - Service Excellence Standards

- **Instruments**

  The organization administered:

  1 Governance Functioning Tool
  2 Canadian Patient Safety Culture Survey Tool: Community Based Version
  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)	100	1	0	101
 Accessibility (Give me timely and equitable services)	120	1	1	122
 Safety (Keep me safe)	749	22	21	792
 Worklife (Take care of those who take care of me)	199	3	1	203
 Client-centred Services (Partner with me and my family in our care)	288	3	1	292
 Continuity of Services (Coordinate my care across the continuum)	98	1	2	101
 Appropriateness (Do the right thing to achieve the best results)	1217	22	12	1251
 Efficiency (Make the best use of resources)	88	0	0	88
Total	**2859**	**53**	**38**	**2950**

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	78 (91.8%)	7 (8.2%)	0	121 (92.4%)	10 (7.6%)	0
Infection Prevention and Control Standards	34 (85.0%)	6 (15.0%)	1	27 (87.1%)	4 (12.9%)	0	61 (85.9%)	10 (14.1%)	1
Medication Management Standards	71 (97.3%)	2 (2.7%)	5	61 (98.4%)	1 (1.6%)	2	132 (97.8%)	3 (2.2%)	7
Ambulatory Care Services	38 (95.0%)	2 (5.0%)	2	77 (100.0%)	0 (0.0%)	0	115 (98.3%)	2 (1.7%)	2
Ambulatory Systemic Cancer Therapy Services	49 (100.0%)	0 (0.0%)	1	98 (99.0%)	1 (1.0%)	0	147 (99.3%)	1 (0.7%)	1
Biomedical Laboratory Services **	70 (100.0%)	0 (0.0%)	1	103 (100.0%)	0 (0.0%)	0	173 (100.0%)	0 (0.0%)	1
Community Health Services	17 (100.0%)	0 (0.0%)	0	56 (100.0%)	0 (0.0%)	0	73 (100.0%)	0 (0.0%)	0

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Community-Based Mental Health Services and Supports Standards	22 (100.0%)	0 (0.0%)	0	112 (99.1%)	1 (0.9%)	0	134 (99.3%)	1 (0.7%)	0
Critical Care	34 (100.0%)	0 (0.0%)	0	93 (97.9%)	2 (2.1%)	0	127 (98.4%)	2 (1.6%)	0
Diagnostic Imaging Services	63 (94.0%)	4 (6.0%)	0	67 (98.5%)	1 (1.5%)	0	130 (96.3%)	5 (3.7%)	0
Emergency Department	47 (100.0%)	0 (0.0%)	0	80 (100.0%)	0 (0.0%)	0	127 (100.0%)	0 (0.0%)	0
Emergency Medical Services	47 (97.9%)	1 (2.1%)	1	110 (99.1%)	1 (0.9%)	0	157 (98.7%)	2 (1.3%)	1
Medicine Services	31 (100.0%)	0 (0.0%)	0	69 (97.2%)	2 (2.8%)	0	100 (98.0%)	2 (2.0%)	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	62 (100.0%)	0 (0.0%)	2	79 (98.8%)	1 (1.3%)	0	141 (99.3%)	1 (0.7%)	2
Organ and Tissue Donation Standards for Deceased Donors	38 (100.0%)	0 (0.0%)	1	79 (100.0%)	0 (0.0%)	1	117 (100.0%)	0 (0.0%)	2
Perioperative Services and Invasive Procedures Standards	99 (100.0%)	0 (0.0%)	1	86 (97.7%)	2 (2.3%)	0	185 (98.9%)	2 (1.1%)	1
Point-of-Care Testing **	35 (100.0%)	0 (0.0%)	3	47 (100.0%)	0 (0.0%)	1	82 (100.0%)	0 (0.0%)	4
Rehabilitation Services	30 (100.0%)	0 (0.0%)	1	67 (95.7%)	3 (4.3%)	0	97 (97.0%)	3 (3.0%)	1
Reprocessing and Sterilization of Reusable Medical Devices	49 (96.1%)	2 (3.9%)	2	60 (98.4%)	1 (1.6%)	2	109 (97.3%)	3 (2.7%)	4

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Substance Abuse and Problem Gambling Services	27 (96.4%)	1 (3.6%)	3	72 (100.0%)	0 (0.0%)	1	99 (99.0%)	1 (1.0%)	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	**1054 (98.0%)**	21 (2.0%)	29	1707 (98.4%)	27 (1.6%)	8	2761 (98.3%)	48 (1.7%)	37

* 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 (Ambulatory Systemic Cancer Therapy Services)	Met	2 of 2	0 of 0
Client and Family Role in Safety (Community-Based Mental Health Services and Supports Standards)	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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
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
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
Client and Family Role in Safety (Substance Abuse and Problem Gambling Services)	Met	2 of 2	0 of 0
Information Transfer (Ambulatory Care Services)	Met	2 of 2	0 of 0
Information Transfer (Ambulatory Systemic Cancer Therapy Services)	Met	2 of 2	0 of 0
Information Transfer (Community-Based Mental Health Services and Supports Standards)	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 (Emergency Medical Services)	Met	2 of 2	0 of 0
Information Transfer (Medicine Services)	Met	2 of 2	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
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
Information Transfer (Substance Abuse and Problem Gambling Services)	Met	2 of 2	0 of 0
Medication reconciliation as a strategic priority (Leadership)	Met	4 of 4	2 of 2
Medication reconciliation at care transitions (Ambulatory Care Services)	Met	7 of 7	0 of 0
Medication reconciliation at care transitions (Ambulatory Systemic Cancer Therapy Services)	Met	7 of 7	0 of 0
Medication reconciliation at care transitions (Community-Based Mental Health Services and Supports Standards)	Met	4 of 4	1 of 1
Medication reconciliation at care transitions (Critical Care)	Unmet	3 of 5	0 of 0
Medication reconciliation at care transitions (Emergency Department)	Met	5 of 5	0 of 0

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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
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 (Emergency Medical Services)	Met	5 of 5	3 of 3
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 (Ambulatory Systemic Cancer Therapy 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 (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 (Emergency Medical Services)	Met	3 of 3	0 of 0
Narcotics Safety (Medication Management Standards)	Met	3 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Client Flow (Leadership)	Met	7 of 7	1 of 1
Client Safety Plan (Leadership)	Met	2 of 2	2 of 2
Client Safety: Education and Training (Leadership)	Met	1 of 1	0 of 0
Preventive Maintenance Program (Leadership)	Met	3 of 3	1 of 1
Workplace Violence Prevention (Leadership)	Met	5 of 5	3 of 3
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Compliance (Emergency Medical Services)	Unmet	1 of 1	1 of 2
Hand-Hygiene Compliance (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Hand-Hygiene Education and Training (Emergency Medical Services)	Met	1 of 1	0 of 0
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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Infection Control			
Reprocessing (Emergency Medical Services)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Ambulatory Care Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Ambulatory Systemic Cancer Therapy Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Diagnostic Imaging Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Emergency Department)	Met	3 of 3	2 of 2
Falls Prevention Strategy (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
Pressure Ulcer Prevention (Critical Care)	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

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

1.6 Summary of Surveyor Team Observations

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

The organization, North Bay Regional Health Centre (NBRHC) is commended on preparing for and participating in the Qmentum survey program. In 2011 the NBRHC opened as an acute care site, providing care services to North Bay and its surrounding communities. It is also the district referral centre providing specialist services for smaller communities in the area. The NBRHC is the result of a merger of the former North Bay General and the North Bay Psychiatric hospitals thus the organization is also the specialized mental health service provider serving all of north eastern Ontario. The mission of the NBRHC is to partner in care, and restore and maintain health for mind and body. The values of the NBRHC are to Care with Courage: Compassion; Accountability; Respect and Excellence.

In addition, NBRHC is a major teaching centre for students in medicine, psychiatry, nursing and allied health professions. The NBRHC is proud to be affiliated with the Northern Ontario School of Medicine (NOSM), Nipissing University, Canadore College and several other Ontario colleges and universities. The student and volunteer program was highly visible during the survey visit. A commitment to building capacity of the future providers and leaders in the healthcare system was evidenced in many departments at the NBRHC.

Overall strengths noted on this survey visit include the role of the Board of Directors in setting in partnership with the chief executive officer (CEO) and senior leadership team the new strategic direction for the NBRHC, with a more time to care vision statement and program role out that evolves from the organizational vision of: Leading Care, Improving Health, Enriching Communities. The journey of performance management and continuous improvement towards excellence was introduced as the: More Time to Care strategy for 2013/14, along with a unique focus on using language for this journey which has meaning to staff.

The NBRHC is a beautiful patient-centred designed organization with lots of natural light for healing. This focus on continuous improvement to the patient experience has resulted in new programs. These programs include: "NOD" (Name, Occupation, Duty) and "It's Safe To Ask". Patients are provided with educational materials regarding their role in safety, their rights at NBRHC and resources to assist them in the community such as the "Do You Need Help at Home?" magnet.

The changes in leadership structure and accountabilities have also evolved during the past two years. There is a new medical leadership model that aligns medical directors to programs in partnership and involves them in continuous improvement work. This work includes keeping an eye on and achieving performance targets and reviewing metrics of their service and selves using a scorecard approach. Communication is open, transparent and when addressing important patient information staff members have adopted the situation, background, assessment, recommendation (SBAR) framework. Leaders have adopted a no-meeting time zone. In addition, and from the board down to point of care a Go, See, Learn philosophy has rolled out across the organization. The communication is transparent to the public and staff members and there is commitment to this approach.

There exists opportunity to continue to build capacity of staff members regarding the More Time to Care journey, as variation of its adoption was noted across the organization in the first two years of its adoption. Leaders are role modelling this approach and by being present and visible the adoption or buy-in will improve.

Members of the Board of Directors of the NBRHC bring a wealth of experience and knowledge to the new organization. They are committed to the vision, hold themselves and the staff accountable for the strategy and have a focus on quality, safety and review of metrics towards targets via the Quality and Finance and Resources committees of the board. The board has supported investment in innovation and building capacity by receiving

education on continuous improvement and participating in 'Go, See, Learn' and is embracing the More Time to Care journey. In addition, the board has committed to adopting and utilizing an ethical framework and making it available as a guide for decision making.

The NBRHC has developed good collaborative community partnerships, with the sharing of performance metrics with the Community Care Access Centre (CCAC) as a result of shared accountability. Community planning, with seasonal surge, in partnership with the Public Health Unit (PHU) and other providers is described as good, proactive and collaborative. During the survey partners described the organizational commitment to focus on families, children, mental health and addictions and community planning for transitions of care. The leaders and staff members of NBRHC are active partners, and always willing, flexible, adaptive and inclusive and provide individualized care for mental health and addictions patients. Collectively, the partners are seen as an involved and active partner, the voice of the community which is listened and heard. The community partners identified the organization as being progressive, innovative, not afraid of change and proactive. In addition, the leaders are open to feedback when provided. Partners described the board and leaders as role modelling the strategic priorities by action.

Opportunities that were identified include a need for the NBRHC to profile what it does more openly by sharing and promoting the good things that are happening regarding care delivery, quality and safety. There is also opportunity to have deeper consultation and integration with respect to varying community cultural needs, and traditional and western approaches to care especially with minority or marginalized communities. Partners described nine First Nations (FN) communities within a 20 minute drive from NBRHC. Future approaches to harmonization of traditional and modern medical practices are encouraged. In addition, partners expressed the desire for continuing support for community rehabilitation programs in partnership with mental health and addictions patients, providers, and others to enable supportive transitions to community from in-patient services and programs.

The NBRHC is in the process of rolling out its hospital improvement plan (HIP) to develop a sustainable system for the future. Currently in progress is: redesign of program delivery; models of care; moving from policy to standard work and performance monitoring. Noteworthy are the changes to the way care is delivered for mental health and addictions patients; care is evolving as moving away from institutionalization with a renewed focus on: "Hospital is not the Home" philosophy with partners. There has been shared success with four long-stay residents having transitioned out to the community with partners' support, and there are more supportive care plans in progress. In addition, the NBRHC has recently implemented an improved reporting system for all levels of incidents and feedback which is called: i-report. The system is user friendly and described as intuitive. The capabilities of trending and using the information proactively to plan and address safety and quality of care concerns are proving beneficial.

Staff members at the NBRHC are committed and work collaboratively in teams towards common goals and with a spirit of camaraderie noted in the culture. A strategic human resources (HR) plan to address retention, recognition, talent management, capacity building, succession planning and wellness is required. Encouragement is offered to continue the focus on staff education and development during times of change. It was observed that in some parts of the organization, staff members are energized by the continuous improvement culture. However, variation in this regard was noted across the sites. With the financial situation of NBRHC being the biggest risk at this time it is even more important to build on and sustain a quality culture with a high performing workforce. In addition, opportunity to formalize talent management and succession planning for staff members and leadership is encouraged. In the future and after the changes in the organization have been implemented, a focus on retention should be foremost considered. The re-prioritization of projects, with a select few metrics to ensure focus, is also suggested to ensure staff involvement and sense of ownership for continuous improvement.

Involvement of patients and families in a formal way via an advisory committee is on the horizon for the NBRHC. Creating a philosophy of bringing the 'voice of the patient' into all board committee and organizational meetings is one of the next steps. Community involvement, feedback and collaboration is already a focus, and this will build on the credibility of leaders in the organization which will be established by way of transparency, openness and listening.

The Kirkwood site in Sudbury is aged and poses challenges for meeting facility standards from both infection control and physical plant standards. It is suggested that a plan to address this in the future be developed.

The NBRHC is on an important journey to provide the best care possible in a sustainable system guided by their patients and community and led by courageous, committed people in partnership with others. All this is a testament to the commitment to its community and patients.

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.	· Rehabilitation Services 7.5 · Medicine Services 7.6 · Critical Care 7.7 · Obstetrics Services 9.6
Patient Safety Goal Area: Infection Control	
Hand-Hygiene Compliance The organization measures its compliance with accepted hand-hygiene practices.	· Emergency Medical Services 8.7

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 Board of Directors of the North Bay Regional Health Centre (NBRHC) has met all the governance criteria evaluated. Board members are fully engaged, knowledgeable about their roles and have lots of volunteer board experience amongst themselves. Some of these members had served on the hospital boards or on the Health Sciences North (HSN) board prior to the-merger. This is a skills-based board with a recruitment strategy of replacing members based on the gaps identified in the annual skills assessment. The board members are also representative of the many communities served by NBRHC and are fair in how they approach community care needs.

The operational review in 2012/13 provided the input for and informed the 2013- 2106 board strategic plan. From this, four strategic priorities have framed the guiding principles for the organization and all initiatives line up to these. They include: Access to the right care; Partnerships with purpose; Our people achieving their best, and Wise choices." The NBRHC is now rolling out the hospital improvement plan (HIP) projects. By way of all this, the board is fully accountable and holds the chief executive officer (CEO) and leadership accountable for following through and achieving expected performance targets. The board has adopted an ethics framework to guide the difficult decisions at all meetings. In addition, the board members were 'socialized' with the new framework by participating in real case scenarios.

