Accreditation Report

North Bay Regional Health Centre

North Bay, ON

On-site survey dates: November 8, 2020 - November 13, 2020

Report issued: December 15, 2020

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 2020. 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 will be treated in confidence by Accreditation Canada in accordance with the terms and conditions as agreed between your organization and Accreditation Canada for the Assessment Program.

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.

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A Message from Accreditation Canada

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

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

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

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

We look forward to our continued partnership.

Sincerely,

Leslee Thompson
Chief Executive Officer

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Executive Summary

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.

Accreditation Decision

North Bay Regional Health Centre's accreditation decision is:

Accredited (Report)

The organization has succeeded in meeting the fundamental requirements of the accreditation program.

About the On-site Survey

- **On-site survey dates: November 8, 2020 to November 13, 2020**

- **Locations**

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

1. Devonshire Campus
2. Emergency Medical Services
3. King Street Campus
4. Kirkwood Place
5. NBRHC-Main SIte
6. 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. Governance
2. Infection Prevention and Control Standards
3. Leadership
4. Medication Management Standards

Service Excellence Standards

5. Ambulatory Care Services - Service Excellence Standards
6. Biomedical Laboratory Services - Service Excellence Standards
7. Cancer Care - Service Excellence Standards
8. Community Health Services - Service Excellence Standards
9. Community-Based Mental Health Services and Supports - Service Excellence Standards
10. Critical Care Services - Service Excellence Standards
11. Diagnostic Imaging Services - Service Excellence Standards
12. Emergency Department - Service Excellence Standards
13. EMS and Interfacility Transport - Service Excellence Standards
14. Inpatient Services - Service Excellence Standards

15. Mental Health Services - Service Excellence Standards
16. Obstetrics Services - Service Excellence Standards
17. Organ and Tissue Donation Standards for Deceased Donors - Service Excellence Standards
18. Perioperative Services and Invasive Procedures - Service Excellence Standards
19. Point-of-Care Testing - Service Excellence Standards
20. Rehabilitation Services - Service Excellence Standards
21. Reprocessing of Reusable Medical Devices - Service Excellence Standards
22. Transfusion Services - Service Excellence Standards

- **Instruments**

The organization administered:

1. Canadian Patient Safety Culture Survey Tool
2. Governance Functioning Tool (2016)
3. Client Experience Tool

Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
Population Focus (Work with my community to anticipate and meet our needs)	71	3	0	74
Accessibility (Give me timely and equitable services)	128	0	0	128
Safety (Keep me safe)	849	6	22	877
Worklife (Take care of those who take care of me)	183	1	2	186
Client-centred Services (Partner with me and my family in our care)	522	23	1	546
Continuity (Coordinate my care across the continuum)	118	0	3	121
Appropriateness (Do the right thing to achieve the best results)	1249	29	17	1295
Efficiency (Make the best use of resources)	93	1	0	94
Total	**3213**	**63**	**45**	**3321**

Overview by Standards

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

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

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

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

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	50 (100.0%)	0 (0.0%)	0	36 (100.0%)	0 (0.0%)	0	86 (100.0%)	0 (0.0%)	0
Leadership	50 (100.0%)	0 (0.0%)	0	93 (97.9%)	2 (2.1%)	1	143 (98.6%)	2 (1.4%)	1
Infection Prevention and Control Standards	40 (100.0%)	0 (0.0%)	0	30 (96.8%)	1 (3.2%)	0	70 (98.6%)	1 (1.4%)	0
Medication Management Standards	77 (98.7%)	1 (1.3%)	0	63 (98.4%)	1 (1.6%)	0	140 (98.6%)	2 (1.4%)	0
Ambulatory Care Services	37 (84.1%)	7 (15.9%)	3	65 (84.4%)	12 (15.6%)	1	102 (84.3%)	19 (15.7%)	4
Biomedical Laboratory Services **	72 (100.0%)	0 (0.0%)	0	105 (100.0%)	0 (0.0%)	0	177 (100.0%)	0 (0.0%)	0
Cancer Care	77 (96.3%)	3 (3.8%)	1	112 (99.1%)	1 (0.9%)	1	189 (97.9%)	4 (2.1%)	2
Community Health Services	42 (95.5%)	2 (4.5%)	0	78 (97.5%)	2 (2.5%)	0	120 (96.8%)	4 (3.2%)	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	45 (100.0%)	0 (0.0%)	0	94 (100.0%)	0 (0.0%)	0	139 (100.0%)	0 (0.0%)	0
Critical Care Services	59 (100.0%)	0 (0.0%)	1	103 (100.0%)	0 (0.0%)	2	162 (100.0%)	0 (0.0%)	3
Diagnostic Imaging Services	66 (100.0%)	0 (0.0%)	2	64 (97.0%)	2 (3.0%)	3	130 (98.5%)	2 (1.5%)	5
Emergency Department	72 (100.0%)	0 (0.0%)	0	106 (100.0%)	0 (0.0%)	1	178 (100.0%)	0 (0.0%)	1
EMS and Interfacility Transport	104 (92.0%)	9 (8.0%)	6	111 (92.5%)	9 (7.5%)	1	215 (92.3%)	18 (7.7%)	7
Inpatient Services	59 (98.3%)	1 (1.7%)	0	81 (95.3%)	4 (4.7%)	0	140 (96.6%)	5 (3.4%)	0
Mental Health Services	49 (98.0%)	1 (2.0%)	0	90 (97.8%)	2 (2.2%)	0	139 (97.9%)	3 (2.1%)	0
Obstetrics Services	71 (100.0%)	0 (0.0%)	2	88 (100.0%)	0 (0.0%)	0	159 (100.0%)	0 (0.0%)	2
Organ and Tissue Donation Standards for Deceased Donors	53 (100.0%)	0 (0.0%)	1	95 (100.0%)	0 (0.0%)	1	148 (100.0%)	0 (0.0%)	2
Perioperative Services and Invasive Procedures	115 (100.0%)	0 (0.0%)	0	109 (100.0%)	0 (0.0%)	0	224 (100.0%)	0 (0.0%)	0
Point-of-Care Testing **	38 (100.0%)	0 (0.0%)	0	46 (100.0%)	0 (0.0%)	2	84 (100.0%)	0 (0.0%)	2
Rehabilitation Services	44 (100.0%)	0 (0.0%)	1	79 (100.0%)	0 (0.0%)	1	123 (100.0%)	0 (0.0%)	2
Reprocessing of Reusable Medical Devices	81 (98.8%)	1 (1.2%)	6	40 (100.0%)	0 (0.0%)	0	121 (99.2%)	1 (0.8%)	6
Transfusion Services **	71 (100.0%)	0 (0.0%)	5	68 (100.0%)	0 (0.0%)	1	139 (100.0%)	0 (0.0%)	6
Total	**1372 (98.2%)**	25 (1.8%)	28	1756 (98.0%)	36 (2.0%)	15	3128 (98.1%)	61 (1.9%)	43

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

Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

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

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

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

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

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

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

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

Summary of Surveyor Team Observations

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

The North Bay Regional Health Centre (NBRHC) is a unique healthcare organization with three primary roles. It provides acute care services to North Bay and its surrounding communities, it is the district referral centre providing specialist services for smaller communities in the area, and it is the specialized mental health service provider serving all of northeastern Ontario.

North Bay Regional Health Centre has 389 beds and numerous outpatient and outreach services in North Bay, and throughout the northeast region.

North Bay Regional Health Centre is one of four major acute care hospitals serving northeastern Ontario; the others being Sault Area Hospital, Timmins and District Hospital, and Health Sciences North (Sudbury). The area is also served by small community hospitals like Mattawa Hospital and West Nipissing General Hospital. North Bay Regional Health Centre’s Regional Mental Health Services provides inpatient beds in North Bay and Sudbury, and outpatient and outreach services throughout the region — from Hudson Bay to Muskoka, and from Sault Ste. Marie to the Quebec border.

The board of directors are knowledgeable, engaged, and supportive, guiding the senior leadership team through the COVID-19 pandemic and the implementation of a new hospital information system.

The organization has a high number of long tenure staff, and has experienced a fairly low turnover rate. Wellness programs are in place, but somewhat hampered by the current pandemic restrictions limiting physical gatherings. A high sick-time rate has been present for some time in the organization, and work is underway to look at new ways to deal with the situation.

The North Bay Regional Health Centre enjoys a strong reputation and collaborative, mutually supportive relationships with local and regional health care partners. Patient survey results indicate a high rate of patient satisfaction.

Detailed Required Organizational Practices

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	
Client Identification Interfacility Transport only: Working in partnership with patients and families, at least two person-specific identifiers are used to confirm that patients receive the service or procedure intended for them.	· EMS and Interfacility Transport 20.8
Medication reconciliation at care transitions Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information at ambulatory care visits when medication management is a major component of care.	· Ambulatory Care Services 8.5

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
	Required Organizational Practice
MAJOR	Major ROP Test for Compliance
MINOR	Minor ROP Test for Compliance

Priority Process Results for System-wide Standards

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

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

Priority Process: Governance

Meeting the demands for excellence in governance practice.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The North Bay Regional Health Centre board of directors are knowledgeable and very engaged. They have continued to meet virtually throughout the COVID-19 pandemic, to support and guide the senior leadership team as needed. The Board expressed sincere appreciation and pride in how the senior leadership team had managed the events of the first wave of the pandemic.

Quality is a key focus of the board, and a strong commitment to safety and quality patient care was expressed. The board receives regular reports on the key quality and risk indicators being monitored, including the implementation of the new hospital information system (Meditech Expanse), incidents of workplace violence, and levels of alternate-level-of-care patients in the hospital. The hospital has been functioning under the direction of the 2017–2019 strategic plan, with the intent to totally refresh the plan in 2020. However, the board made the decision earlier this year to abbreviate the strategic planning process, given the current pandemic environment, which will result in the continuation of the key pillars of the previous plan, but with new actions to be taken over the next twelve months. North Bay Regional Health Centre has been an active member of the Ontario Health Team in the area. The organization chose to remain as an affiliate, rather than a full member, due to the need to focus on internal priorities, such as the hospital information system and the pandemic response.

The board appears to be high functioning, with regular evaluations of individual members and their functioning as a whole. A comprehensive workplan supports the content of monthly agendas, including the review and revisions of board policies and administrative by-laws. The board has adopted an ethical framework, “The All Things Considered,” and each board agenda includes a Declaration of Ethical Decision-Making. The framework was used in recent board deliberations to come to agreement to support a deficit budget, rather than jeopardized the quality of care.

The board is skills-based, and recruitment processes include an open call to the community. The importance of diversity of membership is recognized by the board, and efforts have been made to have representation from the indigenous communities on the North Bay Regional Health Centre board. The

board is encouraged to continue to pursue this representation. A patient representative has recently been added to the board and the voice of the patient is heard through the sharing of patient stories by staff and physicians. Prior to the pandemic, the board also took part in the "Go, See, Learn" opportunity to visit various departments, and speak with staff and patients. Although patients and families have been invited to provide input into the development of a number of new programs, there is not a consistent group of patients and families that are provided education and support, in order to proactively provide input to the teams on the day-to-day functioning of the various departments. The organization is encouraged to look at additional methods to engage patients and families in order to gain the perspective of patients served.

Priority Process: Planning and Service Design

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization engaged internal and external stakeholders in the review of the mission statement and the development of the 2017–2019 Strategic Plan. A full update to this plan was to be completed in 2020. However, given the changing environment internally with the Meditech Expanse implementation, and the COVID-19 pandemic, as well as the changing external environment with the province's move to implementing Ontario Health Teams, the board agreed to an abbreviated process to provide direction for the next twelve months. This plan is currently in development. It is the intent of the organization develop a corresponding operational plan, which will be shared with departments and enable them to develop their goals and objectives in keeping with the strategic directions. The organization has good tools and strategies to monitor progress towards their goals, such as the "priority tracking tool" and a change management strategy.

Patient and family-centred care is identified as a guiding principle for the organization and patients and family members have been asked to provide input for the design of new programs and services. However, the organization is encouraged to expand this approach, and provide support and education to patients and families who have lived experience in specific areas, in order to gather their perspectives on the operations in those areas.

The North Bay Regional Health Centre enjoys a strong reputation among local and regional health care partners. Partners interviewed indicated that communication with the organization was good, and they were able to readily access the chief executive officer and other members of the leadership team as needed. Collaboration and mutual support are felt to be evident, as organizations are working together to meet the needs of the community during the pandemic. North Bay Regional Health Centre was described as an advocate for smaller centres, and partners described the organization as respectful and a team player. An area that the group identified as an opportunity for further growth was for the organization to be more outward-looking, with a greater focus on the health and wellness of the community.

Patient survey results indicate a high rate of patient satisfaction, with the vast majority of respondents rating their hospital stay as an eight out of 10, or greater.

Priority Process: Resource Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization has a strong process to develop and monitor operating and capital budgets. Managers and directors are held accountable for their budgets, and are asked to reconcile variances on monthly operating statements for their departments. Financial analysts are available to support the work of the managers and directors. The board approves the annual operating and capital budgets, and receive regular reports tracking the financial performance of the organization.

