ACCREDITATION
AGRÉMENT
CANADA

Accreditation Report

Qmentum Global™ Program

Brant Community Healthcare System

Report Issued: 14/02/2024

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About Accreditation Canada

Accreditation Canada (AC) is a global, not-for-profit organization with a vision of safer care and a healthier world. Together with our affiliate, Health Standards Organization (HSO), our people-centred programs and services have been setting the bar for quality across the health ecosystem for more than 60 years, and we continue to grow in our reach and impact. HSO develops standards, assessment programs and quality improvement solutions that have been adopted in over 12,000 locations across five continents. It is the only Standards Development Organization dedicated to health and social services. AC empowers and enables organizations to meet national and global standards with innovative programs that are customized to local needs. Our assessment programs and services support the delivery of safe, high-quality care across the health ecosystem.

About the Accreditation Report

The Organization identified in this Accreditation Report is participating in Accreditation Canada's Qmentum Global™ accreditation program.

As part of this ongoing process of quality improvement, the organization participated in continuous quality improvement activities and assessments, including an on-site survey from 13/11/2023 to 17/11/2023.

Information from the cycle assessments, as well as other data obtained from the Organization, was used to produce this Report. Accreditation Canada is reliant on the correctness and accuracy of the information provided by the Organization to plan and conduct the on-site assessment and produce this Report. It is the Organization's responsibility to promptly disclose any and all incidents to Accreditation Canada that could impact its accreditation decision for the Organization.

Confidentiality

Executive Summary

About the Organization

Brant Community Healthcare System (BCHS) is a large, two-site community healthcare system serving Brantford, Brant County, Six Nations of the Grand River, Mississaugas of the Credit First Nation and surrounding communities. With a total of 324 beds, the BCHS is an affiliated teaching site of McMaster University Michael G. DeGroote School of Medicine. Brantford General Hospital is a regional acute health centre and the Willett site provides urgent care and ambulatory services. As the only acute care facility in Brant County, BCHS is committed to providing specialty programs and service for the 130,000 plus residents in the communities serviced.

BCHS are working together to build a healthier community. Their vision is to provide exceptional care by exceptional people, grounded through “CARE” values of compassion, accountability, respect and equity. Over the last two years, like all hospitals in Ontario and the entire health care sector, BCHS faced some of the toughest challenges they have ever endured as they fought the COVID-19 pandemic. Although BCHS faced adversity, the organization rose to the challenge – attempting to strike the right balance between managing daily operations and care services for patients, moving the strategic priorities forward and ensuring the health and wellness of their very own people. Despite the challenges of the COVID pandemic, BCHS has made several notable accomplishments. During the pandemic, they opened a Clinical Assessment Centre–providing testing, assessment, and therapeutics to the community. BCHS also administered critical vaccinations – supporting the health and safety of the community. BCHS has made significant progress on their master planning and Emergency Department redevelopment work, including the acquisition of a new CT scanner.

BCHS is a high performing health care organization that is responding to the community’s exponential growth, increasing demands and expectations for health care services. As BCHS moves forward towards pandemic recovery with a focus on their health care workers, along with the ongoing implementation of their 2020-2025 strategic plan– communications will continue to play a key role.

The strategic Communications Plan will help BCHS to ensure consistent and clear internal and external communications. This plan outlines communication priorities by incorporating feedback from a variety of key communication stakeholders, and aligning to the 2020-2025 Strategic Plan. To assist in effective delivery of key messages, this plan outlines target audiences, messages and avenues of communication for maximum impact and credibility. This plan is to be used as a guide whenever BCHS is communicating with the public, internal and external stakeholders, their partners, their donors and funders. The strategic plan has 5 key goals:

- Advance quality and safety
- Partner to transform care
- Support and empower people
- Build sustainability
- Champion health equity

The 2020-2025 Strategic Plan for the Brant Community Health System guides decisions and allows staff, physicians and volunteers to measure the service that is provided. The plan was developed through thoughtful input and guidance from patients and their families, community partners, staff, physicians, volunteers, elected officials and members of the public. The organization heard from over 1400 people and the plan’s contents and directions are truly a reflection of their input.