The board embraces innovation and investing for future gains. This is evidenced by the support for the More Time to Care strategy, and visiting Thedacare, Wisconsin and participating in Go, See, Learns to best understand how it can support the organization in moving forward. The board reviews organizational performance using a scorecard format, and having quality of care and continuous improvement education sessions built into their meetings. The board posts information and meeting minutes on the board portal as an additional aid in communication.

Opportunities for the board to consider for improvements include formalizing the voice of the patient at board meetings via story telling and community member participation as former patients/family members. It was brought to the surveyor team's attention that this has been built into the CEO's performance objectives for the coming year. Encouragement is offered to continue to evolve the content of all board committee meetings to ensure that quality is a focus, at minimum 25% of the time, at each of these meetings. Also encouraged is to select a few key performance metrics per year that align with the strategic priorities, and ensure their success and sustainability before moving on to others.

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	
5.3 The organization's information about the community is maintained in a format that is up-to-date and easy to understand.	

Surveyor comments on the priority process(es)

The focus on careful planning for current and future opportunities is clearly evident in many ways. The operational review of 2012, followed by the strategic plan in 2013 and now, the current hospital improvement plan (HIP) ensure there are clear performance expectations and deliverables for all staff members, with alignment to the strategic priorities of: Access to the right care; Wise choices; and Our People achieving their best and Partnerships with purpose. The daily and weekly status sheets roll up to the monthly scorecard review where staff members and leaders have opportunity to debrief with their immediate supervisor on how they are doing along with action plans to address improvements. The 'strategy room' is the hub for leader performance monitoring. Factors that influence planning include the organizational values, patient survey experience feedback, and utilization data and benchmarking with other peer organizations.

Policies and procedures are readily available for staff members via the sharepoint intranet, and there is a reminder system in place for staff members to provide updates to the documents on a pre-determined basis. The organization is exploring moving towards standard work procedures versus policies and procedures.

A comprehensive approach to annual operational planning was described by all leaders. Managers are supported by finance analysts for completing their templates and this is the case with variance reporting as well.

There is much pride expressed in having brought the number of projects down from in excess of 600 to approximately 40, and now 22, with more work to be done towards setting focus. However, staff members did express fatigue in the number of initiatives and projects in progress.

There exists opportunity to have readily available for planning purposes, current information about community demographics, health status, and so on in an up-to-date, readily available format. Current information is available from variable sources. Integration and harmonization of culturally relevant practices for minority populations and First Nations and Francophone was expressed by community partners. This was not clearly evident in the organization at the time of the survey, and partners view this as an opportunity for the organization.

Current challenges for the organization as to length of stay (LOS) and opportunities to improve on conservable bed days require review consistent with the current medical model of care, to move the organization towards improvements in LOS that will decrease costs.

The organization is encouraged to partner with primary care to make available, options for lower acuity walk-ins specifically, Canadian Triage Acuity Scare 4/5's in the city. Dosing so would free-up the emergency department (ED) for higher acuity patients. This effort requires improved accountability from primary care in the community as currently, there are 12,000 orphaned patients in the community at large, despite the number of physicians practicing in the area. It was noted during interviews that this will be changing in 2016, with the recruitment of three additional family physicians to the North Bay area.

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 North Bay Regional Health Centre (NBRHC) is a 389-bed acute care site with a 2100 staff complement, and a 218M budget. An operational review has identified a number of opportunities for the organization to balance the budget, decrease costs to have cash available for capital and innovation, and ways to sustain the system into the future. The objective of the plan implemented in late 2012 is to remove 35M annually, with a focus on quality, value for the patient and continuous improvement to gain efficiencies. As a result, and in two years, the number of NBRHC) beds has gone from 397 to 359. Recently, the organization provided staff lay-off notices as a measure towards balancing the 2015/16 budget. Despite these challenges, the commitment to quality of care and not compromising on this was clearly evident in all discussions with the surveyor team. The NBRHC leaders are commended for addressing the challenges they are facing with respect for staffing and preservation of quality of care.

There is focus on financial management and performance by all levels of leadership in the organization. Monthly variance reporting is an expectation, with action plans to address performance and achievements towards metrics and the hospital improvement plan (HIP). There is a request for proposal (RFP) in progress for a new auditor to be in place for 2016/17. The financial policies and controls are clear and adequate.

Leaders are supported with an innovative approach to training sessions called Simplexity which is a creative problem-solving methodology designed to drive creativity in improvement work.

There is a desire amongst staff members and leaders to move beyond addressing pressures and into sustaining a proactive versus reactive mode. During the survey leaders expressed looking forward to reaching a point of 'pay-off' as this will be a relief for all in the organization. High interest rates, the increasing workplace pressures resulting in higher over time and sick time compared to peers and length of stay (LOS) are current pressures.

It is recommended that organizational leaders continue to prioritize projects and strike off the list those that are working well and sustained. A common theme expressed during the survey from both leaders and staff members was that "everything is important" and is a philosophy prevalent at NBRHC. They would like to see a focus on a select-few metrics, work to sustain improvements and then move on.

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		
2.11	The organization's leaders develop a confidential process for staff, service providers, and volunteers to bring forward complaints, concerns, and grievances.	
10.4	The organization's leaders establish a talent management plan that includes strategies for developing leadership capacity and capabilities within the organization.	

Surveyor comments on the priority process(es)

There is excellent human resources (HR) leadership and commitment to staff. The HR strategies are in process of being aligned with the organization's strategic direction towards a longer term goal of becoming the Employer of Choice. During this time of transition and change with restructuring of North Bay Regional Health Centre (NBRHC) the HR team is focused on placement of staff members and providing support as the new organizational model evolves.

There is a continued focus on quality and patient safety and the investments towards the More Time to Care strategy. Some investments in building capacity of staff members by way of professional practice, clinical educational support at the point of care, Lean and staff development (WINGS program for leaders) were described as being available. Despite challenges in the workforce the leaders are committed to ensuring there is support for wellness offerings in the workplace via the Employee Family Assistance Program (EFAP). These include gym memberships and discounts, with discussions on working towards a wellness centre for staff. Labour relations staff members and the HR team have navigated in partnership during these difficult and emotional times to support the process and placements for staff.

The commitment to ensuring self-reflection and feedback on performance was also described during the on-site survey. Formal leaders now receive performance appraisals aligned with the LEADS framework on an annual basis. A performance appraisal is on file every two years for staff members, and this is an improvement since the previous survey in 2012.

Recently, a new incident reporting system called i-report was introduced, with capability for staff members to access 22 different reports using one system online. Staff members described this reporting system as user friendly and intuitive. The information and trending that this system will provide to enable more evidence-based decision-making is a benefit to the NBRHC.

With fiscal challenges and the need for NBRHC to decrease costs there will be a number of staff affected. Despite these changes being experienced currently, both staff members and leaders are commended for their team work, camaraderie and as described during the survey, their resilience and ongoing enthusiasm for the great care they provide.

The NBRHC has been fortunate to recruit into difficult to fill regulated health care positions in recent years. There are workload pressures experienced in some key specialty areas as there are vacancies in the organization and recruitment is 'on hold' with the process of redeployment of staff. This is causing pressure on staff. The HR team and leaders are aware of this and doing their best to navigate in a timely and supportive manner.

Physician recruitment and the credentialing process are organized and thorough. The need for family practitioners in the community will be addressed in early 2016, with the recruitment of three new providers for the community. The leadership development program for medical directors and chiefs includes education on continuous improvement, setting performance targets and measurement towards alignment with the strategic directions. Scorecards for physicians are provided to inform them individually of their performance and how they rate against their peers. The medical leaders also participated in a site visit to Thedacare, Wisconsin to better understand the More Time to Care strategy.

The volunteer program including the "Friends of NBRHC" association has evolved in recent years, moving away from a traditional volunteer structure to a more innovative and sustainable model. This model includes youth, a renewed focus on fundraising using a vendor program, nevada cards and other things and a recruitment drive to have 300 plus NBRHC volunteers available. The surveyor team noted lots of enthusiasm about the improvements to this program at NBRHC.

Opportunities for the HR team are to ensure there is a regular review process to update position profiles. While the NBRHC has capacity building programs, it lacks a formal development plan for leaders. However, the beginnings of this were evidenced with the new performance appraisals aligning to the LEADS framework, and developing objectives as such. A focus on this for retention purposes in the future is encouraged.

Insofar as workplace violence and a behaviour policy, there is a 'step 2' process identified to speak to the manager about a concern or if the concern is about the manager; the next step is to take this to the next most responsible member of management. This process requires review in context with maintaining confidentiality. It is recommended that the complaint be made directly to HR in a confidential manner after which a determination of the appropriate person(s) for the review will occur. In addition, in some areas it was noted that staff members were not well-informed of the policy/program when addressed therefore, it is recommended that more effort be considered to 'socialize' the workplace support offered by NBRHC.

Consideration for building up the wellness program for staff members and ensuring there is a focus on monitoring fatigue is encouraged. Also encouraged is ongoing support for recognition of continuous improvement, service and commitment. The Golden Heart Awards and long-term service awards are appreciated by staff members and viewed as a commitment by leadership of recognition.

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		
12.2	The organization's leaders implement an integrated risk management approach to mitigate and manage risk.	!
12.3	As part of the integrated risk management approach, the organization's leaders develop contingency plans.	!
12.4	The organization's leaders disseminate the risk management approach and contingency plans throughout the organization.	!
12.5	The organization's leaders evaluate the effectiveness of the integrated risk management approach and make improvements as necessary.	
12.7	As part of the integrated risk management approach, the organization's leaders evaluate the quality of contracted services.	

Surveyor comments on the priority process(es)

The organization is commended on its intense level of work and collaboration on the More Time to Care quality initiative. In a climate of multiple competing priorities this has been a process which has gained wide support from the front line to the board level. The Value Leads recognized the intensity of their on-boarding and the reward and insight they gained from working with senior leadership and front line staff. Many were pleasantly surprised by the level of engagement at the front-line level and the flexibility of organization to redefine metrics to make them more effective for the front line, but still be aligned to the strategic plan.

There are regular reports provided to managers regarding incident reporting trends and there has been good feedback regarding the recent implementation of RL6 and the quick submission reporting tool. The most common types of incidents are falls, medication incidents and safety/security/conduct. There are numerous examples of data driving the improvement activities to improve care and reduce the risk of recurrence of adverse events. Specifically, good work has been done to reduce readmission rates via the emergency department (ED) in relative to congestive obstructive pulmonary disease (COPD). Although the organization has not met its identified benchmark to reduce readmission rates, it has been able to identify the need to take earlier action with these patients, with an additional benefit of reduced length of stay for COPD admissions. This is just one example of many of targeted improvement activities which were data driven from big-dot indicators down to departmental level development of indicators.

The good integrated risk management framework, currently in draft for the organization has yet to be fully implemented. Numerous good risk tools are used and have been included in the More Time to Care initiatives, as well as in some briefing notes and discussions at the senior leadership level. The organization would benefit from implementing a clear, integrated risk management approach that uses the 'taxonomy' in its framework as a device to clearly identify the top risks at the departmental, division and corporate levels.

This could then be reported to the board and across the organization in a way that clearly identifies the top risks facing the North Bay Regional Health Centre (NBRHC), rates these risks and establishes the priority for mitigating risks. When asked at different levels of the management team what they identify as the top risks facing the organization it was agreed that financial risk was the highest risk followed by the risk of not being able to sustain quality improvement initiatives from More Time to Care.

There exists an opportunity to formalize the corporate risk assessment process and develop clear mitigation strategies and monitor these for effectiveness. There was a conscious effort to implement the More Time to Care improvement and quality framework and work with risk-related tools at a higher level of management. Recently, Quality and Risk were divided in the organization and there is a good understanding between the two groups of the roles and responsibilities. There are a number of risk assessment tools which are used in different settings. Whilst it is good to have effective tools for the situation needing to be assessed, there is a risk of inconsistency in the follow-up, evaluation and rolling risk information up in the organization. The organization is encouraged to ensure there is a clear process for document management of the risk assessment process inclusive of a risk repository and tracking mechanism.

There is evidence of some prospective analysis using failure modes effects analysis (FMEA) occurring but the process has yet to be fully completed from the point of view of closing the loop to evaluate the effectiveness of the implementation of the mitigation strategy. This work also needs to ensure this is documented and that there is a document management process to ensure flagging occurs for further review or sharing of mitigation strategies across other programs.

Contingency plans have been developed in a number of areas relative to bed surge and emergency preparedness. The organization has commenced the Health Insurance Reciprocal of Canada (HIROC) risk assessment checklists (RAC) process, and is using Datix to gather information regarding risk. The organization is trying to align priorities for quality improvement initiatives based on strategic priorities and requirements as well as identified risks. This is commendable and the organization recognizes this is a work in process that will evolve in the next accreditation cycle.

During the on-site survey there was discussion regarding the sharing and analyzing of patient safety events and how system learning are shared or implemented. Examples were given of care events that were perceived as sub-optimal that went through a review process, which was presented organization wide. The organization has informal structures to share information across departments/divisions and there is a report-out process which can be attended by all. The organization is encouraged to further develop the process for sharing learning from incidents system wide. The process needs to include tracking recommendations and evaluating system-wide opportunities for improvement based on the analysis and learning gained from moderate to severe events in all service areas.

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)

There is evidence that ethics is embedded across the organization. There is an active ethics committee and there is an ethicist available by telephone and who visits the region approximately six times per year. The ethicist is additionally available by telephone or video link to advise on and guide ethics consults and respond to ethics issues between visits.

The committee responsible for the ethics review process for research follows a standardized process and all are 'TPCS 2' certified. At the board level there is good evidence that ethics is embedded into the decision-making process and board briefing notes and motions identify that these have been made in accordance with the organization's ethical framework.

The ethicist provides education and reports up to the board on ethics competency and capacity in the organization. A number of different examples of ethics issues were discussed during the survey visit. The organization is commended on the way it works with multidisciplinary providers and includes them in the ethics consult process.

During the site visits, the ethicist spends the majority of time reaching out to the unit and administrative staff and the board, providing education on both clinical and organizational ethics and conducting information case reviews. The committee reports that there has been a decrease in formal case consults, as a result of the informal case review and consult process. There is a report developed and distributed to senior leadership regarding both formal and informal consults and education sessions.

Despite the evidence of significant educational initiatives and training around the ethics framework, there remain pockets of the organization at the front line where staff members knew that there was someone they could contact relative to ethics but they were not familiar with the framework or how they could play an active role in the ethics process.

The organization is commended on the work already done in the area of principle-based decision making since the previous survey and is encouraged to continue spreading education on the use of the framework at all levels of the North Bay Regional Health Centre.