The organization has, in the past, faced significant financial challenges, and through rigorous actions, including bed closures and a reduction of staff, were able to reach a balanced position. Unfortunately, the implementation of Meditech Expanse in 2019 has resulted a deficit of $5–6 million for the organization, and a three-year recovery plan is currently being developed. The organization practices regular benchmarking, and holds discussions with peers to learn what others are doing to reduce costs.

Priority Process: Human Capital

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

A comprehensive, recently revised Human Resources Plan has identified three key areas of focus for the department. These include education, support, and the growth and development of staff and volunteers.

A number of action steps for each of these areas of focus have been developed, and are currently being implemented. The human resources department is commended for developing and implementing a stakeholder survey, which targeted the management of the hospital, and resulted in detailed information which is further guiding improvement activities for the department.

The staff Worklife Pulse Tool, completed in 2019, identified a number of areas for improvement. The leadership team have recognized that the implementation of Meditech Expanse, as well as the COVID-19 pandemic occurring within the same year, have resulted in significant stress for staff and physicians. The organization is encouraged to continue work to update the Worklife Pulse Workplan (last dated November, 2018) with a comprehensive and measurable plan to address the current concerns of staff.

Revision of the Talent Management Plan is currently in progress, and the organization is encouraged to complete the review, revisions, and implementation of the plan to support the managers who have recently joined the organization.

The human resources team is very cohesive, and described pride in their collegiality and their ability to support each other.

Priority Process: Integrated Quality Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The North Bay Regional Health Centre has been on a quality transformation journey for a number of years, with the goal of providing care that is evidence based, safe, effective, patient-centred, efficient, timely, and equitable. The organization is commended for the energy, focus, and level of resource they have dedicated to this initiative. Currently, quality coordinators are embedded in each major portfolio, including a quality coordinator serving the physicians and the senior leadership team. Managers, directors, and physicians are trained in the use of quality improvement tools and strategies, and physician space has been dedicated as a “strategic room.” Staff are allocated time away from regular duties to participate in quality improvement activities, and physician engagement in these activities is said to be strong. The results of initiatives are shared across the organization, and prior to the pandemic, a monthly “report-out” was held in the auditorium with staff, physicians, and board members in attendance. Huddle boards are found across the departments; however, the relevance of the data displayed is inconsistent and not always meaningful. The organization is encouraged to re-engage staff in monitoring quality indicators, and using the huddle boards as a means of communication, to monitor work being done, and to celebrate the successes.

Patient safety is a key priority for the organization, and a comprehensive quality and patient safety plan is in place. Quarterly reports are provided to the board on quality and patient safety indicators.

Work has been done in the past few years to implement an integrated risk management program across the organization. The roll out of this program was described as bumpy and requiring revisions, with work still ongoing. Based on the Healthcare Insurance Reciprocal of Canada (HIROC) framework, risks have been identified across the organization, and the board receives quarterly reports outlining the major risks and mitigating strategies.

A new incident management system has been implemented, which is felt to more user friendly for staff completing reports. As well, the process surrounding incident management has been strengthened; each incident filed is reviewed by the quality team, and discussions are held with staff and managers to close the loop on changes that may be needed. The patient handbook contains information on how to raise a complaint, and meetings are held with patients and families following an incident. This process has been evaluated and modified through feedback received from patients and families involved in disclosure of incidents. The organization has a patient advocate who supports patients and families as an “independent voice” when concerns are raised. There is a comprehensive disclosure policy and process in place.

Medication reconciliation is well established within the inpatient units of the organization; however, does

require further attention within some ambulatory care areas. It was suggested that the way to transition to having dedicated and well-trained pharmacy technicians is to complete the medication reconciliation process that has supported the significant improvement in the inpatient units. The organization is encouraged to identify and implement the needed strategies to support greater adherence to the process in ambulatory care areas.

Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The current ethical framework was developed to ensure it is applicable to the entire organization. Its development had input from staff and community partners.

A case consultation process referral form is available to all staff and teams. The form is well designed to prepare a team to identify facts, who is accountable, and what decision is required.

The Ethics Committee reports to the Quality Committee of the board. The Ethics Committee collects data from all case consultation processes, and provides a quarterly report to the board's Quality Committee.

The organization's ethical framework is visible across the organization in meeting rooms and with huddle boards. The senior leadership team has used the framework with the board of directors to guide the development of the Medical Assistance in Dying program, and make difficult resource allocation decisions, as well as service reduction decisions, to ensure operational accountability.

Priority Process: Communication

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The North Bay Regional Health Centre has a very comprehensive communication plan, which is updated annually. The plan includes the objectives, tactics, and intended audiences, as well as policies relating to media, crisis communication, and the use of social media. A variety of communication vehicles are used, including social media, to inform both external and internal audiences. An annual report is also issued to the community, outlining the key events of the year, as well as the overall financial health of the organization. This communication plan was updated during the first stage of the COVID-19 pandemic, with particular focus on supporting the emotional needs of staff and physicians, by providing accurate and frequent communications from the command centre.

The organization gathers both qualitative and quantitative data to evaluate the communication provided. Of note was the high sentiment scores registered through social media during the first wave of the pandemic.

The Vocera platform used throughout the hospital has greatly improved the ease and speed with which staff and physicians can communicate, and the organization is commended for implementing this effective system.

With the goal of moving to a fully electronic health record, North Bay Regional Health Centre went live with a new hospital information system, Meditech Expanse, in October 2019. The organization is one of the three of a much larger group of hospitals to move forward in the first wave. In total, twenty-four hospitals will be on this system when all are implemented. Implementation of the new system at North Bay Regional Health Centre was a three-year project, and communication throughout this time was very important. A fan-out approach was used, with written material being provided to each manager and director in order to provide a common and consistent message. As the go-live date approached, face-to-face communication was implemented and twice daily huddles were conducted in all departments, in order to hear concerns and provide support to staff and physicians working to provide safe patient care while transitioning to a new information system. A year later, the system is running smoothly and the benefits of increased patient information flow, increased safety measures, as well as increased data analysis are being experienced by the organization.

In the past two years, these two major events, the COVID-19 pandemic and the implementation of Meditech Expanse, have truly tested the organization’s communication strategies. The organization is commended for its ability to be flexible and learn from both of these situations, implementing new approaches to meet the needs of the internal and external audiences.

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)

North Bay Regional Health Centre is a modern facility serving individuals with a mix of patient services, including acute care, mental health, rehabilitation, complex care, and palliative care. The hospital is bright, spacious, and particularly welcoming, with circulating fresh air in every room. The facility resembles a small city, with a main street and avenues, shops, restaurants, and cafés. The organization's interior design is attractive, with cozy furniture and a variety of beautiful artwork. The outside grounds are nicely landscaped with accessible pathways, and beautiful garden furniture for patients and their families to enjoy. The facility management team is commended for its efforts in providing an environment that is clean and well-maintained.

In terms of patients and staff safety, there are nurse call bells in patients’ rooms and in bathrooms, and the organization has recently purchased staff duress tags that activate a code white. Fire exits are free from clutter, there is a well-developed emergency plan, and safety inspections are conducted regularly. Transport vehicles are built to provide safe medical care and are driven by qualified personnel.

In terms of facility management, work is underway in patient care service areas to assess lighting and how it impacts patient and staff satisfaction. The organization is encouraged to involve patients and families when discussions on lighting take place.

During the hospital tour, it was noticed that some corridors are cluttered with an increasing amount of supplies and personal protective equipment, materials, and workstations on wheels. As such, the organization is encouraged to keep an eye on cluttered areas, and to ensure that hallways in patients care units are kept clear of non-essential items.

There is a complete preventative maintenance program that is managed by trained personnel, and there are backup systems in the event of a systems failure. The organization has two back-up generators, which have considerable usable capacity once engaged. Safety drills are practiced, and are followed by a tabletop debriefing; improvements to enhance patient and staff safety are discussed.

Signage in some areas is clear and effective, while in other areas it is more challenging. Wayfinding is a work in progress, and many changes have been made to help patients and families navigate across the system. For example, with input from patients and families, floor designs with paw prints, heart prints, and kidney bean prints were created as pathways to help improve navigation throughout the hospital. The organization is congratulated for taking this initiative.

Priority Process: Emergency Preparedness

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Emergency code policies are in place. Ongoing engagement occurs with external partners that include the city's disaster response team, police, and fire department. Code brown policy is implemented. All staff receive code brown training and participate in mock drills. There are spill kits throughout the organization. There is a separate building on site at North Bay Regional Health Centre to store hazardous waste material. Protocols are in place to ensure the proper labelling, handling, and transportation of this material.

The Emergency Operations Committee was activated to meet regularly, and includes the senior leadership team, infection prevention and control, and Public Health. Previous pandemic plans focused on influenza, however with the current COVID-19 pandemic, emergency codes such as code orange have been updated to reflect current learning.

The communications team works closely with the emergency preparedness team to plan for media and social media responses, to ensure proactive communication with patients and families, and an appropriate response to emergencies and inquiries.

North Bay Regional Health Centre completed the Organizational Risk Assessment for Infectious Disease (ORAID). The organization also completed a Hazard and Vulnerability Analysis, which is shared with the city. The organization collaborates with the Healthcare Insurance Reciprocal of Canada to enhance risk mitigation planning and testing of systems. North Bay Regional Health Centre has undertaken an Event Tree Analysis and follow up with action planning, that includes training and compliance audits.

North Bay Regional Health Centre has an integrated disaster management plan with Health Sciences North for the Kirkwood site in Sudbury, which is a building shared with Health Sciences North. The plan has been in place since 2006. Due to the location, Health Sciences North leadership is first administration on call and would establish an Emergency Operations Centre on site in the event of a disaster or emergency, and follow up with North Bay Regional Health Centre administration on call. The site has around the clock security presence to support safety for the three inpatient units. This site has an integrated Emergency Response Plan, so that the Health Sciences North and North Bay Regional Health Centre services are trained the same way, use the same policies, and have a unified response.

The organization's Business Continuity Plan and Emergency Response Plan were recently integrated, and the detailed guidance for implementation is being built into emergency code policies.

Priority Process: People-Centred Care

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

Unmet Criteria		High Priority Criteria
Standards Set: Ambulatory Care Services		
1.1	Services are co-designed with clients and families, partners, and the community.	!
2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
3.11	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
8.3	Goals and expected results of the client's care and services are identified in partnership with the client and family.	
15.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Cancer Care		
1.1	Services are co-designed with clients and families, partners, and the community.	!
8.12	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
27.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Community Health Services		
1.1	Services are co-designed with clients and families, partners, and the community.	!
2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	

3.10	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
16.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: EMS and Interfacility Transport		
27.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from patients and families.	!
Standards Set: Inpatient Services		
3.12	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
16.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Leadership		
3.6	There are regular dialogues between the organization's leaders and clients and families to solicit and use client and family perspectives and knowledge on opportunities for improvement.	
10.4	Education and training are provided throughout the organization to promote and enhance a culture of client- and family-centred care.	
Standards Set: Mental Health Services		
3.15	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
15.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!

Surveyor comments on the priority process(es)

Patient- and family-centred care is identified as a guiding principle for the organization, and patients and family members have been asked to provide input for the design of a number of new programs and services. Input is also gathered from members of the Senior Friendly Hospital committee, as well as specialized advisors for programs such as the Medical Assistance in Dying program and the Behavioural

Supports Ontario program.

Generally, patients and families interviewed indicated they felt respected and well cared for. Departments are actively engaging patients in their own care and care decisions. Patients and family members are asked to advise on service design and delivery of care; however, this was not consistently observed across the organization. In some areas, it appears that informative exchanges between staff and patients exist, but patient feedback regarding the quality of care and services they receive is not consistently acquired.

There is an opportunity to expand the current approach to patient and family engagement, and consistently embrace greater opportunities for patients and family members to make a difference in the care being provided. As well, the organization is encouraged to dedicate time and energy in educating and supporting those patients and family members who step forward to provide input.

Priority Process: Patient Flow

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization has a comprehensive Patient Flow program with eight patient flow navigators (PFNs) working seven days a week. Standardized discharge planning tools are used, for example, the Baylock Risk Assessment Score is used to measure and monitor for patients with anticipated challenges or barriers to discharge. The PFNs are assigned to specific units, and are therefore embedded as a part of the interdisciplinary teams. They work very closely with the physicians and social workers to develop and implement discharge plans.

There is a daily bed meeting Monday to Friday that includes PFNs, the bed allocator, the emergency department, infection prevention and control, and the perioperative program coordinator to plan for procedures, transfers of patients across units internally, and discharges. North Bay Regional Health Centre has a threshold of four "No Bed Admits" (NBAs) to trigger a second bed meeting for that day, whereby the bed meeting group escalates to problem solve patient flow and disposition. When the emergency department is challenged with NBAs, it's escalated to the emergency department director and the vice president, who work with the chief of staff to facilitate communication with physicians. The vice president of patient care and chief executive officer participate with all other health service providers from the region, along with the Regional Office (formerly the local health integration network) and Public Health, in "Right Place of Care" where patient flow is discussed regionally to ensure inter-organizational collaboration.