Through these meetings (and process), a new vision, mission and values became clear, resonating with patients, the public and BCHS physicians, staff and volunteers. The new vision of “Exceptional Care – Exceptional People” speaks to the importance of each and every person at BCHS and the value that each person brings to enhancing the patient experience. The mission, “Working together to build a healthier community,” acknowledges that BCHS is part of the solution to ensuring that the communities they serve receive quality healthcare and that BCHS is committed to doing their part. Lastly, the values of compassion, accountability, respect and equity reflect how BCHS will engage and interact on a day to day basis, with patients, visitors and with each other.

From the Organization:
At Brant Community Healthcare System (BCHS), we are working together to build a healthier community. Our vision is to provide exceptional care by exceptional people, grounded through our “CARE” values of compassion, accountability, respect and equity.

BCHS is a primary acute care facility located in Brantford and Paris, Ontario, is comprised of two sites, has a total of 324 beds and has more than 2,700 staff, physicians and volunteers. The system serves over 150,000 residents in Brantford, the County of Brant, Six Nations of the Grand River, Mississaugas of the Credit First Nation, and surrounding communities.

The BCHS is an affiliated teaching site of McMaster University Michael G. DeGroote School of Medicine. We are also the regional centre for Paediatrics, Mental Health, Obstetrics, Gynaecology, CT Scanning, Critical Care, Surgical Services, Ambulatory Care and Emergency Medicine, the site of the Brant Community Cancer Clinic and the S.C. Johnson Dialysis Clinic for patients throughout Brant County and Haldimand-Norfolk.

Surveyor Overview of Team Observations

In 1999, The Willett Hospital in Paris and the Brantford General Hospital became the first two partners in the Brant Community Healthcare System. With a total of 324 beds, the BCHS is an affiliated teaching site of McMaster University Michael G. DeGroote School of Medicine. Brantford General Hospital is a regional acute health centre and the Willett site provides urgent care and ambulatory services. Currently underway, the Emergency Department Renovation Improvement Project is a 25,475 square foot interior and exterior renovation of the existing emergency department at the Brantford General site. The scope of this project includes:

- New walk-in entrance
- Renovation of patient entry, waiting, triage, and registration
- Development of new See & Treat area
- Relocation of Level 1 public corridor
- New ED offices and Indigenous Healing Lodge
- Renovated staff support and lockers
- Renovated Extended Stay area

Brant Community Healthcare System is fortunate to have an engaged Board of Directors (board) composed of active community members who believe in the organization’s leadership's role in rallying community partners to provide integrated, comprehensive care and services to the community in a context of limited funding and increasing patient needs. The board ensures close monitoring of performance indicators as well as quality improvement initiatives.

The BCHS assumes a leadership role at many of the consultation and steering committees, always with a focus on ensuring patients receive the care and services they need, when they need them, and provided by the most appropriate provider. The need for an integrated approach is important in the context of limited funding. The senior leadership team is lean but efficient; made up of passionate professionals who are committed to quality improvement and to providing safe, patient centered. Senior leaders are highly visible and are respected by staff, physicians and volunteers. The organization is currently recruiting a chief executive officer and a chief nursing executive. There is a program in place to identify and develop local talent to ensure succession planning in some clinical and support services. Providing a healthy and safe working environment is of importance. Staff appear highly engaged in their roles and are proud of the organization and their contribution to patient care.

The hospital can count on its compassionate and dedicated staff, physicians, and volunteers. They are proud of the hospital and the safe care and support they provide for the patients and their families. Patient satisfaction surveys and patient focus groups report positive experiences with the care and services they receive. Patients and families are encouraged to participate in their care and leadership addresses all complaints promptly and ensures follow up on actions taken.

Key Opportunities and Areas of Excellence

The organization has been focused on cultural transformation. There is an environment that fosters a sense of belonging and recognition. Teams are committed to providing patient and family focused care. The decision support team has been concentrating on enhancing data accessibility and providing greater insights into quality and patient safety work. There is a commitment to serving the Indigenous Community. The Division of Indigenous Medicine has been established to support culturally sensitive care. In addition, the Indigenous Advisory Committee of the board is working to improve the Indigenous patient and family experiences. There is open and effective communication across the organization. As an example, quality huddle boards are used effectively to facilitate communication and alignment. The emergency department renovation improvement project at the Brantford General site will provide much needed improvements. Leadership, facilities and clinical teams were very nimble and responsive when the sink hole appeared, and they continue to work through this issue. There is evidence of moving towards equity, diversity, inclusion and belonging. The EDI strategic advisor has been hired and is in the process of developing an EDI framework and associated roadmap for the organization to plot a course for future activities. There is a patient safety focus, and this is supported by an updated patient safety plan and patient safety incident toolkit. A Patient Experience Bundle has been fully implemented and planning has begun for the implementation of bedside shift reporting in the new year.