3.1.7 Priority Process: Communication

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Many forms of organizational communication were seen to be in place at the North Bay Regional Health Centre. A communications manager works closely with administration and the board to facilitate flow of information, and this includes a 'Board Matters' column on the intranet which is available for all staff and volunteers.

The communications manager is part of the Emergency Preparedness planning and is familiar with the communications role in the incident management system (IMS), even going so far as to prepare a guide for anyone fulfilling that role in an emergency.

Note is made of the volunteer involvement committee to enhance the role of volunteers.

Information services staff members are involved in regional networks for electronic planning, and are educating the department staff regarding future options with Meditech. However, a written information technology (IT) plan is not available rather, IT is seen only as an item of the work plan posted on the strategy room whiteboards. Similarly, a formal written communications plan is newly minted and has not been shared with staff.

An IT physician advisory committee has been formed to enhance physician participation in electronic documentation. Health records staff members are purging hard copy charts of redundant printed material which is now available electronically, for example, diagnostic imaging and laboratory test results. The next step, which is to systematically cease the printing of information that is available electronically, is seen as both a challenge and an opportunity. Access to electronic records of regional facilities still remains in the future, and eventually will present an opportunity to limit printing from the time of access implementation.

The daily audits of every access of health records by staff members is a by product of a breach of confidentiality several years ago, and which affected thousands of patients.

Most functions for communication provided at North Bay Regional Health Centre (NBRHC) are extended to the Kirkwood site in Sudbury. Discharged charts are not retained at the Sudbury site but are sent by secure transport to the NBRHC health records department. Thinned portions of active charts at the Kirkwood Place site are kept in a locked room, accessed only by two clerical personnel.

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)

A class F license is required for all Emergency Medical Services (EMS) vehicles, and annual training records for driving EMS vehicles are documented. Driving records are followed and checked annually, with documentation. Drivers are required to report any changes to their driving records, both at work and privately. There is a required reporting process for any incidents or collisions involving EMS vehicles.

There is a fleet management program in place, and preventive maintenance is performed and documented at frequent intervals depending on vehicle use. All portable and on-board communication devices are checked and maintained regularly.

The physical environment services at North Bay Regional Health Centre (NBRHC) and Kirkwood Place in Sudbury were visited. There is evidence of comprehensive programs in place at both facilities.

At the NBRHC, facilities maintenance which includes: building maintenance; heating, ventilating and air conditioning (HVAC); boilers; chillers; compressors; medical gases; pneumatic tube system and fire safety is on a 30-year, life-cycled contract with Brookfield. Facilities management is contracted to Health Sciences North at Kirkwood Place. There is a hazard and risk reporting and management system and well-developed escalation processes at both facilities. All equipment and major systems are put on a life cycle management process at the time of purchase.

The ministry infrastructure assessment (VFA) was done at the Kirkwood site and is soon due to be done at NBRHC. Deficiencies are categorized according to risk and submitted in a three-year capital plan. A number of major upgrades have been completed at the Kirkwood site, including elevator overhaul, window replacement and partial roof replacement. The exterior of the building has also been refinished.

Security systems and access controls exist at both sites. Security swipe cards are used to access the obstetrical/neonatal, paediatric, mental health, and medicine units at NBRHC and the dementia unit at Kirkwood. After hours entrance controls are in place.

Leadership at both sites is actively pursuing upgrades to improve efficiency and decrease the environmental footprint of the service. For example, the Kirkwood site manager is a member of Earth Care Sudbury and meeting with Sudbury Greater Utilities to identify opportunities. An external third party has done an energy audit and the team is working on the recommendations. Plans are underway to convert all lights to LED (Light Emitting Diodes) bulbs at Kirkwood, which will realize a significant cost savings. The NBRHC has partnered with New Brunswick Hydro and Ontario Hydro to establish a “Co-Generation Plant” which will provide an independent source of hydro for a prolonged period of time in the event of a major power loss.

Overall, the physical environment is well-managed with robust response and proactive risk management programs in place at both sites. The Kirkwood site will continue to require considerable infrastructure upgrades on account of the age of the building. This site does not have a sprinkler system, which is on the capital plan for 2018. The physical space in food services makes it very challenging to maintain good sanitation standards. There is evidence of below grade leaking in the boiler room.

3.1.9 Priority Process: Emergency Preparedness

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
14.8	The organization's leaders develop and implement an emergency communication plan.	
14.9	The organization's leaders develop and implement a business continuity plan to continue critical operations during and following a disaster or emergency.	

Surveyor comments on the priority process(es)

There is an emergency response plan in place and it is being updated at this time. A policy is in place for each of the codes but these will soon be eliminated and the codes will be incorporated in the main response plan to improve cohesion. Code committees are chaired by directors that oversee each code; any recommendation from these committees is presented to the vice president of corporate services.

Education about codes is conducted at initial orientation and staff members are also educated via e-learning modules.

Mock code exercises are held on a regular basis, observations are documented, and process is improved accordingly. Exercises are also held at Kirkwood Place in collaboration with the Health Science North group.

Internal outbreaks are under the supervision of the infection prevention and control (IPAC) program. Any biological threat is overseen by the chemical biological radioactive nuclear environment (CBRNE) group under the umbrella of code orange. The biological threat committee is co-chaired by the infection control manager and the manager of emergency planning.

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)

Extensive work is being done relative to patient flow at North Bay Regional Health Centre. Daily bed meetings are held and any bed pressures from the emergency department (ED) are discussed. The recent addition of nine patient flow navigators also helps to ensure discharges occur as soon as patients are ready. These navigators review patients seven days per week and reduce delays due to among other things, late referrals or test requests. They also review requests for repatriation and work to avoid some admissions. A consulting firm is arriving soon to review the patient flow process and to provide advice on further process improvements.

A joint project with the Red Cross (PATH program) also reduces risk of re-admission by providing assistance in the community for the first 24 to 48 hours after discharge. The program can provide transportation and home assessment, and perform patient assessments that can then be used by multiple agencies thus avoiding duplication. The program is based in the patient flow department thus, facilitating interdisciplinary communication.

Pre-planned surge periods in the ED during the summer months, and at Christmas time, help prevent last minute staffing issues and reduces pressure on the units. The opening of regular in-patient beds in the ED helps reduce wait time for admitted patients while providing safe care.

Physician engagement in patient flow is generally good but there are some areas where the change in practice poses challenges due to resistance from some clinicians.

Patient flow at Kirkwood Place is well done and strict admissions criteria help maintain the wait-list to a minimum. Repatriation agreements for admissions to the Oak unit help ensure length of stay does not extend beyond the 60-day evaluation period.

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.	!
8.7	All diagnostic imaging reprocessing areas are equipped with separate clean and decontamination work areas as well as separate clean storage, dedicated plumbing and drains, and proper air ventilation and humidity levels.	!
Standards Set: Reprocessing and Sterilization of Reusable Medical Devices		
3.6	The organization selects materials for the floors, walls, ceilings, fixtures, pipes, and work surfaces that limit contamination, promote ease of washing and decontamination, and will not shed particles or fibres.	
5.8	The team wears the appropriate and properly maintained personal protective equipment (PPE) in the decontamination area.	!
8.2	The team follows safe work practices and infection control precautions when handling contaminated devices and equipment.	!

Surveyor comments on the priority process(es)

The medical reprocessing area occupies adequate physical space, with ample room and light, which makes it a pleasant place to work. The staff morale is good, and they are very engaged in the running of the facility, and take part in regular feedback, largely by using "huddles". The staff members are aware of the goals of the department and its quality improvement projects, and are active participants. Sterilization of both the regular instruments and of the endoscopes is of the highest quality. Back-tracking of sterilization lots is simple and easily re produced.

There are no areas where the flow of un sterilized instruments crosses the flow of sterilized instruments.

3.2 Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Episode of Care - Ambulatory Systemic Cancer Therapy

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

Point-of-care Testing Services

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

Clinical Leadership

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

Competency

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

Episode of Care

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

Decision Support

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

Impact on Outcomes

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

Medication Management

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

Organ and Tissue Donation

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

Infection Prevention and Control

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

Surgical Procedures

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

Diagnostic Services: Imaging

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

Diagnostic Services: Laboratory

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

Transfusion Services

- Transfusion Services

3.2.1 Standards Set: Ambulatory Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
13.1	The team has a program for preventive maintenance of equipment consistent with manufacturers' recommendations.	!
13.3	The team retains preventive maintenance records for at least two years.	!
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

Multiple clinics were visited during the on-site survey of the Ambulatory Care priority process. This included the Ambulatory Care Unit (ACU), Orthopedic Unit, and the Renal and Kidney clinics, Stroke Prevention clinic and the Cardio/Respiratory clinic. Staff members that were met in all areas were enthusiastic and keen to profile their work and accomplishments. All the departments visited had spacious waiting rooms, space for private change facilities and accessible washrooms.

It was visually noted there is opportunity for '5S' of supplies and equipment; this was evidenced in the ACU (supplies) and the renal clinic (equipment).

Although a program for preventive maintenance is maintained in the bio-medical department, it is not shared with the department managers or directors that are accountable for patient safety in their respective areas. The program is not formalized and is dependent on vendor equipment maintenance agreements. During the priority process tracers there was consistent lack of awareness of proactive scheduled maintenance times, and there was no record kept for two years. It was observed that equipment was tagged.

Priority Process: Competency

There is an involved interdisciplinary team of providers in the ambulatory care unit (ACU) and various ambulatory clinics. All involved take pride in the services provided. Orientation to the clinics is comprehensive and some staff members are cross-trained to work in different areas. This was described as working in the ACU and the cardio/respirology clinics.

Ongoing professional development to maintain currency and competency in skills is provided. There has been staff turnover because of the bumping processes however, the competency and skill development of staff members in the clinics has been maintained and is comprehensive.

Priority Process: Episode of Care

Wait-list monitoring and continuous improvement projects to improve no-show rates in every clinic are metrics that many of the clinics are monitoring for improvements in order to gain efficiency and improve the patient experience.

In the ambulatory setting, a best possible medication history (BPMH) trial is in process for patients presenting for infusions, and it is going well. Based on the results of this trial and what worked well and lessons learned, there is opportunity to implement a plan to address this required organizational practice (ROP) in all ambulatory settings. In addition, there is a current BPMH at transitions of care for renal patients. Therefore, the organization meets the current expectation for medication reconciliation in the ambulatory clinics.

All of the ambulatory clinics visited during the on-site survey are lovely, private and accessible clinics. Way-finding improvements have been made for the renal clinics by way of following the 'kidney bean' floor stickers.

Priority Process: Decision Support

Although all criteria are met, opportunity exists to support an enterprise scheduling system to support patients that receive care in multiple areas, and to transition patients to the community and primary care. Currently, the processes and charts are paper based. Multiple different documentation tools and scheduling practices were evidenced during the survey and these vary between clinics and providers. Documentation can be in paper form (tracking) or by an electronic scheduling solution, implemented for individual clinics.

Priority Process: Impact on Outcomes

A successful project as a result of setting targets for improvement is noted in the Stroke clinic. The North Bay Regional Health Centre (NBRHC) stroke care metrics are noted to lag peer stroke programs in the province. As

a result of identifying areas of opportunities for improvement the resulting outcomes included new standard work practices, new care pathway and development of tools for patients and care providers. Improvement in referrals to the clinic, time to carotid dopplers and time to tissue plasminogen activator (TPA) are noted as successes.

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

Unmet Criteria	High Priority Criteria
Priority Process: Episode of Care - Ambulatory Systemic Cancer Therapy	
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	
3.2 Team members have position profiles that define their roles, responsibilities, and scope of practice.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	
Priority Process: Medication Management	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Episode of Care - Ambulatory Systemic Cancer Therapy

The assessment provided for every chemotherapy patient at the Ambulatory Care Systemic Cancer Therapy Services at North Bay Regional Health Centre includes the offer of psycho social support. Patients and staff members develop a trusting and respectful relationship. Although only curtains separate the chairs in the unit, patients indicated a preference to be able to see each other during their treatment, and were confident that if privacy was required, they would be able to use a side room for discussion.

As a satellite of Health Sciences North in Sudbury, the chemotherapy unit is able to access patient information from that site, and vice versa. This expedites transfer of care between the two facilities. Any new drug ordered is provided along with a large print hand-out for the patient. The hand-out information includes common side effects and what to do about them if they occur.

Priority Process: Clinical Leadership

Staff members at the Ambulatory Care Systemic Cancer Therapy suite at North Bay Regional Health Centre are working together to assign and adjust workload. Staff members indicate that the weekly huddle includes a celebration component to recognize staff.

Priority Process: Competency

During the survey the staff members that were encountered at the ambulatory cancer services unit at North Bay Regional Health Centre (NBRHC) were unable to easily locate position descriptions, either online or in hard copy. A search of the NBHRC intranet did not yield position descriptions for the registered nurse category. However, many education and training opportunities were identified by staff.

Priority Process: Decision Support

After completing an Institute for Safe Medication Practice (ISMP) self-assessment, the team recognized that the chemotherapy pumps had only soft limits, and not additional hard limits as recommended by ISMP. Prompt action has resulted in new pumps which are in the process of being programmed, training is being arranged and they will be implemented in the New Year.

Priority Process: Impact on Outcomes

The patient observed on the Ambulatory Care Systemic Cancer Services unit demonstrated familiarity with a two-identifier check by readily volunteering birth date at each checkpoint. The assessment provided by the nurse at every visit includes falls since last visit, as well as any changes in medications. The patient readily identified ways in which education was given on ways to stay safe during their treatment and at home.

Priority Process: Medication Management

At the North Bay Regional Health Centre, the preparation of out-patient chemotherapy is conducted in a well-designed set of rooms near the chemotherapy unit, equipped with appropriate ventilation and fume hood, and secure from intrusion by others during preparation. However, the fan in the room is quite loud and may prove distracting to technicians preparing medication.

Spill kits are included in the transport containers whenever chemotherapy agents are transported to other units for non-chemotherapy purposes for example, methotrexate for arthritis to an in-patient medical unit.

3.2.3 Standards Set: Biomedical Laboratory Services - Direct Service Provision

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

Surveyor comments on the priority process(es)
Priority Process: Diagnostic Services: Laboratory
Most of the laboratory standards are assessed by the Ontario Laboratory Association (OLA) and therefore, not reviewed during this visit. The laboratory just completed its mid-term self-evaluation for OLA and will be inspected by that body in 2017.

3.2.4 Standards Set: Community Health Services - Direct Service Provision

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

Progressive leadership for the Regional Geriatric Services of North Bay Regional Health Centre (NBRHC) is noted. This is located in Sudbury, and service is provided by a manager, an executive director, a project and research coordinator and a physician leader. A strategic plan was finalized in the summer of 2015 for the Regional Geriatric Services, after a staff retreat followed by a thorough on-site consultation with each community where geriatric services are being provided.