Emergency medical services communicates with the emergency department lead registered nurse en route, and follows standard criteria for emergent and trauma patients.

Priority Process: Medical Devices and Equipment

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

Unmet Criteria		High Priority Criteria
Standards Set: Reprocessing of Reusable Medical Devices		
9.2	Point of use cleaning of a device or equipment is performed as part of the decontamination process and occurs immediately after use and prior to decontamination in an MDRD and following manufacturers' instructions.	!

Surveyor comments on the priority process(es)

There is an interdisciplinary team supporting medical devices and equipment at the North Bay Regional Health Centre. The team and leaders are committed to ensuring quality medical device reprocessing and preventative maintenance of equipment. An operating room and medical device reprocessing department Quality Improvement Committee supports communication and the work flow of both departments.

There is a strong orientation process, and educational opportunities are available for the team. A recognized course in reprocessing of reusable medical devices is a requirement to work in the medical device reprocessing department. There are comprehensive processes for medical device reprocessing and equipment maintenance. There are manuals and standard operating procedures available. The equipment is maintained by the facilities, biomedical services, and equipment manufacturers. There are quality assurance measures in place, including regular auditing and testing of the sterilization equipment and documenting the outcomes.

All medical device reprocessing is centralized at the medical device reprocessing department, with the exception of the endoscopy reprocessing, which occurs in the endoscopy suite. The reprocessing for diagnostic imaging medical devices was transferred to the medical device reprocessing department approximately one month ago. The reprocessing team continues to work on improving the flow for this process, and have acquired additional equipment anticipated to decrease the processing time and improve tracking.

The medical device reprocessing area is spacious and well lit. The organization has considered ergonomics in the design of the reprocessing area. Rubber mats are provided at all workstations, and sink inserts are available to reduce the requirement to bend while cleaning. Work spaces are clear, and clutter is minimized. Positioned below the perioperative area, dedicated elevators transport soiled and clean equipment to their respective areas. Equipment entering the dirty side of the reprocessing facility follows a natural flow through the department to the clean side. All equipment is calibrated daily, and biological indicators are completed for the first and last load, and any implantable devices each day. All trays are registered for trackable recall, should that be required. The department also includes a large storage area

for sterilized trays and equipment. The endoscopes, gastroscopes and cystoscopes are cleaned in a dedicated area in the operating room. This area demonstrates excellent flow with dirty scopes exiting the back door of the operating room and then moving through the dirty and clean areas. The reprocessing team makes excellent use of technology, with barcoded elements at every step to track each piece of equipment.

The reprocessing teams are supported by technology, including digital lists of required equipment and photographs of each tray. The reprocessing department and the surgical staff have worked together to develop the trays, and continue to work to improve standardization. There are a high number of orthopedic surgeries completed, resulting in a need for a quick turn-around for the large orthopedic instrument sets. There is an opportunity to complete an instrument usage assessment, which may result in an addition to or change in the instrument set usage.

The orthopedic equipment is not always disassembled according to manufacturers' instructions. The team is encouraged to ensure that such equipment is properly disassembled. The point-of-use cleaning of a device or equipment is not always performed, and the team is encouraged to complete point-of-use cleaning immediately after use, and prior to decontamination in the medical device reprocessing department.

The organization has two flash sterilizers, and the reprocessing team is responsible for their maintenance. Due to the rarity of use, only one of the sterilizers is turned on. The flash sterilizer is calibrated daily, and there is a process in place for tracking usage.

The cleaning of the EMS and inter-facility transport equipment and vehicles is completed by the Paramedic Services, according to the Ministry of Health and North Bay Regional Health Centre standards. Single use devices are used for patient procedures, therefore, reprocessing of such medical devices is not required. A preventive maintenance program for medical devices, medical equipment, and medical technology is implemented.

Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Point-of-care Testing Services

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

Clinical Leadership

- Providing leadership and direction to teams providing services.

Competency

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

Episode of Care

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

Decision Support

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

Impact on Outcomes

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

Medication Management

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

Organ and Tissue Donation

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

Infection Prevention and Control

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

Diagnostic Services: Imaging

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

Diagnostic Services: Laboratory

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

Transfusion Services

- Transfusion Services

Standards Set: Ambulatory Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.2	Information is collected from clients and families, partners, and the community to inform service design.	
1.3	Service-specific goals and objectives are developed, with input from clients and families.	
1.4	Services are reviewed and monitored for appropriateness, with input from clients and families.	
2.6	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
Priority Process: Competency		
3.1	Required training and education are defined for all team members with input from clients and families.	!
Priority Process: Episode of Care		
7.12	Ethics-related issues are proactively identified, managed, and addressed.	!
7.13	Clients and families are provided with information about their rights and responsibilities.	!
8.2	The assessment process is designed with input from clients and families.	
8.5	Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information at ambulatory care visits when medication management is a major component of care.	ROP

8.5.1	Ambulatory care clinics, where medication management is a major component of care, are identified by the organization. This designation is documented, along with the agreed upon frequency at which medication reconciliation should occur for clients of the clinic.	**MAJOR**
Priority Process: Decision Support		
12.2	Policies on the use of electronic communications and technologies are developed and followed, with input from clients and families.	
Priority Process: Impact on Outcomes		
13.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
13.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
13.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
15.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
15.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The ambulatory care unit is designated to care for patients with medical and surgical conditions. It is a large area with a total of 18 bays, including treatment and exam rooms, and patient waiting areas. During the exchanges with the leadership team, it was stated that due to the COVID-19 pandemic, many projects were put on hold. The leadership team is aware of the hospital's strategic directions; however, at the present time, unit goals and objectives are not operationalized to meet the strategic plan in a systematic way. In addition, working with patients and families to acquire their feedback regarding the care and services they are receiving is not consistently achieved. Access to care is seamless.

Priority Process: Competency

The ambulatory care unit staff receives a lot of support from their manager, and from a full-time clinical nurse educator. Nurses undergo basic life support (BLS) training annually. Although regular mock code blue exercises are included in their training program, they have not been occurring on the unit since 2019. The unit leaders are encouraged to reactivate code blue exercises, as they are extremely valuable in optimizing overall performance during a code.

Infusion pump knowledge is assessed every two years. Training on infusion pumps is customized according to the needs of the nurses. Pediatric and neonatal infusion pump training is offered to nurses, to help them provide safer treatments to children and infants who are under their care.

Team members performance evaluations are completed inconsistently.

Priority Process: Episode of Care

In the ambulatory care unit, the concepts of medication reconciliation when prescribing or changing a patient's medication is not integrated within an interdisciplinary framework. Furthermore, physicians did not seem to receive guidance from nurses or pharmacists to adopt medication reconciliation principles in their prescribing habits. Although a best possible medication history (BPMH) is collected in the patient's chart, there is no agreement upon the frequency at which the BPMH reconciliation should occur. The team is aware of this reality, and agrees that an interdisciplinary approach to medication management is necessary.

Positive patient identification is confirmed with the patient’s name and date of birth.

Communication between nurses on the unit is verbal, and the SBAR (Situation, Background, Assessment, Recommendation) tool is used when the patient requires an admission to an inpatient unit.

Patients’ rights and responsibilities are posted in the clinic, but patients are unaware of them. The organization may wish to discuss with patients their rights and responsibilities during their stay.

Although the patient advocate plays an important role in the organization, the patients that were met on the unit were not aware of this valuable resource. The organization may wish to develop strategies to increase the visibility of the patient advocate in ambulatory care.

Priority Process: Decision Support

There is a hybrid of both paper chart and electronic documentation in the ambulatory care unit. The organization is encouraged to pursue its efforts in transitioning from a paper chart to a fully integrated electronic one.

Priority Process: Impact on Outcomes

Standard protocols and evidence-based guidelines guide service delivery in the ambulatory care unit. Safety processes to mitigate risks for patients are also followed, such a falls prevention program and using two patient identifiers.

Leadership is planning on using the huddle board as an opportunity to engage staff in discussions on quality improvement.

Standards Set: Biomedical Laboratory Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Episode of Care

The North Bay Regional Health Centre has a full-service biomedical laboratory, and provides an outpatient clinic for the North Bay region. The collection services are primarily for chemotherapy, nephrology, anticoagulant therapy, newborns, and mental health patients. During the COVID-19 pandemic, an assessment centre has been established onsite, and the laboratory completes the time sensitive tests internally while other tests are sent to the Sudbury laboratory for processing.

The Biomedical Laboratory Quality Program is based on annual metrics which align to the corporate strategies, and also includes mandatory reporting metrics as required by other agencies such as Cancer Care Ontario. Many quality initiatives are initiated through incident reports, complaints, or by staff. Once the initiative is identified, the team creates a quality plan, monitors progress, and then measures the end goal to see if the desired outcome was achieved.

The implementation of Meditech Expanse was a significant achievement following two years of preparation and standardization of three separate laboratory systems, and very minor changes were required post go-live. Over the past year, the laboratory staff have faced significant challenges with the shortage of laboratory technologists and added pressures from the COVID-19 pandemic, while continuing to maintain usual operations. They demonstrated resilience in continuing meet their cancer care surgical pathology turn-around targets, and keeping the outpatient clinic open for the community while implementing some new instruments in the microbiology laboratory.

Priority Process: Diagnostic Services: Laboratory

North Bay Regional Health Centre has a full-service biomedical laboratory, and provides an outpatient clinic for the North Bay region. The collection services are primarily for chemotherapy, nephrology, anticoagulant therapy, newborns, and mental health patients. During the COVID-19 pandemic, an assessment centre was established onsite, and the laboratory completes the time sensitive tests internally, while other tests are sent to the Sudbury laboratory for processing.

The biomedical laboratory quality program is based on annual metrics, which align to the corporate strategies, and include mandatory reporting metrics as required by other agencies such as Cancer Care Ontario. Many quality initiatives are initiated through incident reports, complaints, or by staff.

Once the initiative is identified, the team creates a quality plan, monitors progress, and then measures the end goal to see if the desired outcome was achieved.

The implementation of Meditech Expanse was a significant achievement following two years of preparation, and standardization of three separate laboratory systems and very minor changes were required post go-live. Over the past year, the laboratory staff have faced significant challenges with the shortage of laboratory technologists and added pressures from the pandemic, while continuing to maintain usual operations. They demonstrated resilience in continuing meet their Cancer Care surgical pathology turn-around targets and keeping the outpatient clinic open for the community, while implementing some new instruments in the microbiology laboratory.

Standards Set: Cancer 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		
14.14	Clients and families are provided with information about their rights and responsibilities.	!
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		
Priority Process: Medication Management		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

There is good collaboration and communication between the North Bay Regional Health Centre cancer care unit satellite and Health Sciences North in Sudbury.

Wait times are closely monitored from initial treatment at Health Sciences North, to first treatment at North Bay Regional Health Centre, and efforts are made to begin chemotherapy treatments as soon as a diagnosis is confirmed. We would encourage local systemic therapy leadership to remain in ongoing communication with the core program leader at Health Sciences North to understand the provincially measured wait times of referral to consult and consult to treatment, as reported to Cancer Care Ontario and Ontario Health, since this is a measure of access and quality. The timing and accuracy of the detailed Activity Level Reporting (ALR) dictates the funding made available for systemic therapy.

Although patients’ advisors play an important role in the organization, the patients that were met on the cancer care unit were not aware of their existence. The organization may wish to develop strategies to increase the visibility of patient advisors in cancer care.

Priority Process: Competency

All staff have received standardized orientation and training. All nurses have D'Souza Institute training and certification.

There is a huddle board on the unit that focusses on wait-time metrics. This project is at an infancy stage and the organization is encouraged to continue the huddle exercise, as it is an excellent opportunity to engage front-line staff in quality and safety initiatives.

Not all staff members met during the survey had received a recent performance review. The organization is encouraged to offer to staff feedback on a regular basis, as a means of identifying their learning needs and enhancing their competency in clinical care.

Priority Process: Episode of Care

The team described a multi-pronged model whereby the team in Sudbury consults and advises on palliative care, the inpatient palliative team also consults; and in the community, a nurse from the Victorian Order of Nurses (VON) specializing as a symptom management consultant does home visits, and supports palliative care in consultation with family physicians.

Priority Process: Decision Support

The organization is aware of the advantages of implementing an electronic medical record in cancer care, and is encouraged to execute this plan soon.

Priority Process: Impact on Outcomes

Standard protocols and evidence-based guidelines guide service delivery in the ambulatory care unit. Safety processes to mitigate risks for patients are also followed, such a falls prevention program and using two patient identifiers.

Leadership is planning on using the huddle board as an opportunity to engage staff in discussions on quality improvement.

Priority Process: Medication Management

Best practice guidelines and safety protocols for administering systemic chemotherapy from Health Sciences North are followed.