There are significant capital investments that have been completed, are planned and are underway. As with other healthcare facilities, it is evident that there is significant ongoing capital investment that is required to maintain and upgrade the buildings and facilities to ensure business continuity, and to meet evolving care delivery standards. Linked to capital development, planning and advocacy are underway to ensure the organization is able to meet the capacity needs of the growing population both today and into the future. There are a number of large projects and initiatives underway which result in competing priorities. Consideration of priorities and allocation of health human resources will require ongoing review in light of the systemic staffing shortage and the pressures on staff and patients. The current hybrid health record is an organizational risk. The organization is planning for the implementation of the first cloud based Meditech solution in Canada. Once the system is installed, efforts may be made to leverage system features and enhancements to improve patient care delivery and safety. Similar to other healthcare organizations, BCHS is facing health human resource challenges. BCHS will need to continue to look at innovative ways to meet system challenges. Two successes observed include the physician assistants working in the emergency department and the New Graduate Residency Program. There is much uncertainty related to Ontario Health Teams and system transformation. Leaders of the organization will need to continue to monitor and embrace system transformation and continue to be innovative. The organization has an operating deficit. The long-term financing strategy to support the EMR implementation, equipment renewal and capital redevelopment work at BCHS has been initiated.

The organization is working diligently to ensure financial stewardship and this work will need to continue to ensure financial sustainability.

Program Overview

The Qmentum Global™ program was derived from an intensive cross-country co-design process, involving over 700 healthcare and social services providers, patients and family members, policy makers, surveyors, clinical, subject matters experts, Health Standards Organization and Accreditation Canada. The program is an embodiment of People Powered Health™ that guides and supports the organization's continuous quality improvement journey to deliver safe, high-quality, and reliable care.

Key features of this program include new and revised evidence based, and outcomes focused assessment standards, which form the foundation of the organization's quality improvement journey; new assessment methods, and a new digital platform OnboardQi to support the organization's assessment activities.

The organization will action the new Qmentum Global™ program through the four-year accreditation cycle the organization is familiar with. As a driver for continuous quality improvement, the action planning feature has been introduced to support the identification and actioning of areas for improvement, from Steps 2. to 6., of the cycle.

To promote alignment with our standards, assessments results have been organized by core and specific service standards within this report. Additional report contents include, the comprehensive executive summary, the organization's accreditation decision, locations assessed during the on-site assessment, required organizational practices results and conclusively a Quality Improvement Overview.

Accreditation Decision

Brant Community Healthcare System's accreditation decision is:

Accredited with Exemplary Standing

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

Locations Assessed in Accreditation Cycle

This organization has 2 locations.

The following table provides a summary of locations[1] assessed during the organization's on-site assessment.

Table 1: Locations Assessed During On-Site Assessment

Site	On-Site
The Brantford General Hospital	☑
The Willett Hospital	☑

[1]Location sampling was applied to multi-site single-service and multi-location multi-service organizations.

Required Organizational Practices

ROPs contain multiple criteria, which are called Tests for Compliance (TFC). ADC guidelines require 75% and above of ROP's TFC to be met.

Table 2: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Medication Reconciliation at Care Transitions - Ambulatory Care Services	Ambulatory Care Services	5 / 5	100.0%
Client Identification	Ambulatory Care Services	1 / 1	100.0%
	Critical Care Services	1 / 1	100.0%
	Diagnostic Imaging Services	1 / 1	100.0%
	Emergency Department	1 / 1	100.0%
	Inpatient Services	1 / 1	100.0%
	Mental Health Services	1 / 1	100.0%
	Obstetrics Services	1 / 1	100.0%
	Perioperative Services and Invasive Procedures	1 / 1	100.0%
	Point-of-Care Testing	1 / 1	100.0%
	Rehabilitation Services	1 / 1	100.0%
	Transfusion Services	1 / 1	100.0%