The diabetes education clinic of NBRHC is located in the community and uses a community collaborative committee which includes community pharmacy, family health team, optometrist and mental health representatives. This group identifies service gaps and duplications to aid in service planning. Referral is open to anyone that is in contact with the client, and self-referral is also accepted. Referrals are prioritized by the team and some appointments are kept open weekly for those with gestational diabetes, newly diagnosed Type I diabetes and recent hospitalizations. Nursing and medical students/residents are mentored in diabetes learning. Volunteers have reduced the no-show patients from 25% to 4% in the past few years by conducting appointment reminder calls.

The Wordplay Jeux de mots Preschool Speech and Language Services are a component of the Ontario Pre-school Speech and Language program initiative, which provides a full range of accessible speech/language services to pre-school children from birth to the time they start school in Sudbury, Manitoulin. Services are provided in English and French and are available at five clinics in the North East. Some services are also available in other community pre-school programs including day cares, nursery schools and 'Best Start' hubs.

The tracer was conducted at the clinic in Sudbury. The scope of services and funding model is aligned with the Ontario Speech and Language program. Operational planning and goals and objectives also align with NBRHC's strategic objectives. The clinic services include a speech and language program, regional hearing grogram, and blind-low vision early intervention program. The team collaborates with a broad range of partners including physicians, pediatricians, otolaryngologists, nurse practitioners, acute care hospitals and multiple community services and agencies. The clinic is situated in leased space on the fourth floor of an office tower. Contract facilities' personnel manage the building, including the environmental cleaning, which is done after normal business hours. The environment is clean, cheerful and organized. There is adequate space for case consultation and group therapy. The team is actively involved in public relations events and educational activities to raise awareness about the services and to provide health teaching. Students rotate in the clinic on a regular basis. There is one a volunteer attached to the service.

Priority Process: Competency

The drafting of Core Competencies for Regional Geriatric Services is a potential Leading Practice, for nurses to form the basis of orientation, education and evaluation of the specialized skills of the team members. This document will be finalized in spring 2016.

All Regional Geriatric Services staff members are sent for assessor training in Ottawa and orientation consists of 32 self-directed learning modules. Extensive orientation and training is provided with mentoring for a number of months.

The geriatric program supports the far flung outreach staff members with an annual conference involving recognized leaders in the field, as well as on-site specific training and in-service.

All nurses and dieticians at the diabetes education clinic are Canadian Diabetes Educator (CDE) certified. Several community pharmacists are also CDE certified. Diabetes education clinic staff members maintain their education by attending webinars, lunch and learn sessions, and an annual pediatric conference. Staff members new to the team receive their orientation from peers, along with a prepared package and ongoing check-in at six months and one year by the manager.

At Wordplay/Jeu de Mots the services are provided by a knowledgeable, enthusiastic team of professionals including seven speech pathologists, two communication disorders assistants, one infant hearing screener, two receptionists, an administrative assistant and manager.

During the on-site survey visit good interdisciplinary team communication was apparent, and the weekly team huddles have a designated lead. Topics include recognition of successes, new ideas for improvement, safety issues, and so on. A full-day monthly staff meeting is held to discuss open files, and discuss the metrics on the huddle board.

A staff orientation program and ongoing opportunities for training and education are provided. Performance appraisals are completed regularly. The administrative assistant is a worker member of the Joint Health and Safety committee. Monthly health and safety inspections are conducted in the clinic.

Priority Process: Episode of Care

Space for the growing Regional Geriatric Services is limited and has required creative thinking for instance, providing the “Frail to Fit” exercise program at a long-term care (LTC) home so that the space which was

used only occasionally can be converted to full-time alternative use. Other innovative thinking has allowed the sharing of space in the adjacent LTC home.

A case manager from Community Care Access Centre (CCAC) is located on site at the Regional Geriatric Services offices. This has been in place for the past six months, with reports of enhanced communication and learning for all staff concerned. A burgeoning project is to combine the home assessment visits of each service so that clients and their families are inconvenienced as little as possible.

Scarce geriatrician resources are augmented by the use of a nurse practitioner (NP), medical students from the Northern Ontario School of Medicine, and relationships with geriatricians in Southern Ontario. Plus, creative teamwork with the Family Health Team in New Liskeard has allowed geriatric services in the form of a trained assessor health care provider to be offered there, and a similar arrangement is being sought in Timmins.

At the diabetes education centre the weekly case conferences are combined with huddles to provide staff members with a forum for ethical discussions, as well as time to adjust care plans. The weekly huddle/case conference is a forum for quality improvement and problem solving. Everyday ethics issues are discussed at this meeting, although a few issues have required the involvement of senior administrators and the bio ethicist. The diabetes education clinic holds an education day for the community every two years and in 2014 this was attended by 150 people including Local Health Integrated Network (LHIN) representatives.

A peer support group is held at the clinic for all diabetes patients to share their experience and speak with the diabetes educators about issues which may be common. Outreach is provided to remote First Nations communities such as Bear Island, every three months. Outreach is also provided using a Facebook page for young people with diabetes. There is a secure type of Skype link for remote areas which allows for consultation without travel.

Patients that do not have a Primary Care provider often use a specific walk in clinic in town for their primary care, and the diabetes education clinic team has liaised with that clinic to create care plans for diabetes patients that are seen there frequently. The team's social worker sees most new patients to assist with social issues which may impact their disease and disease management. The hearing screener runs the regional audits on infant screens and education programs. Blind - no vision referrals are facilitated following assessment by an ophthalmologist. The Blind and Vision program is contracted to the Canadian National Institute for the Blind (CNIB) early child vision consultants.

At Wordplay/Jeu de Mots, speech and language referrals come from a broad range of disciplines and community agencies. Infant hearing screening records are submitted from the hospitals. Blind - low vision referrals come primarily from pediatricians. The intake process is highly organized, well-managed, and documented. There is a structured No-Show follow-up process which includes a series of follow-up telephone calls and reminder letters.

The legal guardian is informed verbally and in writing regarding the protection of privacy of health information. Consent is obtained and documented. The speech and languages services include parent education/training groups and intervention groups. There is a strong emphasis on self-management and health promotion.

The client files are complete and up to date. Speech language assessments are comprehensive. The Focus outcome measure is used to measure the child’s skills at designated intervals, and the data are used to track progress over time.

Priority Process: Decision Support

In spring 2015, the Regional Geriatric Services team implemented a web-based electronic record which will assist with ongoing planning and evaluation by providing specific data to assess and direct service planning. Information technology (IT) plays an important part in the provision of geriatric services and is an ongoing challenge for consistent access to internet service in many locations.

A comprehensive geriatric assessment process has been formalized in the electronic record, which allows client goals and objectives to be defined and monitored.

Documentation at the Diabetes Education Centre is paper based, but staff members do have access via Meditech to view records at the North Bay Regional Health Centre as well as test results. The IT plan is to move to an electronic record in the future. Paper records are archived at the hospital according to regulations.

At Wordplay/Jeu de Mots, the client files are maintained in paper format until closed, at which time they are scanned and retained electronically. The files are stored in filing cabinets in the reception area of the clinic. There are three electronic systems which support ministry reporting and the administrative functions. An opportunity for improvement would be that filing cabinets, which house the client files, need to be kept locked after business hours to protect the security of client information.

Priority Process: Impact on Outcomes

The Regional Geriatric Service is at the beginning of its formal quality journey however, input from clients is regularly sought by way of program evaluations and surveys. For instance, the Frail to Fit participants are asked to complete a survey before and after and at three and six months post completion of the exercise program. Feedback has been used to change the time of the activity among other things.

The newly formed project and research coordinator position will add value to the quality planning of the program. A workplan for the diabetes education clinic is submitted to the Local Health Integration Network (LHIN) and includes goals and objectives for the program. One recent initiative was the development of a foot screening package to assess risk for skin impairment. The organization's dialysis unit has created 'socks-off' day once per month to assess for circulation compromise. A dietician from the diabetes education clinic team is part of the Renal Nutrition Collaboration in Northern Ontario. The Community Care Access Centre (CCAC) has in the past made home visits to follow up on some of the team's patients. An endocrinologist supports the program and conducts joint appointments with the team for some clients.

At Wordplay/Jeu de Mots, program statistics are shared at the provincial directors' meetings. The team tracks a range of indicators including: wait times, overall patient/family experience and satisfaction at discharge, "FOCUS - Outcomes of Communication Under Six", percentage of babies' hearing screened in North East Ontario, and other things.

There is evidence the team is fully engaged in the quality improvement work. All team members can speak knowledgeably to the indicators on the storyboard and process improvements are underway including what is working well and not working well. Most indicators are on target, or exceeding the target for this fiscal year.

3.2.5 Standards Set: Community-Based Mental Health Services and Supports Standards - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
18.5 The organization shares benchmark and leading practice information with its partners and other organizations.	
Surveyor comments on the priority process(es)	
Priority Process: Clinical Leadership	

The services offered in Community Mental Health (MH) and related support programs include: seniors mental health regional consultation program and behaviour supports Ontario (BSO) program; mobile crisis team; assertive community treatment team (ACTT 1) and ACTT 2; enhanced forensic outreach and the mental health clinic. This clinic offers anger management, anxiety and coping skills, psychotherapy, eating disorders, early intervention psychosis, medication support service, injection clinic, and an anxiety management group.

The catchment area for these services includes the Nipissing District and the Northeast Region. Services are provided to individuals 16 years of age or older. The staff members are interdisciplinary qualified health care professionals and work in partnership collaboratively with clients and their families in a client-centred, interdisciplinary approach to care. The service promotes active participation of individuals in their recovery. The team members document the plan of care in one spot, and call it the: "One Patient, One Plan". Working in partnership in a supportive environment is their philosophy.

The team values diversity in program offerings supports minority and marginalized communities including seniors, clients with eating disorders, mental health and the law, First Nations, and so on. The breadth of services is very broad.

The team is keen to promote awareness events with an aim to eliminate stigma that surrounds persons with mental health and addictions.

Priority Process: Competency

The staff members that work in the community based mental health programs are committed, passionate and experts in the supportive care environments in which they work. Competency training includes non-violent crisis intervention (NVCI), gentle persuasive approach (GPA), and applied suicide intervention skills training (ASSIST). Training is a regular, built-in expectation for the clinics. The staff members conveyed appreciation for each other, and for the opportunity to recognize positive contributions at huddles and celebrating when successful client transitions occur.

The team, like other departmental teams at North Bay Regional Health Centre (NBRHC) have access to an ethicist. There is access to a tool box which can be used to work through situations as a team, and if they cannot settle on a decision, the team will consult with the ethicist.

Priority Process: Episode of Care

Patients referred to the community mental health services are primarily referred to central intake and triage to appropriate clinics. Some programs also have referrals directly from the acute mental health in-patient unit. Assessment and documentation occur at every visit and all treatments are at the consent of the client.

Peer roles are also part of the inter-professional team in the assertive community treatment team (ACTT) programs. These consumer survivors provide an excellent support system for clients in the program.

While the services might not operate 24/7 and are primarily seven days per week, it was identified that there is always on-call support. For the enhanced forensic outreach team the after-hours support is provided by five clinicians who share after hours call and there is video surveillance on the residence.

Transition from service is an important component of the care plan for the patient/client. There is follow-up by telephone or in person following the transition, and each transition care plan is individualized.

The challenges of not having an integrated client file that is seamless from hospital to community and along the continuum was identified.

Priority Process: Decision Support

The mental health clinics and community-based programs ensure there is always an accurate up-to-date chart and documentation towards achieving goals in the client care plan. At every assessment there is monitoring and documentation of suicide risk. This is built into the assessment policy. Should there be any concerns a crisis plan is flagged for the patient, or the patient is sent to the North Bay Regional Health Centre hospital. In addition, the i-report is completed.

The need for a seamless coordinated chart for the client care plan, a plan that all partners within the circle of care can access was identified as an opportunity for improvement.

Priority Process: Impact on Outcomes

Metrics that are important to the staff members to ensure the clients are receiving good timely service include: monitoring of wait times for access into programs and the number of no-shows. In addition, these

teams have projects in the implementation phase to support the hospital improvement plan (HIP) and quality improvements (QI) such as for hand-hygiene compliance. Many of the outcome measures for patients are qualitative and the tools are designed to capture improvements in self-reported behaviour changes related to goals, or a decrease in behaviour frequencies.

The assertive community treatment team (ACTT) team shares information and benchmarks with other provincial ACT teams and it is recommended that other community-based programs also review criteria for program participation and benchmark with peers as a standard.

3.2.6 Standards Set: Critical Care - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
The organization has met all criteria for this priority process.			
Priority Process: Competency			
The organization has met all criteria for this priority process.			
Priority Process: Episode of Care			
7.7	With the involvement of the client, family, or caregiver (as appropriate), the team generates a Best Possible Medication History (BPMH) and uses it to reconcile client medications at transitions of care.		ROP
	7.7.4	The prescriber uses the Best Possible Medication History (BPMH) and the current medication orders to generate transfer or discharge medication orders.	**MAJOR**
	7.7.5	The team provides the client, community-based health care provider, and community pharmacy (as appropriate) with a complete list of medications the client should be taking following discharge.	**MAJOR**
7.8	The team has access 24 hours a day, seven days a week, to supporting services such as laboratory testing and diagnostic imaging, including point-of-care testing.		
12.7	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			
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 Critical Care at North Bay Regional Health Centre is a Level 3, 16-bed secure unit, which provides care to adults and children greater that one year old. There is a separate visitor entrance, with a lounge and 'buzzer' admittance. The physical environment is spacious, well-organized and maintained. There are two negative pressure rooms with separate adjoining anterooms. There are 16 telemetry packs, which are part of the nursing case assignment. One of the patient washrooms has recently been converted to accommodate wheelchair access.

The medical director of medicine and the administrative program director and unit manager provide leadership. The service underwent an external review two years ago, which resulted in some bed closures to achieve a 70% occupancy target.

Annual program planning is done by the corporate clinical services committee. Multiple sources of data are used to refine and update the scope of services offered. There is a quality committee/unit council responsible for ongoing review and management and the quality improvement initiatives and patient safety indicators including adverse events, infection rates, and so on.

The Critical Care monthly meeting is a physician-led multidisciplinary committee, which receives reports on service key performance indicators, progress with quality-based procedures, and planning and evaluating new initiatives.

Priority Process: Competency

The interdisciplinary team includes registered nurses, respiratory therapists and physiotherapy services. There is a unit educator, pharmacist and medical assistant attached to the program. The team is currently working towards a closed unit model. Currently, the anesthetist becomes the designated most responsible physician (MRP) if the client is intubated. Otherwise, it is generally the internal medicine physician covering the unit that would be the designated MRP. Technically however, any physician with admitting privileges can be the designated MRP. The internal medicine physicians provide rotating coverage 24/7, and attend during the day to conduct rounds and see new patients.