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

Wordplay Jeux de mots consists of three intervention programs for young children, namely Preschool Speech and Language Services (Sudbury), Northeast Ontario Infant Hearing Program, and Northeast Ontario Blind Low Vision Early Intervention Program. The Preschool Speech and Languages Services are provided by speech language therapists. Wordplay Jeux de mots program referrals are made by community partners, pediatricians, physicians, and family referrals. The program has been promoted through extensive public awareness campaigns. The Community Advisory Committee members consist of school boards and families, along with other partnerships. Patient and family surveys are conducted to ensure activities can be adapted to accommodate identified needs.

The Diabetes Education Centre provides assessment, education, and support to patients affected by diabetes and their families in an outpatient setting. The centre provides services for gestational diabetes, pediatric and adult patients, as well as an insulin pump program. The Diabetes Educational Centre is comprised of an inter-professional team of nurses, dietitians, pediatricians, and endocrinologists.

Priority Process: Competency

Wordplay Jeux de mots staff are provided ongoing learning opportunities, participate in a community of practices, and receive yearly mandatory education such as the nonviolent crisis intervention training. New

staff are provided orientation and ongoing mentorship for six months.

The Diabetes Education Centre team are certified, or working towards their diabetes education and insulin pump training.

Priority Process: Episode of Care

Most new assessments for Wordplay Jeux de mots can be seen within eight weeks. The individual child and family goals are developed once the assessment has been completed. During the end of care, the program's speech and language pathologist (SLP) will connect with the school board's SLP to facilitate a successful transition. Patients and families are an integral part of the program, and provide ongoing and real-time feedback that is incorporated into program delivery.

Pediatric patients with diabetes are followed by the pediatrician until they turn 18 years of age. At age 17, the patient will be referred to an endocrinologist to ensure a smooth transition; however, the Diabetes Education Centre will continue to follow the same patient throughout the continuum of care. Patients with type 1 diabetes who are on an insulin pump are not discharged, as this is a requirement to maintain the Assisted Devices Program funding.

Priority Process: Decision Support

Parents or family members accompany the children at all Wordplay Jeux de mots visits, as they are very engaged in the learning process, supporting the children with activities to be done at their home. All materials are available in both English and French, to accommodate the child's dominant spoken language. Both Wordplay Jeux de mots and the Diabetes Education Centre continue to document using paper charts, and anticipate of the next wave of the hospital information system, with a significant amount of updating forms, policies, and tools being done in advance.

Priority Process: Impact on Outcomes

The Wordplay Jeux de mots program has Parent Advisory Committees, and parents complete questionnaires to rate their satisfaction on how their children make gains with their identified needs or issues. The program maintains a scorecard which aligns to the hospital's and Ontario Health's strategic plans.

The Diabetes Education Centre is planning to move into the hospital in January, 2021, and have incorporated feedback into the space design to accommodate patients in wheel chairs, walkers, and bariatric chairs, as well as privacy for scales. The new space is anticipated to enhance service delivery.

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

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The leaders and team members of the Community-Based Mental Health Program are to be commended for their strong commitment to quality and safe services for their patients and families. There is a comprehensive array of community-based mental health services supporting patients and families. There is evidence of strong, high-functioning inter-professional teams supporting community-based mental health services. Strengths-based and recovery approaches are evident, with a strong commitment to person-centred care. A person-centred care approach is embraced throughout the program, including the Pieces of my Personhood Assessment. Service specific goals are developed and monitored.

Patient and family input is present throughout the community-based mental health program. This includes the involvement of patients and families in lived-experience advisory boards, input into the assessment process, storytelling, and initiatives to improve the physical environment. The leaders are encouraged to continue the important work of seeking the input of patients and families.

Team members and leaders describe the community-based mental health program as “a wonderful place to work.” They described the work environment as supportive, and stated that they enjoyed coming to work. Furthermore, they were motivated by seeing the progress of patients, and their improved quality of

life. The team noted that they have the appropriate resources to do their work. The team members acknowledged the support of the leadership team. There are strong partnerships with the community and health and community service organizations. The leaders and team members are proud of providing innovative and quality community-based mental health services.

Priority Process: Competency

A strong inter-professional team supports the provision of quality community-based mental health programs. The leaders, physicians, and team members are committed to providing quality and safe services for patients and families. The leaders are acknowledged for their commitment to supporting the education and learning needs of staff. The team spoke highly of the education and training provided. Education and training are provided on ethical decision-making. The team members are familiar with the process to follow, if ethical issues arise. The team values the input of the ethicist and the patient advocate.

The team members stated that the orientation process prepared them to work in the community-based mental health program. The staff are recognized for their accomplishments, in rapid-fire celebrations and acknowledgements during huddles. The leaders are to be acknowledged for completing team member performance evaluations. The team members stated that they felt safe at work, and that the organization provides a safe working environment. The team members noted the importance of violence prevention training. The leaders are encouraged to continue to support staff safety initiatives.

Priority Process: Episode of Care

An engaged inter-professional team is committed to providing quality mental health programs across the continuum. There is a comprehensive array of professionals supporting patients including a clinical pharmacist, social workers, nurses, behavioral support workers, occupational therapists, and physicians. The patients described receiving exceptional care, and being treated with care, dignity, and respect. One patient described the community-based mental health program as “being a life saver for my family.” The patients appreciated receiving follow-up phone calls and text messages from the clinical team. Family meetings are held. Meaningful rounding and huddles occur. This includes safety huddles that are completed following a patient fall. Patient satisfaction surveys are completed. Huddle boards are present and used to support communication, quality improvement, and patient safety. The leaders and team are proactive in addressing issues and concerns. The team members have described their team as passionate, committed, and patient-focused. The team is to be acknowledged for their commitment to medication reconciliation and falls prevention. The team members, patients, and families are involved and committed to the Senior Friendly Hospital Initiative. There is a strong commitment to OPOP (One Patient One Plan). Regular meetings are held with patients and families to provide individualized care planning. The team has regular involvement of patients through their Lived Experiences programs. These individuals provide input from the patient perspective on programs and projects.

There is a comprehensive array of programs and services offered to patients and families. This includes Assertive Community Treatment, Community Crisis Outreach, Early Mental Health Clinic Continuing Care,

Behavioural Supports Ontario, and mental health clinics to name just a few. The Mental Health Outpatient Services provides a variety of programs including central intake and referral services, crisis services (emergency department, mobile, and outpatient follow-up), the Assertive Community Treatment Team, Eating Disorders, Homes for Special Care, Mental Health Clinic, Early Intervention in Psychosis and Mental Health, and the Mental Health and Justice Safe Bed Network. The team is highly motivated, and ensures the patient is at the center of all services. They recently expanded the Justice Safe Bed program beds from a two- to three-day length of stay to 30 days, to allow sufficient time to arrange for housing for the patients.

Community-based mental health services at the King Street site include the Assertive Community Treatment Teams, the Justice Safe Beds program, community mental health consultation, Mobile Crisis, and will soon also include a Community Withdrawal Management Service. Their facilities are appropriate for the services they offer, and the teams adjust to meet the needs of the community. With the COVID-19 pandemic restrictions impacting so many programs, the community mental health teams are to be commended for rapidly switching to virtual platforms, to continue to provide individual and group services. Patients interviewed describe the teams as going above and beyond to support them in improving their health and their lives.

The teams possess diverse backgrounds, expertise, and knowledge to provide excellent mental health services. Teams advocate for the development of new programs. There is a significant amount of regional collaboration with other outpatient mental health programs and community partnerships. The Early Intervention in Psychosis program is participating in a research program with the Centre for Addiction and Mental Health, and the clinical nursing educator promotes various opportunities for education and training via the Ontario Telemedicine Network, online courses, as well as bringing in guest speakers and community agencies.

Priority Process: Decision Support

The team members, physicians, and leaders are committed to using decision support to enable quality patient care. Education and training are provided to the team on the use of technology. Paper and electronic charting is used in the community-based mental health program. The team commented on the value of the planned Meditech Expanse implementation in supporting patient safety initiatives. This is anticipated to be implemented in the community-based mental health program in the fall of 2021. The leaders are encouraged to continue with this important work.

Standardized patient information is collected. Comprehensive information is collected with the input of patients and families. The care plans are developed and updated with the input of patients and families. The Pieces of my Personhood Assessment is completed. Chart audits are completed. Privacy and confidentiality education is provided to the team.

Several members of the community-based mental health teams (such as the Assertive Community Treatment Team) would benefit from having Meditech Expanse access via laptop while out in the community. The supported geographic area is large, and the ability to electronically chart and consult the

medical record while out in the community would be beneficial. This need has been identified, and the team expects that this technology will be available to them soon.

Priority Process: Impact on Outcomes

Staff and leaders are acknowledged for their commitment to quality improvement. Huddles, family meetings, meaningful rounding, safety huddles, scorecards, and huddle boards are used to support safety and quality. The team are engaged with quality improvement activities. Patient satisfaction surveys are completed, with the results shared with the team and patients.

There are goals and objectives for the Community-based Mental Health Program which are congruent with the organizational strategic plan. The leaders and team have access to evidence-based guidelines to support care. The team has presented on best practices locally, provincially, and nationally. Infographics are used to communicate quality improvement results. The leaders are encouraged to continue their quality improvement journey and to seek the input of patients and families.

Standards Set: Critical Care Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Most admissions come direct from the emergency department, with some direct admissions from neighbouring hospitals. Clear goals are set for the service with input from staff, patients, and families.

Priority Process: Competency

The program uses only one type of triple-channel pump with standardized drug libraries. Performance evaluations are completed every two years. The huddle board has a kudos section where staff are recognized. Written communication praising staff is posted on the huddle boards as well.

Priority Process: Episode of Care

A best possible medication history (BPMH) is completed by a pharmacy technician in the emergency department prior to transfer to the critical care unit. The critical care unit’s pharmacist also does medication reconciliation following admission. The Braden scale is completed upon admission, then weekly or more frequently if the patient's condition changes. The critical care unit has specialized beds

and mattresses to reduce the risk of pressure ulcers. Staff turn patients every two hours. Protocols are audited by the clinical nurse educator regularly.

There is an automatic venous thromboembolism (VTE) order upon admission. There is a VTE protocol in place, and sequential compression devices are used to reduce risk of VTE.

Interdisciplinary rounds are done every morning for each patient. There are protocols in place to ensure routine assessment of central lines, including discontinuing the lines if they are not in regular use. The infection prevention and control team also assess the central lines routinely or daily.

The Confusion Assessment Method (CAM) tool is used to assess for delirium. Guidelines from the tool indicate when intensivist needs to be notified. Meditech Expanse has built-in standardized screens to assess for ventilator-associated pneumonia (VAP).

Patients and families are informed and offered social work and spiritual services.

Nurses document on the transfer of accountability screen in Meditech Expanse, and also have phone conversations with the receiving nurse.

The team provided a recent example of when a patient chose to withdraw life-sustaining treatment and the adult children disagreed, but the team supported the family dialogue and ensured acceptance of the patient’s choice. Patients in the emergency department who require admission to the critical care unit are transported there by a critical care unit nurse.

Priority Process: Decision Support

Standardized ongoing assessment and results are documented in the electronic health record, including the Braden scale, Morse Fall Scale, ICU-SOC, Richmond Agitation Sedative Scale, as well as physical exams at the start of each shift and documentation of cardiovascular and respiratory status every four hours. Regular audits on documentation are completed by the clinical nurse educator.

Priority Process: Impact on Outcomes

The team follows several standardized protocols that are built into Meditech Expanse.

Priority Process: Organ and Tissue Donation

Staff receive standardized training for organ and tissue donation from the critical care unit’s clinical nurse educator, following Trillium Gift of Life Network criteria. An order set is followed to ensure consistency of practice that is aligned with the guidelines.

Standards Set: Diagnostic Imaging Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Diagnostic Services: Imaging		
6.7	The team annually reviews and updates the Policy and Procedure Manual.	
17.1	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.	

Surveyor comments on the priority process(es)

Priority Process: Diagnostic Services: Imaging

At the North Bay Regional Health Centre, diagnostic imaging (DI) offers a comprehensive array of services with state-of-the-art equipment. The services provided include MRI, x-rays, computed tomography, ultrasound, breast screening, and nuclear medicine. PICC line insertions, biopsies, and drains are also performed in DI.

The department is strategically located close to the critical care unit and to the operating room. The physical layout of the department facilitates easy movement of patients between the two areas. Acute care unit patients who require radiographic imaging are transported to the department by unit porters. DI has clear signage, and wayfinding to the department is facilitated by paw prints. All restricted areas are clearly marked.

In terms of patient safety, waiting rooms are large and patients who are identified as being at risk for falls are appropriately managed. The patient's name and date of birth are two identifiers that are used to verify patient identity. Mock codes are conducted throughout the department to ensure readiness to respond in an emergency.

The team monitors performance metrics that include primarily service volumes and wait times for tests. Policies and procedures are reviewed but the frequency in which they are reviewed is unclear; the organization is encouraged to develop a systematic process to review DI related policies and procedures.