Table 2: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Information Transfer at Care Transitions	Ambulatory Care Services	5 / 5	100.0%
	Critical Care Services	5 / 5	100.0%
	Diagnostic Imaging Services	5 / 5	100.0%
	Emergency Department	5 / 5	100.0%
	Inpatient Services	5 / 5	100.0%
	Mental Health Services	5 / 5	100.0%
	Obstetrics Services	5 / 5	100.0%
	Perioperative Services and Invasive Procedures	5 / 5	100.0%
	Rehabilitation Services	5 / 5	100.0%

Table 2: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Medication Reconciliation at Care Transitions Acute Care Services (Inpatient)	Critical Care Services	4 / 4	100.0%
	Inpatient Services	4 / 4	100.0%
	Mental Health Services	4 / 4	100.0%
	Obstetrics Services	4 / 4	100.0%
	Perioperative Services and Invasive Procedures	4 / 4	100.0%
	Rehabilitation Services	4 / 4	100.0%
Falls Prevention and Injury Reduction - Inpatient Services	Critical Care Services	3 / 3	100.0%
	Inpatient Services	3 / 3	100.0%
	Mental Health Services	3 / 3	100.0%
	Obstetrics Services	3 / 3	100.0%
	Perioperative Services and Invasive Procedures	3 / 3	100.0%
	Rehabilitation Services	3 / 3	100.0%

Table 2: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Pressure Ulcer Prevention	Critical Care Services	5 / 5	100.0%
	Inpatient Services	5 / 5	100.0%
	Perioperative Services and Invasive Procedures	5 / 5	100.0%
	Rehabilitation Services	5 / 5	100.0%
Venous Thromboembolism (VTE) Prophylaxis	Critical Care Services	5 / 5	100.0%
	Inpatient Services	5 / 5	100.0%
	Perioperative Services and Invasive Procedures	5 / 5	100.0%
Patient Safety Incident Management	Diagnostic Imaging Services	7 / 7	100.0%
	Leadership	7 / 7	100.0%
Patient Safety Incident Disclosure	Diagnostic Imaging Services	6 / 6	100.0%
	Leadership	6 / 6	100.0%
Medication Reconciliation at Care Transitions - Emergency Department	Emergency Department	1 / 1	100.0%
Suicide Prevention	Emergency Department	5 / 5	100.0%
	Mental Health Services	5 / 5	100.0%

Table 2: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
Accountability for Quality of Care	Governance	6 / 6	100.0%
Hand-hygiene Education and Training	Infection Prevention and Control	1 / 1	100.0%
Hand-hygiene Compliance	Infection Prevention and Control	3 / 3	100.0%
Infection Rates	Infection Prevention and Control	3 / 3	100.0%
Client Flow	Leadership	5 / 5	100.0%
Workplace Violence Prevention	Leadership	8 / 8	100.0%
Medication Reconciliation as a Strategic Priority	Leadership	5 / 5	100.0%
Patient Safety Education and Training	Leadership	1 / 1	100.0%
Preventive Maintenance Program	Leadership	4 / 4	100.0%
Antimicrobial Stewardship	Medication Management	5 / 5	100.0%
High-alert Medications	Medication Management	8 / 8	100.0%
Heparin Safety	Medication Management	4 / 4	100.0%
Narcotics Safety	Medication Management	3 / 3	100.0%
Concentrated Electrolytes	Medication Management	3 / 3	100.0%

Table 2: Summary of the Organization's ROPs

ROP Name	Standard(s)	# TFC Rating Met	% TFC Met
The 'Do Not Use' List of Abbreviations	Medication Management	7 / 7	100.0%
Safe Surgery Checklist	Obstetrics Services	5 / 5	100.0%
	Perioperative Services and Invasive Procedures	5 / 5	100.0%
Infusion Pump Safety	Service Excellence for Ambulatory Care Services	6 / 6	100.0%
	Service Excellence for Critical Care Services	6 / 6	100.0%
	Service Excellence for Diagnostic Imaging Services	6 / 6	100.0%
	Service Excellence for Emergency Department	6 / 6	100.0%
	Service Excellence for Inpatient Services	6 / 6	100.0%
	Service Excellence for Mental Health Services	6 / 6	100.0%
	Service Excellence for Obstetrics	6 / 6	100.0%
	Service Excellence for Perioperative Services and Invasive Procedures	6 / 6	100.0%
	Service Excellence for Rehabilitation Services	6 / 6	100.0%

Assessment Results by Standard

Core Standards

The Qmentum Global™ program has a set of core assessment standards that are foundational to the program and are required for the organization undergoing accreditation. The core assessment standards are critical given the foundational functions they cover in achieving safe and quality care and services. The core standards are always part of the assessment, except in specific circumstances where they are not applicable.