Nursing case assignments are done by the unit leader, based on patient acuity. Generally, nurse patient ratios are 1:1 for ventilated patients and 1:2 otherwise. The unit is well-staffed, with good physician engagement and effective communication mechanisms in place.

The orientation and continuing education programs are well-developed and comprehensive. Pediatric advanced life support (PALS) training is encouraged for all staff, but not mandatory. Consultation support is readily available from the hospital pediatric unit or the neonatal intensive care unit staff. All critical care monitors have a link to the Children's Hospital of Eastern Ontario (CHEO) medication information system. Pediatric Broselow code carts are available on the unit. Staff education and audits are in place. The unit educator ensures that all appropriate staff members complete annual recertification, including pump training, and are required to complete a one-day mandatory education day every two years.

Priority Process: Episode of Care

The majority of patients are admitted via the emergency department (ED). The critical care nurse goes to the ED for the transfer of information and accompanies the new patient to the unit.

History taking and care planning is thorough, with good evidence of multidisciplinary involvement noted. Treatment goals are recorded on the kardex. Progress notes are completed by each of the disciplines involved. The records are organized and up-to-date however, locating the clinical information to establish an overall picture of the client's progress and health status is time consuming.

There are well-developed transfers of information. The rapid assessment of critical events (RACE) program has been in place since 2008. The nurse and respiratory therapist led team attend on the general units to provide consultation when a patient's condition is deteriorating. The critical care team also operates the cardiac arrest team and manages the oversight for the replenishment of all the cardiac arrest carts in the organization.

The team reported that magnetic resonance imaging (MRI) is not available at the weekend. This can impact patient length of stay in particular.

The central line infection bundle (CLI) and ventilator associated pneumonia bundle (VAP), and sepsis bundle are successfully implemented and show sustained and very low CLI and VAP rates.

The clinical pharmacist is an integral part of the team. The uptake of the antimicrobial stewardship program is noted. Medication reconciliation has been implemented on admission and transfer within the hospital.

An opportunity for improvement would be to explore the feasibility of MRI service at weekends.

Priority Process: Decision Support

The client record is in paper form except for diagnostics. Evidence-informed guidelines are widely used in practice. Currently, there is a major focus on the implementation of the ministry funded quality-based procedures (QBP). For example, pre-printed physician orders are being used for chronic obstructive pulmonary disease, community acquired pneumonia, acute exacerbation of congestive heart failure, acute myocardial infarction, and stroke and sepsis.

Priority Process: Impact on Outcomes

The falls prevention program has not been fully implemented. Plans are in place to complete implementation in the near future.

Priority Process: Organ and Tissue Donation

The organ and tissue donation program is fully aligned with the Trillium Gift of Life program and standards.

3.2.7 Standards Set: Diagnostic Imaging Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Diagnostic Services: Imaging		
1.4	The team establishes partnerships to provide coordinated diagnostic imaging services.	
7.1	The team has an annual program for preventive maintenance of equipment consistent with manufacturers' recommendations.	!
7.3	The team retains preventive maintenance records for at least two years.	!

Surveyor comments on the priority process(es)

Priority Process: Diagnostic Services: Imaging

The diagnostic imaging (DI) department is a spacious and accessible service, with multiple areas for privacy/change rooms, discussions with patients and smaller waiting rooms in the department. Way-finding improvements have evolved and staff members have been working hard on signage to improve access to the DI department from the main entrance. Green 'paws' now guide patients and visitors to the department and 'pink paws' guide to the Ontario Breast Screening Program (OBSP).

The equipment is state-of-the-art, and there is a dedicated registered nurse (RN) to the department to support interventional biopsy procedures, peripherally inserted central catheter line insertions.

The DI team is responsive to the needs of the community and operates seven days per week, as well as evenings for some modalities. There is on-call access for the emergency department (ED) and any emergent issues after hours.

A peer review program has been initiated amongst the radiologists to ensure quality reporting standards is in progress, with a two-month trial to be completed shortly. Following this, a formal quality assurance audit process will be implemented.

Utilization management or a review process to monitor DI services is in place however, encouragement is offered this team to choose some quality improvement metrics that will enhance the patient experience, while adding value and decreasing costs.

Opportunities to establish partnerships to collaborate on appropriateness of orders, with primary care and ED for example, are encouraged as there is no current process to determine this. Some work has been done with knee exams. All magnetic resonance imaging (MRI) scans must be preceded with an x-ray first. It is recommended a collaborative partnership with primary care and the acute inpatient units and ED be established via the Choosing Wisely campaign recommendations and benchmark with other DI providers. There is a good relationship with Cancer Care Ontario (CCO) for the OBSP program.

Preventive maintenance is scheduled by the vendors, and a report that follows. It is recommended that the DI management team be aware of this schedule in advance, with inventory of all equipment in the department, as overall accountability for safety in the department is the responsibility of the team.

The high cost capital equipment purchased with the move into the new North Bay Regional Health Centre site four years ago will require replacement in a few years. The team is aware of this and a strategic replacement list is being coordinated for the NBRHC to collaborate with the Foundation. The computerized tomography (CT) scanner is approximately 10 years old and the wish is for a second new scan is to be added.

3.2.8 Standards Set: Emergency Department - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The emergency department (ED) is an integral part of the strategic plan. It is involved in data collection to better identify the population being served, and possible modifications to its services. For example, a shortage of general practitioners (GPs) in the town was identified, was a peak of patient-driven visits in the late afternoon and evening. In response, the organization modified its staffing accordingly to prevent long waits in the emergency department during these periods.

The workspace facilities are excellent, and certainly adequate for the demands. There are enough isolation rooms, and special facilities. Equipment is state-of-the-art. The team feels involved, valued and included in the management of the department, largely via the use of huddles on a regular basis.

Priority Process: Competency

The emergency department (ED) team is made up of people from many health disciplines; all appropriately trained and credentialed. They receive orientation to the department, and undergo a probationary training period. They are regularly updated on use of infusion pumps, and all infusion pumps are standardized.

Educational needs of staff members is addressed and training is documented.

Workload assignments are fluid and change with need. Nurses are trained in avoidance and reporting of workplace violence. Staffing is regularly assessed with input from staff members during the huddle process.

Appropriate pediatric assessments and services are available.

Priority Process: Episode of Care

All clients/patients are triaged consistent with the Canadian Triage Acuity Score (CTAS) and pediatric CTAS standards. Patients are continually observed and treatment is modified as necessary from the time they enter the emergency department (ED) until the time they leave.

Laboratory, x-ray and all consultative services are available continuously. A best possible medication history (BPMH) and medication reconciliation are done for all patients in accordance with accepted standards. The whole emergency area is set up to maximize patient confidentiality and staff members are aware of the necessity for confidentiality. Informed consent or acceptable alternatives is always obtained. Information is appropriately transferred between health care facilities and the patient and family.

Priority Process: Decision Support

Decision support is based on sound principals as provided by medical literature and peer groups. Results are shared with stakeholders, peer hospitals and patients and their families. All ethical guidelines are followed. All records are accurate, up to date, confidential yet easily accessible to accredited personnel. There is a partial digitization of the records, which staff members find easy to use. All staff members are instructed appropriately in the keeping of medical records.

Priority Process: Impact on Outcomes

A falls prevention strategy is in place. The huddle process is used to share information, safety briefings, sentinel events and evaluation of team performance. It is also used to recognize individual achievements and competence. The huddle is also the forum for review and reporting on quality improvement initiatives. Quality improvement initiatives are closely monitored and altered as necessary.

Priority Process: Organ and Tissue Donation

There is high awareness of the importance of potential organ and tissue donation. The Trillium Gift of Life program coordinates all potential donor situations. The staff members are fully aware of the importance and the protocol for organ and tissue donation.

3.2.9 Standards Set: Emergency Medical Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
16.10 The EMS team seeks an independent double-check before administering high-alert or high-risk medications.	!
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	
Priority Process: Medication Management	
The organization has met all criteria for this priority process.	
Priority Process: Infection Prevention and Control	
8.7 The organization measures its compliance with accepted hand-hygiene practices. 8.7.3 The organization uses the results of measuring hand-hygiene compliance to make improvements to its hand-hygiene practices.	ROP **MINOR**
9.2 The team properly uses personal precautions and personal protective equipment.	
Surveyor comments on the priority process(es)	
Priority Process: Clinical Leadership	

The Emergency Medical Services (EMS) team is mostly bilingual. Interpreters for virtually any language are available by telephone when necessary. The team integrates its services into the needs of the community. There is a medical oversight team which helps to guide the activities of the EMS. Additional medical oversight is available by connection to the base unit in Sudbury, or by connection locally to the emergency physicians at North Bay Regional Health Centre.

Priority Process: Competency

All team members are properly credentialed. They all undergo an orientation process to the service. They are instructed in the use of all devices they are required to use. They are instructed in work-related injury prevention, and have access to whatever materials they need to prevent injuries. They have just acquired a bariatric stretcher to assist with moving large patients. They are given support in stress-related counselling and in managing workplace conflicts.

Education needs are documented and continuing education is provided.

Priority Process: Episode of Care

All patients are appropriately restrained in transit. There is an attendant with the patient at all times. The destination site is notified in advance so preparations can be made. Documentation and medical information is transferred between health care providers according to protocol. Two client identifiers are used. There is appropriate awareness of potential infectious situations. Personal protective equipment (PPE) is used as necessary. High-level PPE is also available.

The dispatch area is new, and set up with the latest technology. Staff members are bilingual, with almost any language interpreters on call. Back-up systems are in place and checked at least two times per year.

Canadian Triage Acuity Scores are used for assessment. The scene is assessed for safety of Emergency Medical Services (EMS) personnel. The only high-alert medication used is epinephrine.

Priority Process: Decision Support

Evidence-based guidelines provided by Ontario Emergency Medical Services (EMS) are used. These are reviewed on a regular basis, and all staff members are aware of them.

Priority Process: Impact on Outcomes

The Emergency Medical Services (EMS) obtains information and feedback from its clients and uses this to direct quality improvement. Quality Improvement is managed and communicated with staff, and largely by the use of the "huddle". Baseline indicators, such as response times of both the communications centre and the EMS teams, are monitored carefully.

Priority Process: Medication Management

The only high-alert medication used in EMS is epinephrine. Narcotics are also used. Storage and use of these items is carefully monitored.

Priority Process: Infection Prevention and Control

There is adequate information provided from the organization to the EMS services regarding proper hand washing. However, the EMS organization as a whole does not practice hand washing as often as it should. The hand washing stations are dated and inadequate. Perhaps this will be rectified when they move to their new facilities Two stations were noted to have no liquid in them. The necessity for proper and frequent hand hygiene should be emphasized to the EMS staff.

Proper handwashing techniques are not practiced at the Emergency Medical Services (EMS) centres. Personal protective equipment is used appropriately at the EMS sites. Vehicles and equipment are cleaned and disinfected after every use.

Staff members are generally current with their immunizations. Those that refuse immunizations are noted and documented.

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

Unmet Criteria		High Priority Criteria
Priority Process: Infection Prevention and Control		
1.1	The organization regularly reviews which IPC components are included in the IPC program, based on a risk assessment and organizational priorities.	!
2.1	The organization has an IPC team responsible for planning, developing, implementing and evaluating the IPC program.	!
2.6	The organization consults with the IPC team when planning and designing the physical environment; this includes planning for construction and renovations.	!
2.8	The organization involves environmental services and the IPC team to maintain processes for laundry services and waste management.	!
2.10	The organization follows applicable standards for food safety to prevent food-borne illnesses.	!
4.1	The organization completes a risk assessment to identify high-risk activities, and then addresses them in policies and procedures.	!
4.7	The organization monitors compliance with IPC policies and procedures and makes improvements to the policies and procedures based on the results.	
9.5	The organization regularly evaluates compliance with its policies and procedures for cleaning and disinfecting the physical environment and makes improvements as needed.	
9.6	When cleaning services are contracted to external providers, the organization establishes and maintains a contract with each provider that requires consistent levels of quality and adherence to accepted standards of practice.	
9.7	When cleaning services are contracted to external providers, the organization regularly monitors the quality of the services provided.	
Surveyor comments on the priority process(es)		
Priority Process: Infection Prevention and Control		

The North Bay Regional Health Centre employs four infection control practitioners (ICPs) for the North Bay sites. A local pathologist provides physician leadership. This is augmented by a consultative relationship with an infectious diseases physician at Sunnybrook Hospital in Toronto that provides a monthly review as well as ad hoc consultation. The local Health Unit is represented on the multidisciplinary committee as well as on the medical committee which liaises with the medical advisory committee (MAC).

Three of the nurses are certified in infection control while the fourth, newer nurse is working toward the same. Three of the nurses also are certified with the Canadian Standards Association for the regulations of infection control during construction and repair of hospital facilities.

An informal risk assessment has led to the development of policy and procedure for several potential problems such as pandemic, Ebola, Clostridium difficile and others. Staff members have indicated that a formal assessment of infection control risks and their potential occurrence has not been documented.

The department uses evidence-based sources for practice guides such as: Provincial Infectious Diseases Advisory Committee (PIDAC), American Association for Professionals in Infection Control and Epidemiology (APIC) and Health Canada. The organization is a member of the Regional Infection Control Network (RICN) and the Infection Control Network Ontario: North East. The manager of the infection control department at North Bay Regional Health Centre (NBRHC) is a member of a national working group for classification of post-operative infections.

Monthly education on infection prevention and control (IPAC) is provided for staff. Education is in the form of games, puzzles, contests and updates on the electronic blog. Education has been provided for external partners as well for example, the local long-term care home. Volunteers are sent an article every month from IPAC for their paper printed newsletter.

Hand-hygiene compliance audits result at well over 80%. Audits are carried out by multiple staff. There is the hand-hygiene improvement committee which has recently added group therapy and in-patient mental health to the list of areas being audited for hand-hygiene compliance. Food Services staff members indicate that they are audited for hand hygiene as part of staff-as-a-whole when they are present on patient care units, but are unaware of audits in their own department.

Influenza vaccination of staff members and volunteers is at 89% for fall 2014. Patients in long-stay units are also offered the influenza vaccine.

A pandemic plan is in place and updated however, IPAC is not invited to be part of other emergency planning, which otherwise may add value for the emergency preparedness group. A biological response committee has been formed to address emerging diseases.

The IPAC nurses review all emergency department records for the previous day to monitor influenza like Illness (ILI) incidence, and respond appropriately with increased cleaning regimes for the department, and increased influenza vaccination for staff.

Laboratory results indicating any pathogen are printed directly to the IPAC office for follow up. A new software system will be implemented soon, which will allow timely access to results of microbiology tests being conducted off site.

Housekeeping routines are well-documented and communicated to staff, with standardized checklists and visual reminders of appropriate cleaning for a variety of situations and isolations. A whiteboard in the housekeeping staff room reminds every on-coming staff member which rooms and units have a patient with an antibiotic resistant organism (ARO), methicillin-resistant staphylococcus aureus (MRSA) or vancomycin resistant enterococci (VRE) result. The housekeeper can then note these rooms on the shift worksheet and indicate follow-up to be performed on that shift.