A huddle board is strategically located on the unit, and serves to promote team discussions and collaboration; it is also designated as a source of inspiration for discussions on quality and safety initiatives.

In terms of patient experience, there is no mechanism at the present time to capture patient satisfaction in relation to DI care and services. The department is encouraged to develop a formal process to receive and to respond to patient and family feedback regarding the care and services they receive.

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

Emergency department leadership is working with IT and Decision Support to develop a new Distress Assessment and Response Tool (DART) since the implementation of the new hospital information system. The organization is encouraged to establish that as soon as possible, to assist the team in measuring wait times, and to support informed decision-making. Emergency department leadership is represented in the organization's Emergency Preparedness Team, that meets quarterly. Emergency codes are practiced routinely to ensure staff and physician preparedness. The organizational pandemic plan and implementation includes the emergency department. There are protocols in place for patients that are at risk of self-harm or harm to others, to ensure security support and the crisis team involvement. Emergency department leadership, with senior leadership support, have recently submitted and received approval for a renovation in the emergency department to create two safe rooms.

Priority Process: Competency

New staff receive five days of in-class training, followed by being buddied with an experienced emergency department nurse for five to six weeks. Staff begin in less acute areas, and progress in six to eight months

to more acute areas with a buddy. After two years in the department, staff complete Canadian Triage and Acuity Scale (CTAS) training, and which allows them to work triage. Existing staff receive Advanced Cardiovascular Life Support (ACLS) and Pediatric Advanced Life Support (PALS) retraining, re-certification, and review of all medical directives every two years. Some go on to complete additional specialization with trauma courses.

Two types of Baxter infusion pumps are used in the emergency department: one is the same standard as the rest of organization, and the second is for rapid infusion. Initial training is provided as well as annual competency skills review and audit, supported by manufacturer manuals.

It appears that the ED team is very close-knit and collaborative. There's an annual barbeque and Christmas party that is well attended. The team is very inclusive of all disciplines and open with other departments.

Priority Process: Episode of Care

Emergency medical services (EMS) calls the emergency department en route to hospital; the paramedics are greeted by the lead registered nurse on shift, sent to the most appropriate area of the department, and receives the information verbally and in writing via a standardized EMS format. Following the triage assessment by the registered nurse, the physician assesses the patient, and communicates with the patient and family. When concerns arise, additional team members get involved; this can include the clinical manager and the patient advocate. Any time patients or families have concerns, they are provided with the contact information of the manager and the patient advocate. Pharmacy technicians are in the emergency department from 0700 to 2100 daily, completing a best possible medical history on all patients requiring admission. Pharmacists also collaborate with Geriatric Emergency Medicine nurses to complete medication reconciliation. Anyone presenting with anxiety or depression are assessed thoroughly for a risk of self-harm using a standardized tool built into Meditech Expanse; crisis intervention workers are involved around the clock, safe rooms are used, patients are asked to change into safe clothes, and security is involved as necessary. At registration, the patient's health card is used, as well as confirming name, date of birth, and address. If they have had a previous presentation, information is validated and updated. There is a telephone transfer of information between the emergency department and inpatient nurses, as well as a standardized transfer of accountability (TOA) form completed in Meditech Expanse. Patients transferring to the critical care unit have a face-to-face TOA, since the critical care nurse comes to transfer the patient from the emergency department. If there are transportation challenges when patients choose to leave against medical advice, they can be given a taxi chit, be connected with the Priority Assistance to Transition Home (PATH) program with the Red Cross, or assisted with the organization's community transport vehicle.

Priority Process: Decision Support

Policies and procedures are reviewed every seven years. It is suggested that the department incorporates Registered Nurses’ Association of Ontario Best Practice Guidelines into policies. Annual education days support ongoing staff development.

Priority Process: Impact on Outcomes

Policies and procedures are reviewed every seven years. The emergency department manager and team collaborate with the mental health team to do periodic walk-abouts in the emergency department to identify safety hazards. There is a safety pause at shift huddles where all staff can identify safety risks and raise concerns. Anything posing a risk to staff is communicated to the occupational health and safety team. Adverse events and near misses are reviewed as a team during safety huddles and documented in the incident management system. Emergency department level of service and numbers of patients who left without being seen are measured. An example is the recent revision of the stroke protocol to improve the door-to-needle intervention time. Collaborative planning occurred between the emergency department, emergency medical services, and diagnostic imaging to improve the process, and clarify roles ultimately resulting in a reduction in time to treatment.

Priority Process: Organ and Tissue Donation

Staff and physicians from critical care unit, emergency department and the operating room are directly involved in the development and review of protocols related to organ and tissue donation. When potential cases are identified, the team is brought together by the local Trillium Gift of Life Network coordinator to plan with the network's retrieval team that comes from urban centres, providing transplant services to areas such as Toronto, London, and Ottawa.

Standards Set: EMS and Interfacility Transport - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.4	Transport planning is undertaken with input from patients, families, and partners.	
Priority Process: Competency		
5.1	Required training and education are defined for all team members with input from patients and families.	!
5.4	Education and training are provided to team members on how to work respectfully and effectively with patients and families with diverse cultural backgrounds, religious beliefs, and care needs.	
5.21	Patient and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
Priority Process: Episode of Care		
19.14	A process to investigate and respond to claims that patients' rights have been violated is developed and implemented with input from patients and families.	!
20.8	Interfacility Transport only: Working in partnership with patients and families, at least two person-specific identifiers are used to confirm that patients receive the service or procedure intended for them.	ROP
	20.8.1 At least two person-specific identifiers are used to confirm that patients receive the service or procedure intended for them, in partnership with patients and families.	**MAJOR**
Priority Process: Decision Support		
24.2	Policies on the use of electronic communications and technologies are developed and followed, with input from patients and families.	
Priority Process: Impact on Outcomes		
25.2	The procedure to select evidence-informed guidelines is reviewed, with input from patients and families, teams, and partners.	
25.3	There is a standardized process, developed with input from patients and families, to decide among conflicting evidence-informed guidelines.	!

25.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from patients and families.	!
25.5	Guidelines and protocols are regularly reviewed, with input from patients and families.	!
25.6	There is a policy on ethical research practices that outlines when to seek approval, developed with input from patients and families.	!
26.1	A proactive, predictive approach is used to identify risks to patient and team safety, with input from patients and families.	!
26.5	Safety improvement strategies are evaluated with input from patients and families.	!
27.1	Information and feedback is collected about the quality of services to guide quality improvement initiatives, with input from patients and families, team members, and partners.	
27.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from patients and families.	
27.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from patients and families.	
27.12	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from patients and families.	

Priority Process: Medication Management

The organization has met all criteria for this priority process.

Priority Process: Infection Prevention and Control

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The District of Nipissing Paramedic Services provide emergency medical services (EMS) and interfacility transport across five communities, with a population of approximately 88,000 people. This service is a department of the North Bay Regional Health Centre, and hence guided by the Health Centre’s mission and strategic plan, as well as applicable policies and procedures. The association with North Bay Regional Health Centre has many benefits for EMS, including support from many of the corporate services, such as quality improvement and risk management.

An annual operational deployment plan is developed based on data from the prior year’s volumes of

services required and delivered. This annual plan is adjusted as the need arises. Formal mutual aid agreements are in place with local and regional partners, including fire departments, police, and other first responders. In addition, a formal agreement is in place with Lake Temagami First Nations to support transport outside of the conventional ambulance, such as by boat, snowmobile, or all-terrain vehicles (ATV).

The Medical Oversight Team (MOT) for the Nipissing Paramedics Services is provided by a group of approximately 30 physicians associated with Health Sciences North. This MOT supports a number of other emergency medical services in northern Ontario. The Ministry of Health of Ontario regulates EMS, and as such is reviewed every three years in regard to the compliance with standards and protocols set by the ministry.

The Nipissing paramedics are seen as a community service, and frequently engage in community events and education sessions. Staff that were interviewed identified that there is very little engagement of patients and families, and that feedback would be welcomed. At this point, patients and families are not engaged in designing or planning any of the services, nor in evaluating services. The North Bay Regional Health Centre is encouraged to develop a more formal program to engage patients and families in the services being provided.

Priority Process: Competency

The EMS and Interfacility Transport team includes dispatch centre staff, paramedics, advanced trained paramedics, community paramedics, and administrative staff. Four supervisor positions have been recently added to provide mentoring and additional support for staff. Continued medical education is mandatory for all paramedics and compliance with this education is monitored. Paramedics have rapid access to the medical oversight team for support, and regular education and training session are held to support learning needs.

The team has access to a third-party peer support program to assist with stress management. As well, all Occupational Health and Safety programs from North Bay Regional Health Centre are available to the team.

"Parade moments" or virtual huddles have been recently implemented. These huddles are held three times a day, and all staff on duty at the time attend. The huddle is used to communicate information and review concerns or incidents that have occurred. Staff expressed pride in their team and the work that they do to care for their community.

Mentoring and performance feedback is provided by the recently-hired supervisors.

Priority Process: Episode of Care

Calls made to the dispatch centre are responded to in a standardize manner, and information is gathered in order to triage the urgency of the call, as well as to determine the need for infection prevention and

control precautions. This has been very important throughout the COVID-19 pandemic, in order to ensure paramedics are prepared and have the right level of personal protective equipment upon interfacing with the patient. The dispatch centre is staffed to support a surge of calls, and back-up systems are in place in the event of power disruptions or events resulting in a loss of communications.

The paramedic staff are well versed in the clinical practice guidelines and standardized protocols that are used to assess the physical, emotional, and mental status of the patient. Treatment protocols are followed, and additional advice can be obtained from the supervisor and from the medical oversight team. Verbal orders obtained from the medical oversight team are recorded and available for future reference. Policies and procedures are followed for high-risk care procedures. Narcotics are contained in small kits that are assigned to individual paramedics, who are then responsible for documenting any usage. Independent double-checks are conducted when administering narcotics and other high-alert or high-risk medications. All supplies are disposable, and nothing that touches the patient is reprocessed. All other surfaces are cleaned using an appropriate disinfectant. Sharps containers are available in the ambulance, and biohazardous waste is collected and returned to the ambulance bay. The patient and family are engaged in the care to the extent possible, and provided with relevant information.

Currently, identification of the patient during interfacility transfer is conduct solely through interactions with staff from the sending facility. The department is strongly encouraged to implement the two-patient identifier process for all interfacility transport events.

Priority Process: Decision Support

Assessment and care protocols are provincially standardized, and all documentation is recorded in an electronic template. Once entered, the data is stored as a patient record, along with the results of any tests that are done at the time. These records are kept on a server, and archived after a fifteen-month period. Information is readily retrievable if required for any reason. Patients are able to access this documentation upon request.

Priority Process: Impact on Outcomes

The dispatch centre monitors and documents critical response times for each portion of the call and the work of the team that is dispatched. A large number of the protocols and procedures used by the paramedics are provided by the Ministry of Health, and are standardized across the province. Monitoring data mined from these protocols and procedures is reviewed regularly, and reports are issued identifying any variance to the expected outcomes. Patient safety incidents are documented and disclosed in accordance with the North Bay Regional Health Centre’s policy. There are no formal methods by which patients and families are engaged in the identification of potential risks or quality improvement initiatives, and the organization is encouraged to consider formalizing a method to gather this data.

Priority Process: Medication Management

All medications available to the paramedics are sourced from the North Bay Regional Health Centre pharmacy. The central drug distribution system in the pharmacy provides unit dose medications. All

narcotics are kept in a double-locked area within the ambulance bay, and pre-filled kits are assigned to each of the advanced prepared paramedics on duty. Audits of the medications available are conducted annually, and more frequently if changes are made. The North Bay Regional Health Centre’s high-alert medication policy is followed.

Priority Process: Infection Prevention and Control

The infection prevention and control (IPAC) program at North Bay Regional Health Centre supports the IPAC needs for EMS and Interfacility Transport. Hand hygiene education is provided to the emergency medical services team, and audits are being conducted by the supervisors. The results are shared, and have been improving. The department has also suggested they will begin conducting personal protective equipment audits, and this is encouraged. All policies and procedures regarding the handling of biohazardous waste are being followed. EMS also adheres to the hospital’s immunization policy.

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

Unmet Criteria		High Priority Criteria
Priority Process: Infection Prevention and Control		
14.5	Results of evaluations are shared with team members, volunteers, clients, and families.	
Surveyor comments on the priority process(es)		
Priority Process: Infection Prevention and Control		

There is a strong commitment to infection prevention and control (IPAC) at the North Bay Regional Health Center. The team is staffed with dedicated and trained infection control staff, and are supported by physicians within the organization. As infectious disease specialists are not available in-house, they have contracted this expertise for support, as required.

The infection prevention and control team are engaged, committed to quality and safety, and were described as "The Dream Team."

The infection prevention and control program is supported by leadership and the senior executive team. There is reporting to the Board of Trustees through the Quality Committee. Infection prevention and control is supported by two Infection Prevention and Control Committees, which meet on a regular basis.