Emergency and Disaster Management

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the following table.

Assessment Results

The Emergency Preparedness Team is to be commended for its work and efforts related to emergency preparedness, and for their work in response to the pandemic. Planning for disasters, and risk mitigation processes are sound. Linkages with appropriate stakeholders are in place. BCHS works with Get Ready and uses the Atlas software that houses all information related to emergency preparedness. BCHS integrates its emergency management system with other agencies. The organization has formal mutual aid policies and agreements with neighbouring organizations and services that describe how resources, facilities, and services will be shared during an emergency or disaster.

Code procedures and processes are developed and in place. Many emergency code procedures are reviewed on a regular cadence with full training provided. Emergency response plans are regularly tested with drills and exercises for some codes. Code of the Month is practiced across the organization. Work is underway to develop, update and review less frequent codes such as Code Black, Silver, and Purple, and ensure policies, procedures and regular drills and exercises are in place. Education and rollout will follow. It is planned that all codes will be tested in the next year.

Fire prevention strategies including regular inspection, testing, maintenance and education are in place. The organization has conducted a comprehensive risk assessment and appropriate risk mitigation strategies are in place. A wholesome business continuity plan is developed and in place. The organization has backup systems for essential utilities and systems.

Debriefing results are used to revise and improve disaster and emergency plans. The debriefing process is well advanced. Staff members appear knowledgeable in mpergency Preparedness procedures and whom to contact in the event of a situation. Policies and procedures for identifying and responding to outbreaks are in place. Pandemic planning is complete and in place.

With regards to areas for improvement, the team is currently looking at two items. First, the team wants to enhance and further develop their relationships with external partners. Second, the team has identified the need to focus on cyber incident response preparedness and cybersecurity.

Table 3: Unmet Criteria for Emergency and Disaster Management

There are no unmet criteria for this section.

Governance

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the following table.

Assessment Results

Brant Community Healthcare System (BCHS) is supported by a Board of Directors (board) that is dedicated and committed to the provision of care to the communities it serves. This accountability includes adopting and delivering on the organization’s mission, vision and values, as well as the development and fulfillment of its strategic plan. The Bbard ensures the organization meets the health care needs of its patients and families, effectively using the resources that are available to provide services to the community and in collaboration with regional partners. There is a strong corporate business model with well-developed collaborative partnerships. Services are readily accessible to those who need them in the context of the organization’s mission.

The Board understands its roles and responsibilities, and those of senior management. New board members are oriented to their role as they join the organization. Formal mentorship is in place to support sound onboarding of new members. Skills are considered when new board members are sought. The members indicated that there are processes in place to evaluate the governance structure and function. The board is considering equity, diversity and inclusion and has an Indigenous Board Committee in place. A process is in place to monitor the performance of the chief executive officer and the chief of staff. The organization's bylaws are reviewed on a regular cadence.

The organization encourages input from patients/families, other organizations and the broader community in the delivery of services and in the operationalization of the strategic plan. Communication channels and linkages are built with the community, Foundation, volunteers and other stakeholders. The board has recently added a voting patient representative to one of its committees. There may be additional opportunities for the board to further advance its patient centered care approach by embracing additional venues to hear and to include the lived experience and expertise of the patient lens in the co-design, co-delivery, co-evaluation of patient engagement and in service design.

Feedback from community partners consistently described BCHS and board as collaborative, and as building positive relationships. The board demonstrates accountability for safety and quality of care and is committed to quality improvement. A risk management approach to mitigate and manage risk is in place. The board is aware of the organization’s risk assessment program and provides appropriate oversight. The board has approved the ethics framework. demonstrates an understanding of ethical decision making and has used the ethical framework in its deliberations.