Laundry and waste handling flow is well-coordinated and provides for safety of staff, patients and external companies that pick up the variety of wastes on a weekly basis, and pick up and deliver laundry on a daily basis.

Food is received at a dedicated shipping bay with immediate access to refrigeration, freezer or dry goods storage. Staff members in Food Services are required by the organization to obtain Food Handler certification. Staff members indicated that they complete hand hygiene education annually online however, they are unaware of any auditing occurring in their department. Alcohol-based hand rub was not in evidence in the department, though handwashing sinks are provided.

The medical devices reprocessing department (MDRD) at NBRHC provides good separation of clean and dirty equipment.

At Kirkwood Place in Sudbury, the aging facility presents unique challenges for maintaining the separation of clean and soiled. In Food Services, the used trays arrive in the clean food preparation area, travel through it to the dishwashing area, and are stored in that same area once clean, then traverse back through the same doorway to be plated with food.

Also at Kirkwood Place, due to security concerns, sharps containers are found only in a locked medication room, which means that the used injection equipment must travel through the public corridor before being deposited in the sharps container. It was also noted that the medication room contains older, wooden cupboards with potentially porous surfaces.

Infection prevention and control oversight at Kirkwood Place is provided via contract with Health Sciences North however, there is no evidence of a formal evaluation of that service. It is also questioned whether there has been an infection control risk assessment completed for the mental health care units in light of their unique challenges.

It was observed and reported by staff members of Emergency Medical Services (EMS) that hand hygiene is inconsistently carried out.

3.2.11 Standards Set: Medication Management Standards - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Medication Management		
8.1	The organization has a process for determining the type and level of alerts required by the pharmacy computer system which include, at minimum, alerts for medication interactions, drug allergies, and minimum and maximum doses for high-alert medications.	!
10.2	The organization limits the variety of general purpose infusion pumps, syringe pumps, and patient-controlled analgesia pumps available.	!
21.5	Service providers provide clients with written information on whom clients can contact for questions about their medications and their availability at the end of service or transfer of service.	

Surveyor comments on the priority process(es)

Priority Process: Medication Management

The pharmacy department manages the medication process in an efficient manner. Many of the observations from the previous survey visit have been taken into account and corrected or improved since then. The pharmacy department has undergone a “deep dive” review and many recent quality improvements have been completed internally. Projects completed include: review of insulin wastage, decrease in wastage of prepared intravenous (IV) solutions, and improvement in turnaround time for processing new prescriptions. Information on medications, added or removed from the hospital drug formulary is provided by e-mail or via the hospital blog. Presentations are offered when significant or high-risk medications are added to the formulary. Medication libraries used in the different infusion pumps are reviewed on a yearly basis, but uploads are less frequent as it requires a manual process since the pumps do not have wireless capability.

Many policies are in place to support the medication cycle across the organization. Pharmacists are involved clinically on the units and observation from several surveyors confirmed their important contribution to safer patient care.

Medication administration on the units is in compliance with the standards and medication storage is secure on the units. Medication rooms are locked and no medications were seen left on counters or on the medication carts.

The pharmacy computer is continually updated but it still lacks a dose check against documented safe minimum and maximum doses. This is especially important for high-risk, pediatric and chemo drugs. There is work underway to provide a minimum/maximum dose check for chemotherapy agents, and once completed it should be expanded to cover all medications.

Medication management at the Kirkwood site in Sudbury is done in a safe and efficient manner. The pharmacy technician is only working part-time but a pharmacist is available daily, and a back-up system with a local community pharmacy is in place if a medication is needed urgently.

3.2.12 Standards Set: Medicine Services - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
The organization has met all criteria for this priority process.			
Priority Process: Competency			
The organization has met all criteria for this priority process.			
Priority Process: Episode of Care			
7.6	With the involvement of the client, family, or caregiver (as appropriate), the team generates a Best Possible Medication History (BPMH) and uses it to reconcile client medications at transitions of care.		ROP
	7.6.4	The prescriber uses the Best Possible Medication History (BPMH) and the current medication orders to generate transfer or discharge medication orders.	**MAJOR**
	7.6.5	The team provides the client, community-based health care provider, and community pharmacy (as appropriate) with a complete list of medications the client should be taking following discharge.	**MAJOR**
11.6	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			
The organization has met all criteria for this priority process.			
Priority Process: Impact on Outcomes			
16.11	The team regularly reviews and evaluates its quality improvement initiatives for feasibility, relevance and usefulness.		
Surveyor comments on the priority process(es)			
Priority Process: Clinical Leadership			

The on-site tracer included a 28-bed general medicine unit, 28-bed district stroke unit and six-bed pediatric unit. The service planning process is done via the corporate planning cycle. Goals and objectives and quality improvement objectives and targets are established in line with the strategic directions. In addition to the internal sources of data, the program benchmarks with peer hospitals to rationalize the services offered.

The units are well-equipped and extremely well organized. Medical and surgical supplies and linen are

replenished daily. The cardiac arrest cart is checked daily. There is a bariatric room and negative pressure rooms on the general medicine unit.

The team welcomes a broad range of student placements in medicine including for practical and baccalaureate nursing students. The volunteers play an important role in the delivery of care for the Hospital Elder Life program.

There is a quality improvement committee and a stroke committee specifically focused on the implementation of the stroke quality based procedure.

Priority Process: Competency

Care is coordinated in all three areas by a full range of disciplines. Five family medicine teams provide medical coverage on the general medicine and stroke units. Cross-consultation with medical specialists is readily available. Registered nurses (RNs) and registered practical nurses (RPNs) provide nursing care. Other disciplines include speech pathologist, physiotherapy and dietary. There is a speech pathologist and physiotherapist on call for weekend coverage for stroke. There are two RNs on the pediatrics unit. The pediatricians provide paediatric medical coverage on a rotating basis.

There is comprehensive, well-documented orientation for all three clinical areas. The nursing educator maintains all credentialing, certification, and training records. All medicine staff members have received intravenous (IV) pump training.

There are well-established team communication processes in place, with visible evidence of a highly functioning, knowledgeable and dedicated 'team spirit' in all three areas. Medical staff engagement is also evident.

An opportunity for improvement would be that this excellent team could benefit from the addition of a physician member on the quality improvement committee.

Priority Process: Episode of Care

Clients/patients are admitted either from home, physicians' offices or the emergency department. The unit leader determines the level of care and assigns the patient to either a registered nurse (RN) or registered practice nurse (RPN). The admission assessment is comprehensive. Care plans are well done. The family plays a central role in care planning and discharge preparation. A full progress assessment is documented on each shift, and if the client's condition changes.

A group of family physicians that specialize in palliative care meet end-of-life care needs of clients and their families. In addition, close working relationships exist between the general medicine units and the palliative care unit. Psychiatric consultation services are available.

The Elder Life program is a volunteer-based program led by the recreation therapy staff coordinator, aimed at preventing delirium in the elderly. The coordinator assesses the clients to determine the level of activity and the plan of care for the volunteers to provide.

Falls prevention, venous thrombo embolism prevention, and pressure ulcer prevention are fully implemented, including comprehensive audit processes. Medication reconciliation on admission has been implemented.

Clients/patients receive an information package at the time of admission. Education is customized to each client/family during the in-patient stay, and is documented in the electronic record. Information transfer mechanisms are well developed. Daily bullet rounds include all disciplines. The nursing service uses the in-patient medicine report sheet for change of shift transfer. The situation background assessment recommendation (SBAR) tool is used for all nursing calls to physicians. Physicians use clinician-to-clinician transfer.

An opportunity for improvement would be for patient education to include information on the North Bay Regional Health Centre's bill of rights.

Priority Process: Decision Support

The client record is primarily electronic except for the medical progress notes and orders, and a number of general forms. The electronic record is comprehensive. Staff members report that is it easy to use and facilitates effective interdisciplinary communication.

There is a broad range of evidence-informed pre-printed order sets in place for palliative care, stroke, and so on.

Priority Process: Impact on Outcomes

For the medicine services there is evidence of a strong commitment to safety in all three areas. For example, client/family education materials cover a broad range of information regarding the client/family role in safety including falls prevention, medications, safety rules/ safe sleep policies for children. The staff orientation and continuing education and skills training programs in all three areas include a comprehensive safety education and certification plan.

Team engagement in the corporate quality improvement agenda is apparent. The manager reported that greater involvement of team members in selecting the improvement initiatives has enhanced buy-in from staff. The More Time to Care boards illustrates evidence of improvement in some areas, including medication reconciliation and venous thrombo embolism (VTE) prophylaxis compliance on general medicine. The decision time to admit to admission has significantly exceeded the target on the pediatric unit.

Opportunities for improvement would be the need for better integration of the stroke and other quality-based procedures (QBP) indicators and targets, with the corporate indicators on the stroke and general medicine units. The feasibility of the service quality improvement initiatives should be evaluated at regular intervals as this work moves forward.

3.2.13 Standards Set: Mental Health Services - Direct Service Provision

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

Mental Health Services - Acute In-patient Psychiatry Unit (AIPU)

The leadership team for mental health is engaged and actively identifying opportunities to provide supports to clients throughout the continuum of care. A community outreach team has been implemented which includes a police partner in the community. This group/team reacts to issues raised by known clients in the community and it is reported that their intervention has proven successful in reducing the number of acute admissions with early intervention.

The More Time to Care quality board is prominently displayed and there are regular weekly huddles which are well attended. During these times, goals and how the unit is tracking towards these goals are discussed. This is also a time to recognize good work done by the team.

Kirkwood Site

Leadership is working with staff members and partners during this time of transition, as beds will be closed on the fourth floor and longer term patients will transition to another facility. It is impressive to see the continued commitment to the patient and improving services at the facility. The organization is encouraged to ensure that regular measures of staff stress are monitored during this transition phase, and that appropriate supports are offered.

Priority Process: Competency

North Bay Regional Health Centre site:

There is an educator on the unit that works with the staff, and the educator has developed an excellent on-boarding/orientation process. There are check lists and competency assessments which are part of this process. The management and educator work with unit staff to identify opportunities for formal and informal training and teaching moments.

There is a strong culture of care for the patients, inclusive of moving towards a least restraint approach. The security personnel are a strong part of the team and play an elemental role in the response to patient conduct incidents and "code whites." The team members support each other in de-escalating conduct incidents using non-violent crisis intervention (NVCI) techniques.

Kirkwood site:

There is a highly competent team with specialized knowledge of dementia care and regional tertiary care at Kirkwood. Team members participate in learning opportunities via e-learning and the clinical nurse educator. The Canadian Mental Health Association also has provided education related to implementation of clinical pathways. The staff members are extremely cohesive and remarkable in their dedication to the patients they serve, and who have highly specialized care needs and often have not been successful in other care environments.

Priority Process: Episode of Care

North Bay Regional Health Centre site:

The acute in-patient unit was visited during the survey, and it has a strong multidisciplinary team whose members work together to achieve the best outcomes for the patient from the time of admission to discharge. The initial assessment and admission process is comprehensive, with most patients being placed on the unit with standard 15-minute observations for at least 24 hours. As soon as the patients are able, they are involved in goal-setting and eventual discharge planning. There is a well-established report and rounding process on the unit.

The multidisciplinary team has excellent awareness of past history of patients between visits, with good links to community supports. The team is thoughtful in the assessments and review process ensuring the wishes of the patients, and using the least invasive treatment. During the observed rounds great empathy was demonstrated by all team members to understand every patient and work with them to help achieve their goals and ultimate discharge.

There is a clinical pharmacist on the unit that works several hours during the day reviewing medications and providing services to physicians, nurses and patients. There is an exceptional pharmacy assessment form which is systemic in nature. Recommendations are developed and reviewed by nursing and medical staff, and medications or therapeutic interventions may be adjusted accordingly. The pharmacist also takes an active role in the medication reconciliation process. Medication reconciliation is done at all points of admission, transfer and discharge. Sometimes, the medication reconciliation at admission is done without involving the patient. Staff members commented that sometimes, obtaining reliable information from the patient can be challenging.

Transfer of accountability is done well, using an oral and written process. The written report is done in a table format which allows nurses that have been off duty for some days to readily see any changes in patient status or the plan of care.

Any concerns or complaints are managed at the point of receipt, or brought forward to the manager and there is a process to ensure that these concerns are registered via the patient advocate for tracking purposes.

The environment on the unit is comfortable and the patients report a high level of satisfaction with the services they received, even though they noted at times that they did not have all the freedoms they may like. They recognized that goal-setting and privilege- earning are an important part of their care plan, recovery and discharge.

Kirkwood site:

There is an excellent intake and assessment process when patients are admitted. The approach to medication review and the "medication wash" clinical pathway from the Canadian Association for Mental Health (CAMH) is exemplary. There is a thorough review of referral letters, medication reconciliation and a process of slow adaptation of the care plan for patients on the third floor unit. The staff ratios and expertise of the staff members provide a safe environment for them and the patients which improves patient outcomes.

The initial risk assessment and process for observation on both of the units is excellent. The team works collaboratively across both units and there is excellent exchange of information at shift report and when the care plan is updated. Families are satisfied with services delivered, with many patients demonstrating remarkable rehabilitation between 30 and 60 days which allows them to be discharged home from rehabilitation or re-admitted to a long-term care facility when discharged from the third floor unit.

There is a good process in place to monitor 'leaves' from the fourth floor unit and to follow up should patients either voluntary or involuntary fail to return after a leave. Behaviour and safety contracts are used and patients on the fourth floor unit take accountability and responsibility and pride in their goal development.

Medication reconciliation is completed and there is an extremely impressive reduction to the number of medications required to therapeutically manage patients following the "medication wash" process.

Despite challenges with the infrastructure at this site, and significant restrictions in rooms, this site provides competent and compassionate care to patients.

Priority Process: Decision Support

The organization uses a Meditech system which is adequate but does not fully meet the needs. As a result, there is both a paper and electronic process to charting. Some of the physicians note that the meditech features do not always provide the options for documentation that would suit them best. The assessment tools for patients are both paper-based and electronic. Many assessments such as for falls and the Braden scale are in meditech, whilst the mental health admission assessment is paper based. Clinical pathways and pre-printed orders (PPOs) are utilized to ensure consistency in care and effective care.

Priority Process: Impact on Outcomes

North Bay Regional Health Centre site:

The acute in-patient unit has embraced the More Time to Care initiative. The unit has worked to identify and

subsequently modify objectives and metrics for quality improvement. Weekly huddles are well-attended by staff. There is clear evidence of contributions of staff members to providing solution-based ideas for improvement on the unit. The managers identify the desire to spend more time on the unit with the staff members to improve work flow and process and to provide additional feedback which has been well received by the front line staff.