The infection prevention and control team and leaders are acknowledged for their work during the COVID-19 pandemic. The team and leaders were flexible and adaptive to a rapidly changing situation, and demonstrated effective working relationships with Public Health. Their innovative efforts include the addition of personal protective equipment officers and point-of-care assessments, which support front-line staff. The teams are encouraged to continue their ongoing efforts to educate and support physicians, staff, patients, and families on mask use and hand hygiene in all areas of the hospital.

The infection prevention and control team has excellent policies to support placing patients on and off isolation. It was noted, however, that on evenings and weekends, there is sometimes a reluctance to remove isolation precautions, despite clear direction in the electronic record that the precautions can be removed once a defined criterion is met. Focused education on these policies may help to reduce delays in removing isolation precautions.

Performance measures to monitor infection prevention and control are determined based on organizational and IPAC priorities. The organization has the opportunity to improve the sharing of information with teams, patients, and families. The organization may want to share IPAC program successes, and audit information through the quality boards in each department. As well, once the

patient information screens are operational, this may provide another opportunity to share infection prevention and control successes and education.

The infection prevention and control team are involved during the planning stages of any new construction or renovation project. The teams are fortunate to have a modern facility, with 15 negative-pressure rooms to support the isolation of infectious diseases. The renovation of additional rooms into private rooms rather than open double-rooms was a creative initiative that provides more flexibility in managing patient needs. Additionally, the team is involved in medical device and new product procurement.

The hospital-acquired infection rates are tracked, and the information is shared. The team and leaders are acknowledged for their commitment to hand hygiene, and in building capacity for continued education and audits.

The infection prevention and control team are encouraged to continue their work on educating staff throughout the hospital on proper protocols and precautions. Some examples on which to focus include the proper wearing of masks outside of patient care areas, sharing of food, labelling and dating food in patient and staff refrigerators, and the use of patient refrigerators by staff.

The housekeeping staff are to be commended for their outstanding efforts in supporting infection prevention and control throughout the facility. The front-line staff spoke confidently and knowledgeably about their roles in patient safety. Regular audits support their work and are used as an ongoing educational tool.

The kitchen is well designed to support the flow of food preparation. The movement of clean and dirty trays is well separated to prevent cross-contamination.

Standards Set: Inpatient Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
11.9	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
16.11	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
16.12	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The inpatient services are led by an engaged and dynamic leadership team who model the ICARE (Integrity, Commitment, Advocacy, Respect, and Excellence) organizational values.

The medicine program consists of two medical units, which include palliative care and continuing complex care beds. At the onset of the COVID-19 pandemic, one of the units was designated as a COVID-19 unit, and extensive education and daily huddles were provided to the team to ensure readiness. A personal protective officer role was created to observe adherence to donning and doffing of personal protective equipment, and oversee code blue calls for potential COVID-19 patients (code 19) coming from the emergency department. All the staff were trained on point-of-care assessments, in the event an aerosol generating procedure was required. The team felt prepared and ready to deal with the pandemic.

The surgical program has two inpatient units that accommodate medicine, palliative, and surgical patients. These busy units have a high turnover, as the teams support surgical patients in recovery and

early discharge. Their success in care is reflected in the declining length of stay required post-operatively.

The pediatric unit is an eight-bed unit that also serves as overflow for the adolescent and mental health patients. These beds are also used for adult overflow when required. The neonatal intensive care unit (NICU) is an eight-bed level 2C facility, with staff trained to manage the complex medical needs of neonates. The organization has supported cross-training staff between these units, increasing the flexibility of managing patient care on these specialized units.

Priority Process: Competency

A comprehensive orientation is provided to new staff who complete the mandatory education, along with a unit-specific orientation, a combination of online modules, checklists to complete, and ongoing support from a staff mentor. The clinical nurse educator (CNE) promotes professional development opportunities including virtual in-services, physician educational series, and skills days.

Recently, the CNE introduced a quality initiative to monitor infants to avoid the development of flat head syndrome, within a structured program. The nurses are being supported in the new initiative with an educational series. The neonatal intensive care unit supports neonates who are born with neonatal abstinence syndrome. These babies are managed within the unit and subsequently, in conjunction with the pediatric unit for further care.

The medical teams have emphasized palliative care education with the frontline, to support new palliative services. This education enables staff to make better use of palliative consultations, and to directly support the goals of patients and families while under their care.

Medical Assistance in Dying has also been emphasized by the educator, and the staff have received the information and training necessary to support inquiries and facilitate consultations.

Priority Process: Episode of Care

The inpatient services throughout the North Bay Regional Health Centre feature large patient rooms with sufficient space to provide patient care, perform procedures, and provide privacy, even in the four-bed wards. Lifts are widely available. Whiteboards in the patient rooms are used to inform and orient patients, and include the estimated discharge date.

Front-line staff have several work areas at which they can access the electronic health record, meeting rooms for discrete multidisciplinary discussions, and lounges in which to pause, regroup, and take a break. Corridors are not crowded and there are spaces available that prevent the need to practice hallway medicine, even when patient volumes are high.

Inpatient services are predominantly led by a dedicated family physician group that cares for their own admitted patients. The family practitioners share on-call duties to cover orphan patients admitted to the organization. As the organization evolves, there may be an opportunity to expand the inclusion of

hospitalists, nurse practitioners, and physician assistants to provide consistent and accessible care to support the out-of-hospital providers. The organization has done extensive work in developing order sets and care plans to support consistent care across providers and units.

Discharge planning is begun upon admission, and the expected length of stay is recorded for each patient. The organization must remain vigilant about this process to ensure that patients are supported in discharge as early as medically indicated, and that this practice is consistent across providers.

The inpatient teams have done a great job to ensure that the goals of care are clarified within 24 hours of admission. This momentum should be monitored to ensure that this conversation continues, as the organization returns to normalized operations.

In addition to inpatient care, the pediatric department also supports a busy Maternal/Newborn Clinic that follows all postpartum discharges within 24–72 hours. The team has been successful in managing some gaps of care created by the reallocation of public health resources due to the pandemic, and hopefully, these resources will return as the situation is stabilized in this area.

North Bay Regional Health Centre has done extensive education on palliative care, ensuring that patients are identified, and front-line staff are comfortable in supporting palliative patients. The new Palliative Service coordinates the ability of this team to respond to consultations throughout the hospital. The six dedicated palliative care beds include two suites and four comfortable rooms, suitable for patients and their families.

Transitions to other departments, to and from other facilities, and to the community have not been formally evaluated. The teams speak knowledgeably about the transition process, and work has been done to standardize these processes. Further evaluation may present opportunities for continued improvements. During the discharge planning process, the team works with the patients to facilitate a smooth transition, and patient satisfaction surveys are an ongoing opportunity to improve patient care.

Priority Process: Decision Support

The inpatient services teams benefit from the upgrades to the Meditech system, and the increased functionality it provides. As the front-line staff and leadership become more comfortable with the platform, it will open opportunities to pull data to support the teams and their pursuit of excellence.

Priority Process: Impact on Outcomes

The inpatient services throughout the organization utilize the huddle board on a weekly or biweekly basis to pass information, receive feedback, and provide information on performance metrics. The use of the huddle concept varies between departments, and would benefit from further education to make it meaningful to educators, managers, and front-line staff.

The Medical Assistance in Dying program has been strongly supported by the organization and by team

members. With each event, there is a team debriefing which includes any family members who wish to take part. These debriefings have resulted in ongoing improvements to program delivery.

Quality improvement initiatives and performance indicators to track have been identified in many inpatient units. Specific objectives are not consistently clear, and the interventions to improve these parameters are often lacking. Specific timeframes for the audit are not included in the initiative. Increasing and formalizing patient and family involvement in quality improvement initiatives is another opportunity for the organization.

Quality improvement initiatives had made significant strides prior to being hit with the COVID-19 pandemic. With this systemic interruption, the evaluation of the feasibility and relevance of these initiatives has not been completed. As the organization settles into the new normal, re-starting these quality improvement initiatives and conducting evaluations has been identified as a priority by the quality improvement team.

Standards Set: Medication Management Standards - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Medication Management		
13.3	Chemotherapy medications are stored in a separate negative pressure room with adequate ventilation, and are segregated from other supplies.	!
14.5	Steps are taken to reduce distractions, interruptions, and noise when team members are prescribing, writing, and verifying medication orders.	
Surveyor comments on the priority process(es)		
Priority Process: Medication Management		

In October of 2019, North Bay Regional Health Centre implemented Meditech Expanse, which has been a significant improvement in the medication management system by providing computerized prescriber order entry (CPOE). The system reduces hand written prescriptions and opportunities for errors, and it has almost eliminated unapproved abbreviation use and transformed the clinical practice. Nurses are now administering medications using an electronic medication administration record (eMAR), and scanning of the barcode on the patient’s wrist band and on the medication at the beside has achieved a closed-loop medication system. Medication scanning is being monitored, and where opportunities for improvement are identified, the clinical nurse educators work with their nursing teams to improve compliance and patient safety. The organization had adapted to the significant change in nursing workflow, which was supported by a change management strategy.

The Medication Safety Committee meets monthly, and oversees many of the medication system improvements such as the review of the safety incidents, accreditation reports, and compliance with medication scanning rates. One recent safety improvement involved the inclusion of INR level to flow onto the nursing screen so that the level could be checked in the eMAR prior to administering Coumadin to the patient.

Some notable improvements include a reduced number of wrong patient and wrong medication errors. The organization invested in several pharmacy technician positions to provide seven days a week coverage in the emergency department and on the units. These staff were supported in their new role by a comprehensive education and training program. As well, Meditech Expanse enabled the improvement in the compliance of medication reconciliation on admission, transfer, and discharge. One gap noted by the teams is that sometimes, the admitting physician writes admitting medication orders based on an outdated medication history. This is an area of risk, and requires extra staff effort to undo the error. A combination of education and platform support could be considered to mitigate the risk in this area. In addition, there is opportunity to invest similar resources in the ambulatory care clinics to support

medication reconciliation.

The hospital pharmacy is spacious and well lit. The team uses the space well to manage workflow, and divides the space to support specialized areas. Although the facility is relatively new, recommendations have changed and the team has adjusted their workspace to continue to meet pharmacy standards. With the changing requirements and the impacts on multiple areas in medication management, the team is evaluating how best to move forward so as to best address change in a coordinated project.

The organization has done outstanding work in developing order sets, and in implementing programs such as the antimicrobial stewardship program. As the organization moves forward, the team may consider expanding the role of the clinical pharmacist to include authorizing the change of medication from intravenous to oral as per the protocol, and to adjust the type of antibiotic based on microbiology sensitivities.

In addition, the clinical team may consider increasing the scope of the clinical pharmacist to include ordering laboratory testing, as required by specific types of medication. The timely order of blood work in line with clinical guidelines would streamline testing and reduce delays.

There is a comprehensive opioid stewardship program in place, which includes strategies to detect and manage drug diversion. In conjunction with the surgical program, an opioid reduction program has been initiated to reduce the quantity of narcotics prescribed post-operatively.

Within the pharmacy, steps have been taken to reduce distractions and interruptions. Within patient care areas, the space available to the clinical pharmacist varies from floor to floor. While suitable in many departments, the space available for the clinical pharmacist in some areas is limited, and is not conducive to working without frequent interruptions and distraction.

The sterile compounding rooms (both hazardous and non-hazardous) do not meet the new Ontario College of Pharmacist Accreditation Standards, and North Bay Regional Health Centre is encouraged to plan for these future renovations.

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		
15.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The mental health facilities at North Bay Regional Health Centre are modern and well designed to support their intended function. The forensic psychiatry units provide mental health assessment, treatment, and rehabilitation in secure units that maintain the safety of the patients and the staff. Within the organization, the teams are able to adjust, to meet the changing requirements of the individual as their medical condition stabilizes, in accordance with the imposed legal requirements. The teams follow strict protocols to maintain their own safety and that of their patients in the provision of care.

The forensic psychiatry unit is well-equipped to facilitate recreation and physical activity, in fully equipped and secure indoor and outdoor areas. Patients are encouraged and supported as they medically stabilize, and advance through the program.

The Acute Inpatient Psychiatry Unit (AIPU) is a well-equipped unit assessing, diagnosing, and treating acute psychiatric illnesses. The inter-professional team works cohesively to provide resources to their patients, and supports them in transitioning from inpatient to community care.

The mental health teams also provide care for patients on floors dedicated to patients with mental health

issues and co-morbidities, and dementia patients who require additional assistance with the activities of daily living. These complex patients receive care in modern units with bright dining areas, recreation facilities, and dedicated, inter-professional staff.

The Child and Adolescent Mental Health Unit has six beds. There is a kitchen with a dining area where children and adolescents can eat and prepare food. The facilities include a space for television, play activities, and arts and crafts. The inpatient pediatric unit is able to accommodate additional patients, should the need arise.