The unit has a high rate of reporting patient safety incidents and management is responsive to following up on these, inclusive of giving feedback at the huddles. Staff members are aware of the higher risk environment and have a good situational awareness. They are prompt to respond to events and have a thorough assessment and reassessment process for patients. Dangerous objects are removed from patients at the time of admission and close observation is provided so that early intervention can occur in the event of patient escalation.

It was observed on the unit that a number of opportunities to practice good hand hygiene were missed.

Kirkwood site:

The team participates in regular huddles to review data and metrics and brainstorm on improvement solutions. There is a high level of engagement which is particularly impressive given the pending closure/transition for the fourth floor. There are few behaviour/conduct incidents and those that do occur are managed competently by the skilled staff, with NVCI techniques. There has been a commitment to falls risk reduction which is balanced with an approach to least restraints. There are some falls that typically do not cause harm due to the effective falls risk reduction processes.

Staff members expressed concern about how some patients will cope when they are required to transition out of the fourth floor due to the closure of beds on that floor. Some patients have lived on that floor for several years.

There remain risks relative to the environment and limitations of the aging infrastructure, but staff members have developed work arounds to some of these for example, use of mirrors on poor sight lines, and limiting supplies kept on the unit due to limited storage space.

3.2.14 Standards Set: Obstetrics Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
9.6	With the involvement of the client, family, or caregiver (as appropriate), the team generates a Best Possible Medication History (BPMH) and uses it to reconcile client medications at transitions of care.	ROP
9.6.4	The prescriber uses the Best Possible Medication History (BPMH) and the current medication orders to generate transfer or discharge medication orders.	**MAJOR**
9.6.5	The team provides the client, community-based health care provider, and community pharmacy (as appropriate) with a complete list of medications the client should be taking following discharge.	**MAJOR**
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		
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 obstetrics program is an eight-bed in-patient unit with four overflow beds and the level 3 neonatal intensive care. There are approximately 960 deliveries per year. The program works closely with the high-risk team at Mount Sinai Hospital in Toronto, and the Children's Hospital of Eastern Ontario (CHEO) to facilitate the appropriate level of care for high-risk mothers and newborns.

Program planning and revision of services is an ongoing process well-aligned with the corporate strategic directions, Local Health Integration Network (LHIN), Provincial Council of Child Health (PCMH) and LHIN

priorities. Examples of data sources used to review and improve the scope services include: Ontario's Better Outcomes Registry and Network (BORN) Ontario, PCMH, and internal administrative data. The Maternal Newborn clinic was recently incorporated with the maternal newborn in-patient services thereby maximizing the use of resources, and creating physical space to accommodate the Healthy Babies Healthy Children clinic in close proximity to the in-patient services. This change allows for more cohesive collaboration between the hospital and community services. A formal value stream mapping exercise has been conducted with broad input and involvement of the nursing staff.

Program goals and objectives flow from the corporate priorities. Additional goals flow from the yearly analysis of the BORN Ontario initiatives and the annual managing obstetrical risk efficiently (MORE ob) environmental scan. There is a need to further align these initiatives with the corporate priority setting process and score card.

There is 24-hour rooming in. The unit layout is organized and spacious, with ample room for privacy and accommodating family. This enthusiastic team welcomes students from all disciplines. Staff members have input to job design and work assignments at regular staff meetings and the program council. Staff members and leadership spoke highly of the collaborative and collegial work environment.

Preventive maintenance of all equipment is automated and managed by the bio medical engineering department.

Priority Process: Competency

There is a well-established, cohesive interdisciplinary team of 24 registered nurses (RNs), five obstetricians, five pediatricians and three midwives, along with the shared services of a pharmacist and social worker. Obstetricians and midwives perform all deliveries. The team has implemented the managing obstetrical risk efficiently (MORE ob) program and there is evidence of established processes in place to maintain and enhance practice with continued participation in this program. The core team carries out annual self-evaluation of team functioning as a part of the continuation of MOREob.

The obstetricians are on site during the day, and they take call from home after hours. Pediatricians rotate for 24-hour coverage and are on site during the day and evening hours, and take call from home during the night. Both disciplines have established protocols for transfer of information at handover of care. The off-going pediatrician returns on site and does a clinician-to-clinician transfer of information with the on-coming physician. The obstetricians use text and clinician-to-clinician telephone exchange to transfer information.

The unit is staffed with five registered nurses on the day shift including a charge nurse, and four registered nurses on the night shift. Nurse-to-nurse transfer of information occurs at change of shift.

There is evidence of a comprehensive orientation program at both the organizational and program levels. Required annual recertification is tracked on the eLearn Medworks system. All staff members receive intravenous pump training annually, which is tracked and recorded by the clinical educator.

Staff members that were spoken to during the survey report they had received a performance appraisal in the previous year.

Overall, there is evidence of a highly engaged and dedicated interdisciplinary team. Strong physician engagement was visible during the on-site visit. The team spoke proudly about the continued support of senior leadership, and in particular the continued corporate investment in the ALARM program and MORE ob program to ensure the team standard of practice and knowledge base stays current.

Priority Process: Episode of Care

All pre-natal clients are admitted via the obstetrics out-patient clinic. A full history is completed and appropriate referrals are made to other services as required. Clients are assessed for risk of adverse outcomes. Determination of the appropriate level of care is done in close consultation with partner tertiary/quaternary level specialists.

Care planning is well done and reflects interdisciplinary participation. Post-partum clients are managed by a care map. Progress on daily goals is fully documented. Client education is provided throughout the episode of care. The pamphlet: "Guide To Care For You and Your Baby" is reviewed in the out-patient clinic and provided to assist the family prepare for the delivery. clients receive ongoing education during the in-patient phase covering self-care, care of the newborn and preparation for transition to home.

Cesarean sections (C-sections) are performed in the birthing suite. The circulating nurse from the operating room (OR) attends all C-sections.

The social worker is an integral member of the interdisciplinary team, providing advice, referrals and bereavement counselling. Referrals to social work come from the pre-natal clinic, directly from physicians' offices, and from the in-patient team.

Standardized criteria are used to determine the mother and infant's readiness for discharge. During the survey clients spoke highly of the care experience, particularly the level of knowledge and attentiveness of the nursing staff, and the thoroughness of the education they received.

Opportunities for improvement have to do with alignment, medication reconciliation and transition planning. The team is working with the OR team to tighten the alignment between the OR and obstetrical prioritization schema for urgent cases. Medication reconciliation has been implemented on admission, but has yet to be implemented on transfer and at discharge. A process to contact the client/family to evaluate the effectiveness of the transition plan has yet to be implemented.

Priority Process: Decision Support

The client records are well organized and primarily in a paper format. There is a well-established process to review and adopt evidence-based guidelines with full participation of the interdisciplinary team. Multiple pre-printed orders are clearly evident and maintained in line with current best practices, such as the Society of Gynecologists and obstetricians of Canada (SGOC) guidelines.

Priority Process: Impact on Outcomes

The commitment to quality improvement and promotion for evidence-based care is clearly evident in the on-site tracer. For example, neonatal assessment protocols are in place for bilirubin screening, infants of Group B strep positive mothers, neonatal hypoglycemia, and neonatal abstinence syndrome. A recent family-centred quality improvement initiative to improve the management of infants' risk factors for neonatal abstinence syndrome has been successfully implemented. As a result, the length of stay in the neonatal intensive care unit has decreased from an average of between 17 and 20 days to approximately four days, and made it possible to transfer the infant to the pediatric unit and allow the mother and family to be with the newborn.

Departmental Improvement objectives and metrics are tracked on the NICU and birthing unit performance scorecard. However, the team noted this is a work in progress. Examples of current indicators include medication reconciliation on admission, percent positive responses to: ”I was included in all decisions about my care”, and completion of a hearing screen on newborns.

Daily team huddles are done at 0700 hours and again at 1400 hours to address safety and improvement opportunities.

The new i report system has recently been introduced to report adverse events. The summary analysis reports are sent to the managers. A formal process needs to be established to review and analyze adverse events and near misses to identify root causes and use the information to make improvements.

Client satisfaction is monitored annually via the National Research Corporation (NRC) and the managing obstetrics risk efficiently (MORE ob) program. The team needs to consider whether this frequency is sufficient to keep track of the client perspective regarding the quality of care and services provided by the team.

The obstetricians conduct regular meetings to conduct case reviews. Consideration should be given to broaden these reviews to include other members of the interdisciplinary team. Consideration should also be given to improving the use of indicators in the Better Outcomes Registry Network (BORN) database to inform future quality improvement opportunities.

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

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Standard operating procedures are provided mainly by the Trillium Gift of Life program. These are reviewed and agreed to by the local donation committee, which is headed by a physician. Members of the committee undergo documented performance reviews, with feedback on a regular basis. There is a signed contract with Trillium, and a Trillium coordinator is available at all times.

The organization's donation goals are well-identified and the identification of potential donors is 100%. By working with Trillium, the team had 48 potential donors, with 29 consents and 27 donors. Four lives were saved, with one heart, one liver and two kidneys transplanted. There is adequate physical support for the donation program.

Priority Process: Competency

The donation team is headed by the chief of staff. The team is made up of qualified and accredited personnel with well-defined roles. A donation coordinator is available at all times via the Trillium Gift of Life program.

Regular performance reviews with feedback are conducted and documented.

Priority Process: Episode of Care

The donation team obtains complete information about the donors and their history, using standardized questionnaires.

Priority Process: Decision Support

Adequate records are kept for identification and tracking of the donors' recipients, and organs transplanted. There is close coordination with the Trillium Gift of Life program, and many of the policies and procedures come from Trillium. Standardized questionnaires are used to obtain a complete donor history.

Priority Process: Impact on Outcomes

There is a debriefing of the donation team following every donation where performance is reviewed and suggestions made for possible improvement. Sentinel and adverse events are reviewed. The team tracks its data well, and uses the data to plan improvements.

Priority Process: Organ and Tissue Donation

The donation team respects the wishes of the patient and the patient's family at all times, and helps them grieve their loss. There is respectful and ethical interaction with the family. There is a clear line of demarcation between patient status and donor status. All appropriate testing is done before donation, including comprehensive tissue matching. There is close coordination between the donation team and the recovery team, and provided by the transplant coordinator. Proper surgical techniques are used for procurement. Attention is paid to post-operative appearance. The family is allowed to view the body.

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

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

The organization has met all criteria for this priority process.

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

Point-of-Care Testing (POCT) is limited to glucose level at North Bay Regional Health Centre. There is a POCT quality person in the laboratory that ensures proper calibration and maintenance of the equipment is done. A mid-point self-assessment was performed recently, as required by the Ontario Laboratory Association (OLA) and their accreditation visit is scheduled for 2017.

3.2.17 Standards Set: Rehabilitation Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
3.7 The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	
Priority Process: Episode of Care	
6.7 The team follows defined criteria to gather information from other service providers when determining whether to offer services to a client or family.	
7.5 With the involvement of the client, family, or caregiver (as appropriate), the team generates a Best Possible Medication History (BPMH) and uses it to reconcile client medications at transitions of care.	ROP
7.5.5 The team provides the client, community-based health care provider, and community pharmacy (as appropriate) with a complete list of medications the client should be taking following discharge.	**MAJOR**
11.5 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	
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 rehabilitation services group knows well the population it serves and it collaborates with partners to ensure services that it can not provide are available in the community. The teams, both for in-patient and out-patient care, know their objectives well via their score boards and they review them on a regular basis to ensure they are realistic and measurable.

Priority Process: Competency

The rehabilitation services are provided using an interdisciplinary team approach. The team members have clear roles and responsibilities within the team. There are regular interdisciplinary meetings to discuss patient status and discharge planning. The orientation process to the organization and the rehabilitation area seems comprehensive and well conducted. New staff members are educated about safety and how to use the equipment specific to these areas.

Performance evaluations are completed on a regular basis and team members are recognized during the huddles.

Priority Process: Episode of Care

The patients admitted to the in-patient rehabilitation area are thoroughly evaluated and the patient and family are involved early in their treatment, selecting their goals of therapy and being aware of their care plan.

The out-patient rehabilitation area is spacious and has adequate staffing, but the wait-list for access to treatment can be long, especially if patients are screened as a priority 3. There is no wait-list to access the private services also available in the out-patient area but patients are charged for the services provided, which limits access for those without third-party insurance coverage.

Pressure ulcer risk is assessed and any pre-existing ulcers are evaluated on admission to the in-patient unit and treated according to standardized interventions. The risk of falls is also assessed on admission. Both risks are assessed and documented on a weekly basis. Patients are also assessed for pain and a standardized pain scale is used to monitor trends. Medications prescription, storage and administration appropriately follow current institution policies.

Priority Process: Decision Support

The patient record is accurate and complete. Privacy and confidentiality are important issues for the team and are maintained appropriately. Appropriate guidelines are selected and are evidence based. New staff members are educated about information systems available to them. There is no research activity requiring research and ethics review in the rehabilitation area.

Priority Process: Impact on Outcomes

Significant improvement has been made for client identification and the use of two client identifiers. There is evidence supporting ongoing activities related to staff and patient safety. Fall prevention, safe storage of medications, and training for safe handling of equipment are some examples.

The team uses the unit scoreboard to monitor its progress in regards to quality improvement initiatives. The staff members also can bring improvement ideas that are prioritized by the team. The team also shares its results freely and broadly.

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

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
12.2 The team meets applicable legislation for protecting the privacy and confidentiality of client information.	!
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 has been a recent change in management at the facility which has been well-accepted by the staff. A lot of effort has gone into working with the More Time to Care initiative and staff members have been actively involved in developing objectives and measurements and actively participate in huddles.

There is alignment with the strategic plan and staff members indicate that purposeful partnerships are particularly important to them. They are currently working on addressing issues of right place, right time, and right person to care for clients that may be brought to the service with acute intoxication or substance use and may have higher needs. As the service does not offer medical detox, staff members and leadership have identified the importance of ensuring clients are brought to the appropriate service for detoxification. They are working with partners especially the police to ensure the safest and best treatment facility is utilized. Feedback was received regarding the quality journey and the desire to continue working towards strategic alignment with partners.

There are two significant service and system level reports that will be received soon and which will be used to drive objective setting and service delivery across the continuum of mental health and addiction services. There was an opportunity identified to focus improvement activities on uniting and consolidating addiction and mental health services in the region and with bordering partners such as Health Science North.

Priority Process: Competency

There has been a recent change in management, and there are opportunities to work to increase the rate of completed performance appraisals. The managers interviewed during the survey are committed to the process and have a strong history of completing these in their previous service areas.

There is clear documentation of education received by staff. The documentation in particular shows a good response to suicide risk reduction education. Not all staff members working in this area have completed necessary hand-hygiene education. Good practice and competency in care was demonstrated and seen, especially in the area of medication management, considering that these staff members are not medically trained. The staff members that oversee the medication distribution process to clients would benefit from regular updates regarding medication management and working with narcotics and controlled substances.

There are good safety processes in place to respond to, and de-escalate potentially violent incidents. Staff members are aware of their personal safety and work well as a team to ensure client and staff safety. A calm and supportive environment was noted during the survey.

Priority Process: Episode of Care

The thorough intake and assessment process leads to the development of an integrated care plan. For the 21-day residential program there is a carefully planned approach which prepares clients for their eventual discharge in a phased and well-timed module approach. At all times risk reduction is discussed and clients are active participants in the care planning process and given options.

The module approach to this rehabilitation program is favourably reviewed by both the clients and staff. The clients feel that staff members listen to their needs and are deeply dedicated to ensuring a successful program and discharge. Clients are able to self- refer and access is extremely good with no wait times. They are also able to stay in touch with the team after the treatment has been completed and if needed, they can self-admit for even short stays to avoid triggers of behaviour that would lead to relapse.

Clients expressed gratitude for the program's use of plain language and the ability to engage at all times with their care providers and peers in a supportive and healing environment. Clients did express an opportunity to have better consistency in the communication they receive from workers. Sometimes, they felt they may receive one answer from one worker and a different answer from another worker. Additionally, they sometimes felt that assessment of some basic medical or first aid needs was delayed. The new position of a nurse being added to the team could address this shortcoming for communication. There is also an opportunity identified by staff members to have the nurse complete the pre-admission medical component of the new assessment form currently being implemented.

Priority Process: Decision Support

The client record is well maintained. Paper assessments and patient information is manually entered into the Meditech system after the assessment process. There is an opportunity to move towards a more automated process however, given the environment and location at which the assessment occurs. Staff members are satisfied with the current paper based system. As the service evolves the use of electronic assessments completed on tablets or laptops would reduce duplication of work by entering data off the paper forms.

Data are protected appropriately relative to privacy and confidentiality however, the environment in the withdrawal management area has some areas that would benefit from further assessment. As clients enter

the withdrawal management area there are several co-located rooms which offer good sight lines for the addiction workers to observe clients in withdrawal. There are good facilities in a shared room so that clients can obtain food and drink and also, ability to move into a separate room to place a telephone call. Unfortunately, there is also ability for clients to look into other rooms where clients of the opposite gender are located. This represents a potential privacy breach and may mean that behaviours and challenges during the withdrawal process are observed by co-located clients. The organization is encouraged to review the layout and conduct a privacy risk identification process to determine what/if additional controls can be put in place to better ensure the privacy/confidentiality and dignity of clients undergoing withdrawal.

Priority Process: Impact on Outcomes

The service has identified a quality improvement plan which is aligned with both Accreditation Canada standards criteria and the strategic plan. There is a clearly defined road map and staff members had open discussion with the surveyor team during the visit regarding opportunities to improve or maintain gains in improvement activities. Client privacy and confidentiality was discussed as one of these opportunities and it is on their radar. They also regularly monitor their progress in the required organization practices and there was good discussion regarding two client identifiers. The service has found an effective and unique way to avoid the use of wrist bands and still ensure appropriate two client identifiers. This is achieved with picture identification and personal identification on their person. Staff members are encouraged to be ever vigilant with checking identification, especially as part of the medication management process which is a high risk area.

An environmental risk assessment and risk reduction plan has been developed and education regarding code white response and non-violent crisis intervention (NVCI) provided. There is an opportunity to review risks related to the use of the withdrawal management rooms and crisis rooms, as already noted elsewhere in the report. Staff members gave feedback that heavy workload support would be beneficial given the reports of high and regular utilization of these beds. Management is working with partners to ensure that appropriate referrals and diversions to, and from the service are identified.

Front-line staff members and management share the goal of developing a hub of excellence which goes beyond the detoxification and addictions services offered. The goal includes looking at mental health and addictions services globally and becoming an allied service across the region, and with bordering regions. Internally, an opportunity was identified to continually work at communication in and between teams in the interest of best possible client outcomes and to reduce the perception of: "my client."

3.2.19 Standards Set: Transfusion Services - Direct Service Provision

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

Surveyor comments on the priority process(es)
Priority Process: Transfusion Services
Most of the laboratory standards are assessed by the Ontario Laboratory Association (OLA) and therefore, not reviewed during this visit. The laboratory just completed its mid-term self-evaluation for OLA and will be inspected by that body in 2017.

3.2.20 Priority Process: Surgical Procedures

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

Unmet Criteria		High Priority Criteria
Standards Set: Perioperative Services and Invasive Procedures Standards		
29.1	The team collects information and feedback from clients, families, staff, service providers, organization leaders, and other organizations about the quality of its services to guide its quality improvement initiatives.	
29.2	The team uses the information and feedback it has gathered to identify opportunities for quality improvement initiatives.	

Surveyor comments on the priority process(es)

The operating suite is a state-of-the-art facility, with seven major operating rooms (ORs) and three minor rooms. All procedures are done within the specialties represented. There is no neurosurgery, cardiac, thoracic, vascular, plastic or pulmonary surgery offered. There is an excellent flow-through of surgery, with minimal waiting times for procedures and efficient use of OR time.

The different disciplines function as a coordinated team in an open and transparent manner. There is a willingness of the team to accept change as both a challenge and an opportunity for improvement. Most of the unmet criteria from the 2012 survey are now addressed, except for contacting and obtaining feedback from the clients and families during the post-operative period.

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 (2016)

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

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

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

- **Data collection period: October 16, 2014 to October 21, 2014**
- **Number of responses: 17**

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	0	100	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	0	100	89
12 The composition of our governing body contributes to high governance and leadership performance.	0	0	100	93
13 Our governing body’s dynamics enable group dialogue and discussion. Individual members ask for and listen to one another’s ideas and input.	0	0	100	96
14 Our ongoing education and professional development is encouraged.	0	0	100	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.	0	0	100	82
19 We benchmark our performance against other similar organizations and/or national standards.	6	6	88	72
20 Contributions of individual members are reviewed regularly.	6	0	94	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	0	100	81
22 There is a process for improving individual effectiveness when non-performance is an issue.	6	0	94	64
23 We regularly identify areas for improvement and engage in our own quality improvement activities.	6	0	94	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.	0	0	100	84
25 As individual members, we receive adequate feedback about our contribution to the governing body.	0	0	100	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.	6	0	94	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	0	100	92
31 We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	0	0	100	87
32 We have explicit criteria to recruit and select new members.	0	0	100	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	0	100	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: Community Based Version

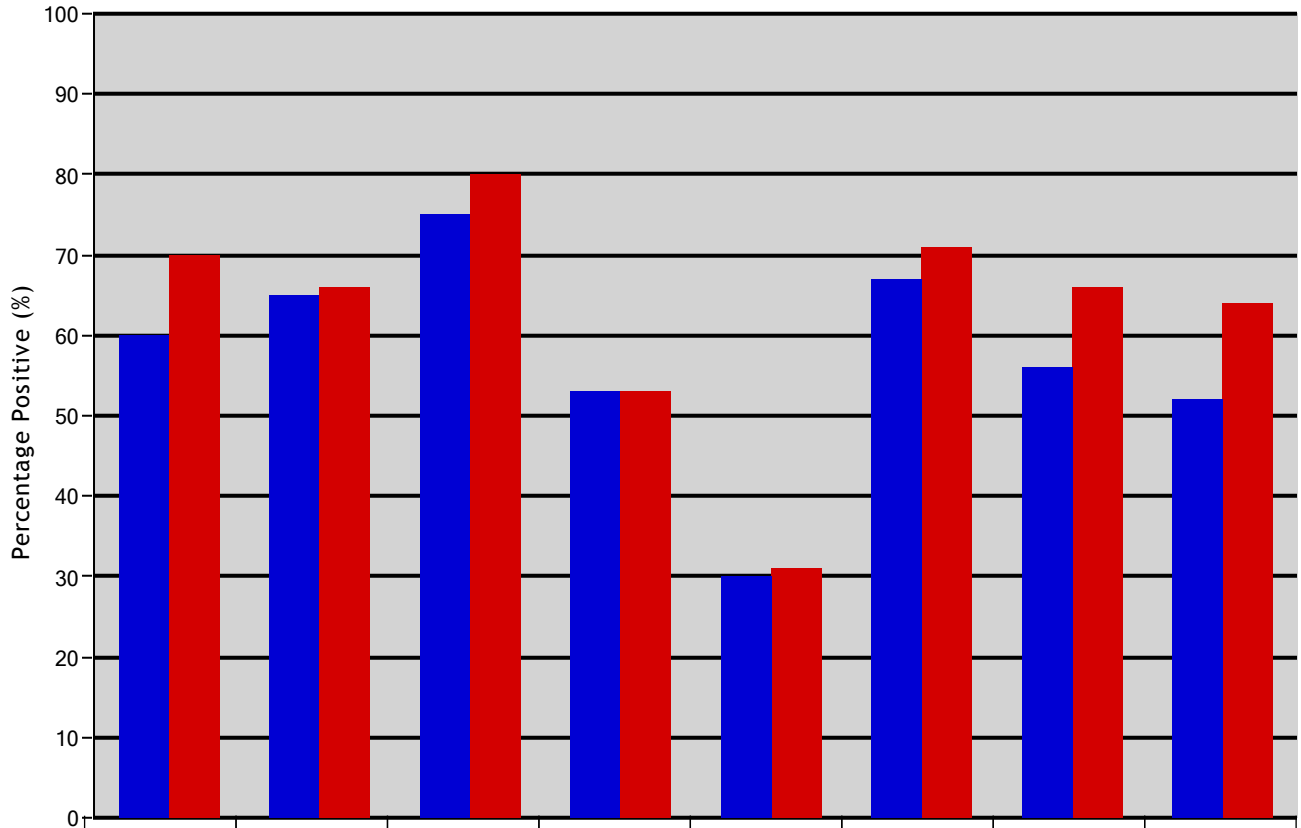
Organizational culture is widely recognized as a significant driver in changing behavior and expectations in order to increase safety within organizations. A key step in this process is the ability to measure the presence and degree of safety culture. This is why Accreditation Canada provides organizations 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: November 3, 2014 to November 21, 2014**
- **Minimum responses rate (based on the number of eligible employees): 302**
- **Number of responses: 386**

Canadian Patient Safety Culture Survey Tool: Community Based Version: 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
	60%	65%	75%	53%	30%	67%	56%	52%
	70%	66%	80%	53%	31%	71%	66%	64%

Legend

North Bay Regional Health Centre

* Canadian Average

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

4.3 Worklife Pulse

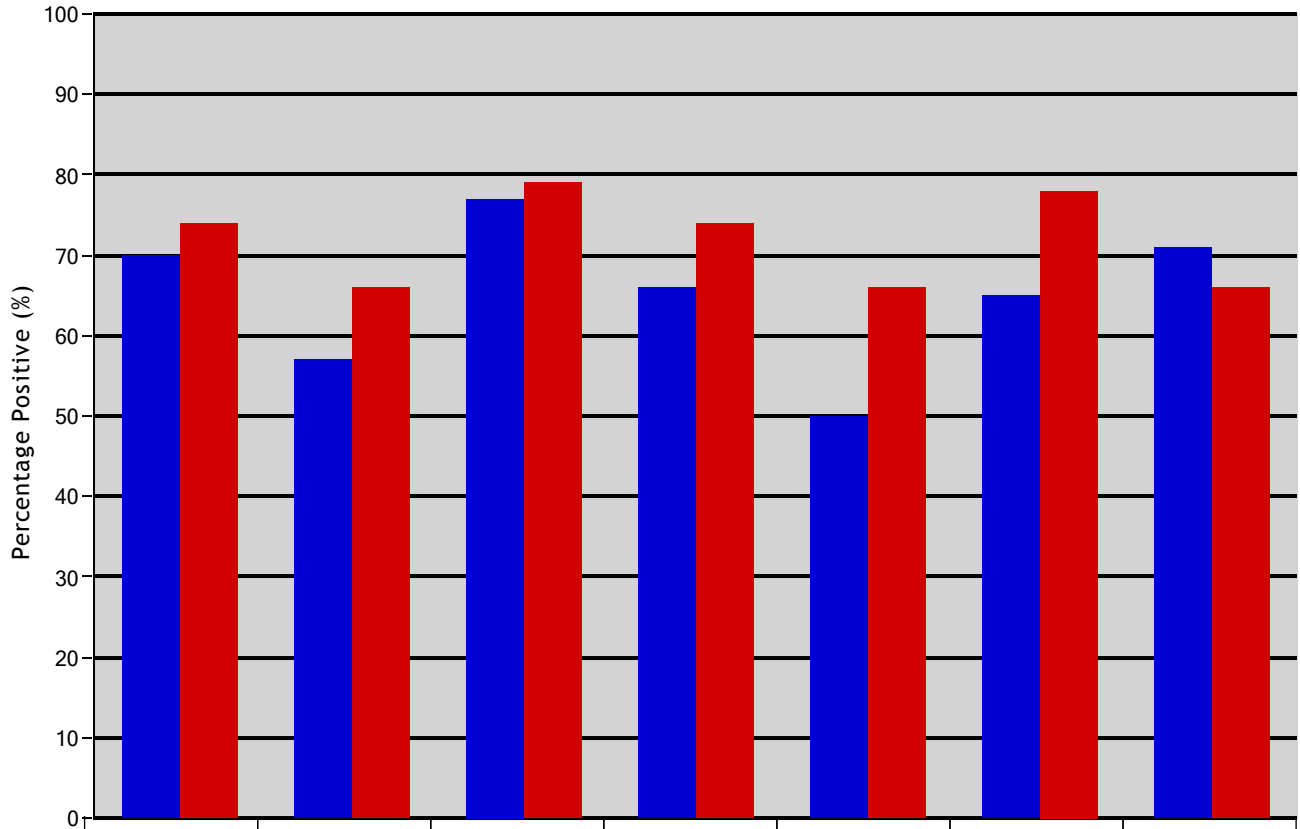
Accreditation Canada helps organizations create high quality workplaces that support workforce wellbeing and performance. This is why Accreditation Canada provides organizations with the Worklife Pulse Tool, an evidence-informed questionnaire that takes a snapshot of the quality of worklife.

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.

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

- **Data collection period: September 29, 2014 to October 18, 2014**
- **Minimum responses rate (based on the number of eligible employees): 328**
- **Number of responses: 555**

Worklife Pulse: Results of Work Environment



	Job	Training and Development	Coworkers	Immediate Supervisor	Senior Management	Safety and Health	Overall Experience
	70%	57%	77%	66%	50%	65%	71%
	74%	66%	79%	74%	66%	78%	66%

Legend

North Bay Regional Health Centre

* 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.

4.4 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 making decisions about ethical dilemmas and problems.
Resource Management	Monitoring, administering, and integrating activities related to the allocation and use of resources.

Priority processes associated with population-specific standards

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

Priority processes associated with service excellence standards

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

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