The Mental Health and Addictions program is led by a cohesive and dedicated inter-professional team. The Inpatient Mental Health Services, Outpatient Mental Health Services, and Forensic Services all report under the same portfolio, which promotes ongoing communication and awareness of all patient care services. The inpatient services work to ensure smooth transitions of care into the outpatient setting for ongoing support.

The program goals and objectives are aligned to the hospital’s strategic plan, and four priorities and metrics are monitored using a dashboard. During monthly leadership meetings, managers present a patient story to ensure the voice of the patient is captured and informs program design and services.

Priority Process: Competency

The Child and Adolescent clinical nurse educator has initiated education on intravenous administration for the nurses on acute inpatient mental health units and to date 50 percent of the team have completed their certification. During the interim, the critical care unit has been assigned as a buddy unit, to support the nurses and enable ongoing practice of intravenous insertions, and to maintain competency.

There is ongoing collaboration between the forensic and inpatient mental health units for all professions, including psychiatrists, nurses, occupational therapists, and physical therapists. Team leaders in the forensics department move staff around depending on patient load, which provides enhanced learning opportunities and skill development.

Priority Process: Episode of Care

Mental health crisis workers are in the emergency department around the clock to support acute admissions; the psychiatrists admit adult patients, and pediatricians admit youth and adolescent patients to the inpatient units. Some patients may be transferred directly to the inpatient units from another feeder hospital. The officer of the court refers patients to the forensic psychiatry unit, to Deer Lodge for fitness to stand trial, or to treatment and rehabilitation.

Evidence-based practices are incorporated into patient care, which includes a recovery plan of care. Patients are asked about their personal goals, which then become a part of their plan of care. Peer support workers are available to consult with patients in their recovery journey.

In partnership with the Emergency Program, the Mental Health Program has initiated a new project to create safe rooms within the emergency department. During the planning phase, patients were asked to participate in design of the space.

Within the forensic psychiatry units, patients are provided orientation well in advance to the transition, to ensure they are prepared for the change in the environment. There are staff assigned to each patient who follow them throughout their continuum of care in the inpatient forensic psychiatry setting. A peer support coordinator is a valuable member of the team, and supports the patients through lived experiences.

Upon discharge from the inpatient services, there is coordination of follow-up services into the appropriate community mental health services both for forensic and acute inpatient psychiatry units.

Priority Process: Decision Support

There have been significant improvements in the delivery and standardization of patient care with the implementation of Meditech Expanse. In particular, medication reconciliation on admission and discharge is much better, although there was a learning curve with the new processes.

Review of online documentation has been completed by clinical nurse specialist groups to ensure that staff are having conversations with other staff at the transfer of accountability, and not just ticking the box. As a result, the staff have resumed their verbal reports between shifts, and from the emergency department to inpatient mental health unit.

Priority Process: Impact on Outcomes

Patient care standards and practices are shared among the ten forensic psychiatry hospitals across the province, in an ongoing quality initiative that ensures that both quality of services and potential risks to the public are standardized.

At the system level, there are regular meeting with a quality coordinator, provincial representatives, and director groups to establish policies and procedure, and standardize access to services.

Standards Set: Obstetrics Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The obstetrical program at North Bay Regional Health Centre is supported by committed leaders, physicians, midwives, and team members. The teams and leaders are engaged, proactive, and committed to providing quality care to patients and families. The interdisciplinary team includes clinical nurse educators, nurses, obstetricians, midwives, and social workers. The team members stated that they have the resources to do their work.

Program goals and indicators are developed and monitored. Huddle boards are visible, and are used to support communication and quality improvement. The team has used the huddle board to bring forward needs that are identified by the front-line staff. One example brought forward is the requirement for more wall outlets in the hallway for charging the increasing number of mobile medical equipment. The leaders are encouraged to continue to seek the input of team members, patients, and families in developing, monitoring, and communicating program goals and priorities.

Partnerships and relationships have been supported, including Public Health and Ontario Ministry of Children and Youth Services. There is a strong commitment to developing partnerships to continue to improve the obstetrical program and the services provided to patients and families. This includes the strong partnership developed with Public Health, with a shared commitment to the Healthy Babies Healthy Children program. The leaders are encouraged to continue with this important work.

Priority Process: Competency

A strong inter-disciplinary team supports the obstetrical program. Team members have been recognized for their commitment to patient care. This includes some team members receiving the Golden Heart Award. The Managing Obstetrical Risk Efficiently Program (MORE-OB) was implemented in 2013, and there is a long-standing commitment to this safety and quality journey. The team has received three MORE-OB recognition awards, and in 2016, received the Provincial MORE-OB Patient Safety Award.

A learning environment is fostered for the team. This includes the support of a clinical nurse educator, e-learning, and education and training opportunities. The clinical nurse educator assists the team members in attaining and maintaining core competencies. The education and training provided includes violence prevention, fetal heart surveillance, neonatal resuscitation, and breastfeeding education, to name just a few. The team members stated that their learning and educational needs are supported. A strong orientation is provided for the team members. The team members stated that they valued the opportunity to work in the many facets of the maternal and child program, and that they were well prepared by the orientation to do so. However, the team noted that at times, the obstetrical unit can need additional staffing, due to an increase in the number of patients. The leaders are encouraged to continue to monitor workload and service demand, and implement measures as appropriate.

The team members stated that they felt safe at work. They noted the value of violence prevention education and supports, such as the staff duress system. The team have practiced mock codes. The leaders are encouraged to continue to support the safety of team members, and to involve the team in the development of innovative staff safety strategies.

The team members stated that they are aware of the process to follow if ethical concerns arise. The team has worked though ethical issues and concerns, and have worked with the ethicist and patient advocate. The leaders are encouraged to continue to support ethics education for team members. The team members spoke highly of the value of performance evaluations. The leaders have a plan to complete performance evaluations, and are encouraged to continue to implement this plan.

Priority Process: Episode of Care

The leaders, team members, and physicians are committed to quality obstetrical care. This commitment includes the implementation of the Managing Obstetrical Risk Efficiently Program (MORE-OB). The Service of Obstetrics Committee meets monthly, and includes the participation of obstetricians, mangers, midwives, the clinical nurse educator, and service head of medicine. This committee provides support and direction to the obstetrical program. The C-section rates continue to be higher than benchmarks, and the organization has recognized this as an area requiring additional focus. Continued work to identify the contributing factors to target areas for education and resources is encouraged as the organization moves forward. The input of patients and families in this process is encouraged.

There is a comprehensive array of obstetrical services to support patients and families, including an antenatal clinic, eight labor and delivery beds, a C-section suite, and the Maternal/Newborn Clinic. The

birthing unit team is a multidisciplinary team of obstetricians, midwives, registered nurses, and social workers. The leaders and team members are committed to working effectively as an inter-disciplinary team. They were described as being a great team, with a high level of support from their leaders. The team is committed to best practices to improve the maternal and child program. Nursing staff are also offered the opportunity to cross train to support either or both of the pediatric and neonatal units, as required. This flexibility is valuable to maintain adequate staffing due to the volume fluctuations experienced in each of these areas.

Patients and families acknowledged the quality of the care provided. They described being treated with care, dignity, and respect. They stated that they felt supported in their discharge, and aware of the supports that are available. Furthermore, they noted that they were encouraged to ask questions. There are white boards in the patient rooms. Patients have provided input into the development of such initiatives as a resource library. Every patient completes a survey prior to discharge, which requests feedback on the overall patient experience. The survey included specific questions regarding communication, and the passage of information regarding discharge and transition may help the organization to further develop and design processes. The leaders are encouraged to continue to involve patients and families in the co-design of programs and services.

Priority Process: Decision Support

The patient record includes electronic and paper-based components, as the transfer from paper to the electronic platform is implemented. The transfer to Meditech Expanse occurred in the first wave; however, it was identified that some components of the electronic charting process will be deferred to the second wave. This would allow the team members time to begin implementing this process into their practice. Some identified gaps include the inability to access outpatient labs via Meditech Expanse, and the inability for nursing to input or review social history on the Meditech platform. Addressing these gaps will assist the further transition to a computer-based format. The leaders are encouraged to continue with the development and implementation of a single electronic health record.

Standardized information is collected on the patient charts. An in-depth assessment is completed. Chart auditing occurs. Education and training are provided to the team members on technology and the newly implemented hospital information system. Leaders and team members are committed to protecting the privacy of patient information.

Priority Process: Impact on Outcomes

There is a culture of quality improvement within the obstetrical program. Huddles, bedside white boards, and a huddle board support safety and quality. The leaders and team members are committed to selecting evidence-based guidelines to support quality obstetrical care. The Service of Obstetrics Committee oversees the development of clinical practice guidelines using the Society of Obstetricians and Gynaecologists of Canada and MORE-OB guidelines to support their work. There are also linkages with the quality coordinators.

The electronic incident reporting system is used by team members. The leaders review incidents, and make changes as appropriate. The patient safety incidents are reviewed, with the information used to improve the quality of the obstetrical service.

Patient satisfaction surveys are completed. The leaders and team members are responsive to patient feedback. The team works with Public Health to support the Baby Friendly Initiative. The leaders are encouraged to continue to implement and evaluate quality improvement initiatives with the input of patients and families.

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

Policies are in place for guidance for donation after circulatory death (DCD). Services are coordinated with organ procurement organizations through the local Trillium Gift of Life Network coordinator.

Priority Process: Competency

Staff receive standardized training for Organ and Tissue Donation for Deceased Donors from the critical care unit clinical nurse educator, following the Trillium Gift of Life Network criteria. An order set is followed to ensure consistency of practice that is aligned with the guidelines.

Priority Process: Episode of Care

The standardized Canadian Standards Association tool is used to document information on donor histories.

Priority Process: Decision Support

According to the Canadian Standards Association standards, updated records are kept in the electronic record that include a unique patient identifier for the purposes of tracking the organ or tissue donated. Organ and tissue registries are available through the local Trillium Gift of Life Network coordinator.

Priority Process: Impact on Outcomes

Staff and physicians from the operating room, emergency department, and the critical care unit are directly involved in the development and review of protocols related to organ and tissue donation. When potential cases are identified, the team is brought together by the local Trillium Gift of Life Network coordinator to plan with the network's retrieval team.

Priority Process: Organ and Tissue Donation

In addition to the core clinical team, spiritual care and social work support are provided to families. The staff are trained and monitored to ensure that end-of-life care remains consistent with expected practice.

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

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The perioperative service is led by passionate and innovative leaders, physicians, and team members. They are commended for their commitment to provide quality and safe surgical care.

The perioperative area is clean, well-maintained, and provides for a functional workflow both within and outside the operating suite. There are wide corridors and recessed spaces in the hallways to store equipment. There is a negative pressure ante-room in the operating room. The operating rooms are of an appropriate size. The team noted that they have the appropriate resources to do their work.

Volunteers support the perioperative program. There is a volunteer board, “Meet the Stars of Our Department: Our Volunteers,” acknowledging the important work of volunteers in the perioperative program. Service specific goals and objectives are developed and monitored. This includes improving wait times and access to care. The leaders are encouraged to continue with this important work.

Priority Process: Competency

A strong inter-disciplinary team supports the provision of quality perioperative services. The leaders and team are committed to providing quality and safe services for patients and families. The leaders are acknowledged for their commitment to supporting the education and learning needs of staff. Team members have been recognized for their commitment to quality surgical care. This includes some team members receiving the Golden Heart Award, which they proudly display on their lanyards.

Education and training for the team is a priority. The support of the clinical nurse educator was viewed as critical in supporting the team to meet education and training needs. The clinical nurse educator assists the team members in attaining and maintaining core competencies. The team members stated that their learning and educational needs are supported. Late shift start-time occurs approximately three times a month to support team education. There is a collegial working relationship in the perioperative service. The team members acknowledged the support of their team members and leaders. The leaders are acknowledged for the completion of performance evaluations. The team members stated that they felt safe at work, and that they felt the organization provides a safe workplace. The leaders are encouraged to continue to support the safety of team members.

Historically, the staffing in the operating room suite has had limited turn over. However, recently there has been approximately 45–50 new staff. The leaders and team members have met this challenge. An extensive orientation of approximately six months prepares nurses to work in the operating suites. The team members stated that the orientation was great, and prepared them to work in the perioperative service. The leaders and team are to be commended for their commitment to infusion pump safety.

Priority Process: Episode of Care

The leaders, team members, and physicians are committed to quality and safe perioperative services. This is demonstrated by the commitment to Choosing Wisely, the Surgical Site Infection Prevention Bundle, and the National Surgical Quality Improvement Program, to name just a few. There is an Operating Room Committee of the Department of Surgery which meets on a regular basis. This committee provides support and direction to the perioperative service.

There is a comprehensive array of perioperative services to support patients and families. This includes a 64-bed medical surgical unit, pre-admission day care, recovery room, endoscopy suite, seven surgical suites in the main operating room, and one in the ambulatory care area, pain management clinic, and ophthalmology clinic. There is a strong interdisciplinary team of surgeons, anesthesiologists, social workers, physiotherapists, pharmacists, and occupational therapists, to name just a few. The leaders and team members are committed to working effectively as an inter-disciplinary team. The team was described as excellent and very committed to safe patient care. The team is committed to best practices to improve the perioperative service, including participation in provincial and national initiatives. The Opioid Reduction Initiative involves the participation of team members, patients, and families. The team is to be commended for their commitment to medication reconciliation, pressure ulcer prevention, and falls prevention. Regular auditing occurs.

The patients and families acknowledged the quality of the surgical care provided. They stated that they would highly recommend the surgical program for people requiring this service. They described being treated with care, dignity, and respect. They stated they felt prepared for the surgical procedure, and were supported in their discharge. They expressed concern that due to COVID-19, support people were unable to accompany them into the surgical waiting area; however, they understood the rationale for such restrictions.

Priority Process: Decision Support

The staff and leaders are committed to using decision support to enable quality surgical care. Education and training are provided to the team on the use of technology. Meditech Expanse has been implemented. However, there are some paper based processes, such as between the surgeons' offices and the Meditech system. There is an electronic board for urgent after-hours operating room bookings, including the physician order, time of decision to treat, and priority.

Standardized patient information is collected. Comprehensive and up to date information is collected with the input of patients and families. The care plans are also developed and updated with the input of patients and families.

Priority Process: Impact on Outcomes

Staff and leaders are acknowledged for their strong commitment to quality improvement. This includes the participation in provincial and national patient safety initiatives, including a surgical site infection reduction initiative and an opioid reduction initiative. The leaders and team members are committed to selecting evidence-based guidelines to support quality surgical care. The team members and patients are engaged in quality improvement. Patient satisfaction surveys are completed with the results shared.

Best practices are supported by participating in such initiatives as Choosing Wisely and the National Surgical Quality Improvement Program. The team and leaders are to be commended for their commitment to best practices and quality improvement. The leaders and team are encouraged to continue with this important work and to continue to seek the input of patients and families.

The electronic incident reporting system is used by team members. The leaders review incidents, and make changes as appropriate. The patient safety incidents are reviewed with the information used to improve the quality of the perioperative service.

Priority Process: Medication Management

There are strong processes to support medication management in the perioperative service. The perioperative team works closely with the pharmacy department to ensure quality medication management. The team noted that they have the appropriate medications to deliver the surgical services. The medications are secured appropriately, and the medication carts are standardized. Medication administration is documented. Emergency and life support equipment is available.

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

A point-of-care testing (POCT) technologist manages the daily POCT program at North Bay Regional Health Centre. The POTC technologist trains nurses in point-of-care glucose testing on an annual basis. There is a record keeping log of all nurses that are trained. In addition, just-in-time training also occurs when it is required.

A Point-of-Care Testing Advisory Committee meets quarterly to provide review and input to the point-of-care trending and any identified issues. The committee consists of representatives of stakeholders for POCT device use. The committee coordinates the development of POCT programs and the use of POCT devices for the North Bay Regional Health Centre. The committee ensures the appropriate use of the devices and the principles of best practice. Policies and procedures are developed in accordance with the Ontario Laboratory Accreditation requirements.

Standards Set: Rehabilitation Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Clear goals are set for the service with input from staff, patients, and families.

Priority Process: Competency

The team described an internal expert resource to support culturally-sensitive Indigenous care, as well as external partnerships with Elders to support Indigenous ceremonies and practices. Staff are supported to develop documented goals, and have a formal performance evaluation every two years. This is a very comprehensive, inter-disciplinary team that includes speach and language pathologists, nurses, personal support workers, social workers, occupational therapists, physical therapists, a dietician, and recreation therapist. Patients are involved in the development of their treatment plans from the outset, at admission. Progress to discharge goals is monitored daily, and measured using a stoplight system. Standardized transfer of accountability tools and a verbal SBAR (Situation, Background, Assessment, Recommendation) is done for the transfer of patients. This team participates in daily bullet rounds and safety huddles three times weekly.

Priority Process: Episode of Care

The team uses the standardized Morse Fall Scale (MFS) to assess falls risk upon admission, weekly, and after falls, which is embedded in the new hospital information system. Falls risk is reviewed in the unit

safety huddle three times weekly. Patients are mobilized frequently, with assistance when required. The Braden tool is for consistent, standardized assessment. Skin assessments are completed by nurses upon admission and weekly, unless required more frequently. The team confirms the patient name, date of birth, and check the identification arm band. Prior to treatment administration, an additional check is made by scanning the bar code on their arm band. A standardized transfer of accountability tool is used, as well as a verbal SBAR (Situation, Background, Assessment, Recommendation) report between sending and receiving clinicians.

Priority Process: Decision Support

This team conducts weekly audits of patient records. A standardized transfer of accountability tool is used to support the safe transition of patients.

Priority Process: Impact on Outcomes

The service manager is the district stroke coordinator. Canadian Best Practice Guidelines are used, as well as Registered Nurses' Association of Ontario best practice guidelines, and college standards from all health disciplines involved.

Standards Set: Transfusion Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Episode of Care

This is in place, as previously demonstrated in the Ontario Laboratory Accreditation.

Priority Process: Transfusion Services

A Transfusions and Blood Conservation Committee provide oversight to the transfusion services at the North Bay Regional Health Centre. This is an inter-professional committee with representation from anesthesia, surgery, medicine, family medicine, emergency department, the blood bank, a blood conservation coordinator, and pharmacy, and is chaired by the Department of Laboratory Medicine. The committee serves to improve the quality of patient care and clinical outcomes through the promotion of blood conservation and best practice.

The Canadian Blood Services manages the supply of blood products, and provides oversight to all hospitals. During the COVID-19 pandemic, Canadian Blood Services requested a 10 percent reduction of all inventory in anticipation of a shortage. Due to the temporary cancellation of elective surgeries the shortage did not occur, but the hospital needed to balance patient safety with the potential wastage of products.

Most recently, the blood conservation coordinator created a medical directive to improve the management of anemic patients scheduled for surgery, which allows for oral or injectable iron or erythropoietin to improve hemoglobin and avoid the need for blood products.

Instrument Results

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

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: November 7, 2018 to November 11, 2018**
- **Number of responses: 12**

Governance Functioning Tool Results

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1. We regularly review and ensure compliance with applicable laws, legislation, and regulations.	0	0	100	91
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	0	0	100	94
3. Subcommittees need better defined roles and responsibilities.	83	8	8	72
4. As a governing body, we do not become directly involved in management issues.	0	17	83	84
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	8	92	93

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
6. Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	95
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	0	100	95
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	0	0	100	96
9. Our governance processes need to better ensure that everyone participates in decision making.	67	8	25	61
10. The composition of our governing body contributes to strong governance and leadership performance.	8	0	92	94
11. Individual members ask for and listen to one another's ideas and input.	0	0	100	97
12. Our ongoing education and professional development is encouraged.	0	0	100	85
13. Working relationships among individual members are positive.	0	0	100	97
14. We have a process to set bylaws and corporate policies.	0	0	100	94
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	97
16. We benchmark our performance against other similar organizations and/or national standards.	0	25	75	71
17. Contributions of individual members are reviewed regularly.	9	18	73	68
18. As a team, we regularly review how we function together and how our governance processes could be improved.	0	17	83	82
19. There is a process for improving individual effectiveness when non-performance is an issue.	10	10	80	58
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	0	0	100	84

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
21. As individual members, we need better feedback about our contribution to the governing body.	42	8	50	46
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	8	0	92	76
23. As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	93
24. As a governing body, we hear stories about clients who experienced harm during care.	8	8	83	81
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	0	0	100	89
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	0	0	100	85
27. We lack explicit criteria to recruit and select new members.	100	0	0	75
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	0	8	92	83
29. The composition of our governing body allows us to meet stakeholder and community needs.	0	0	100	91
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	92
31. We review our own structure, including size and subcommittee structure.	0	0	100	85
32. We have a process to elect or appoint our chair.	0	0	100	84

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

Overall, what is your assessment of the governing body's impact over the past 12 months, in terms of driving improvements to:	% Poor / Fair	% Good	% Very Good / Excellent	%Agree * Canadian Average
	Organization	Organization	Organization	
33. Patient safety	0	27	73	77

Overall, what is your assessment of the governing body's impact over the past 12 months, in terms of driving improvements to:	% Poor / Fair	% Good	% Very Good / Excellent	%Agree * Canadian Average
	Organization	Organization	Organization	
34. Quality of care	0	0	100	78

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

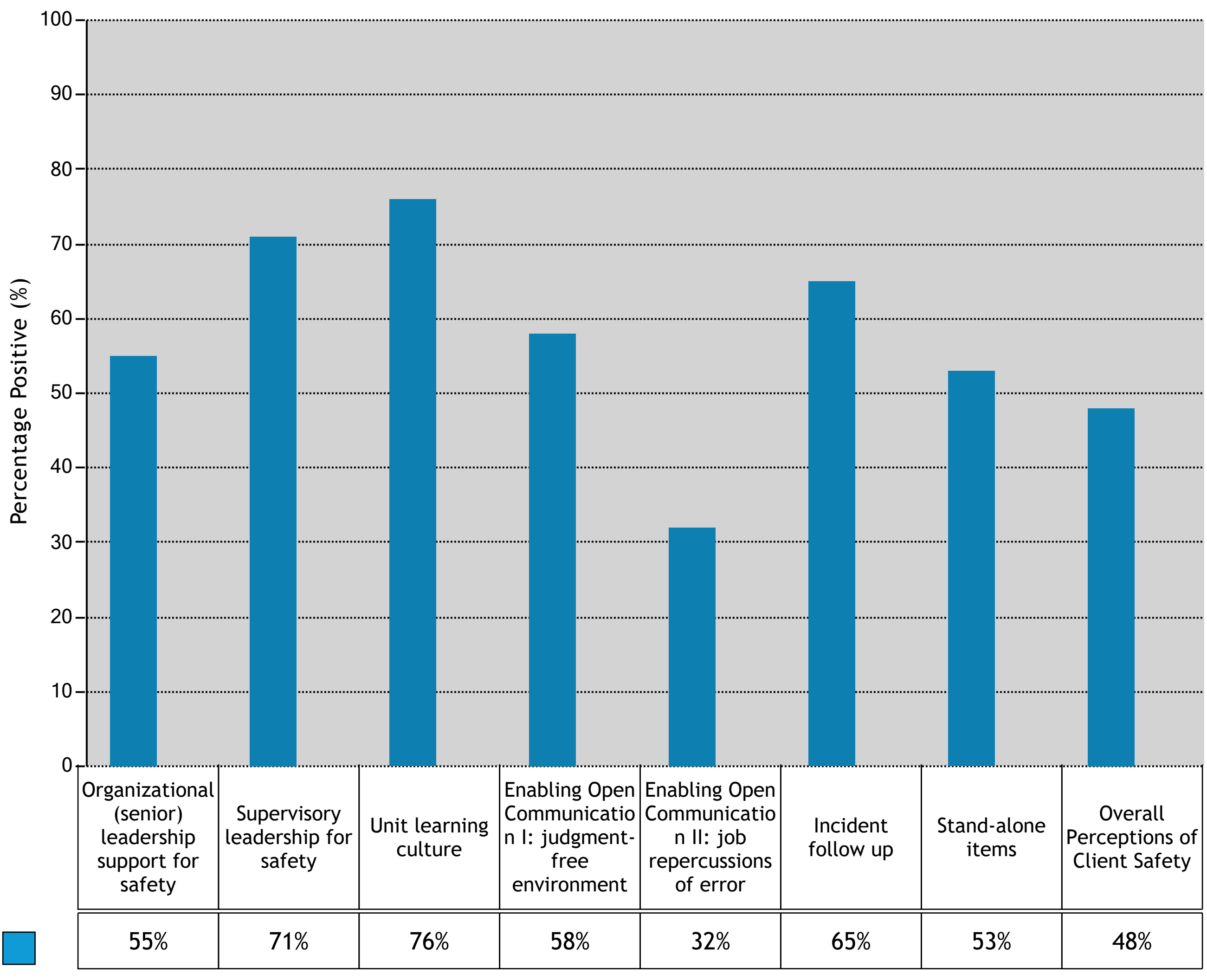
Canadian Patient Safety Culture Survey Tool

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

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

- **Data collection period: April 11, 2018 to May 5, 2018**
- **Minimum responses rate (based on the number of eligible employees): 302**
- **Number of responses: 307**

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



Organizational (senior) leadership support for safety	Supervisory leadership for safety	Unit learning culture	Enabling Open Communication I: judgment-free environment	Enabling Open Communication II: job repercussions of error	Incident follow up	Stand-alone items	Overall Perceptions of Client Safety
55%	71%	76%	58%	32%	65%	53%	48%

Legend

North Bay Regional Health Centre

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 15 business days.

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

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

Action Planning

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

Appendix B - Priority Processes

Priority processes associated with system-wide standards

Priority Process	Description
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

Priority Process	Description
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

Priority Process	Description
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
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