BCHS is proud of its patient focus, and the board is supportive of and committed to meeting the needs of the patients and their families.

Table 4: Unmet Criteria for Governance

There are no unmet criteria for this section.

Infection Prevention and Control

Standard Rating: 98.7% Met Criteria

1.3% of criteria were unmet. For further details please review the following table.

Assessment Results

The Infection Prevention and Control (IPAC) committee and related teams have regular meetings and demonstrate a strong focus on safety and quality. The team is aware of how the age of the building may impact effectiveness of infection control. But they are justifiably proud of the work being done to achieve positive outcomes for infection control at BCHS as demonstrated by good measures of infection rates, re-admission rates, and level of care to protect patients, families and staff.

Infection prevention and control policies and procedures are effectively managed using the Docs online platform. The platform includes automatic notifications for updates and reviews are managed by members of the committee and appropriate approvals are obtained if policies are substantially changed or newly developed.

The organization and the IPAC committee are recognized for having IPAC members at the table to participate in the committees and groups who will be overseeing the many construction and redevelopment projects that have started (i.e., the Emergency Department) and will be upcoming. Establishing a relationship between IPAC and capital projects is an important link to ensure that as BCHS develops its physical environment it also aligns with, and meets, infection control best practices.

The team is commended for its creative and enthusiastic approach to communicate and educate all staff on infection prevention and control. The organization has mandatory IPAC training which the team complements with in-person education at huddles (including 1-1 with staff if needed), e-learning with You Tube videos, identifying staff to be present at designated units to prompt and answer questions, and having an IPAC week with relevant activities.

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The team is commended for its creative and enthusiastic approach on communicating and educating all staff on infection prevention and control. The organization has mandatory IPAC training which the team complements with in-person education at huddles (including 1-1 with staff if needed), e-learning with YouTube videos, identifying staff to be present at designated units to prompt and answer questions, and having an IPAC week with relevant activities.

The team is commended for their approach to monitoring and measuring indicators and quality improvement. Hand hygiene audits are conducted and yield data which the IPAC team has used to initiate initiatives, such as changing signage to try and increase hand hygiene compliance rates, and training additional staff to do hand hygiene audits so additional audits can be completed. The team also has regular surveillance for outbreaks and additional infections, such as orthopedic surgical site infection rates.

The team has established cleaning procedures that vary in frequency and intensity as appropriate to the requirements of the patient and the built environment. This includes enhanced cleaning as needed in response to issues/trends identified with staff sickness, an outbreak, or other safety concerns and routine cleaning, such as in the emergency department, clinic spaces, and offices.

As noted by the IPAC team, two interrelated challenges face BCHS and the IPAC team. First, the buildings have risks related to infrastructure and failures, such as a sinkhole, that can significantly impact patient care since there is already a limited ability to control infections and mitigate the risk of outbreaks (lack of private rooms). And compounding this is the increasing and changing population of the community which introduces risks for overcrowding and the presence of more complicated infections. BCHS is commended for securing the necessary funding and approvals for the emergency department renovations and is encouraged to continue advocating vigorously for additional new capital projects to address the IPAC issues associated with the current building.

Table 5: Unmet Criteria for Infection Prevention and Control

Criteria Number	Criteria Text	Criteria Type
2.5.4	Team members, and volunteers have access to dedicated hand-washing sinks.	NORMAL

Medication Management

Standard Rating: 99.4% Met Criteria

0.6% of criteria were unmet. For further details please review the following table.

Assessment Results

The medication management processes of BCHS have been reviewed through this onsite survey process. At a governance level, the structural accountability of medication management processes and outcomes is through the Medication Utilization Committee that reports to MAC, various subcommittees including Antimicrobial Stewardship, Medication Safety Committee, Infusion Pump and Parental Manual Committee and close connection with Collaborative Practice Advisory Council, Infection Prevention and Control, Falls Committee, Operational Committees, Quality, Patient Safety and Risk Committee. Patient and Family Advisors are embedded in some committees such as Medication Reconciliation and issues of relevance are also brought to the attention of the CFAC. The Pharmacy department has a critical role in facilitating the collaborative approach with multiple areas of the organization and is commended for their proactive and advanced knowledge of safe system design. Key functions of the various committees include keeping the formulary updated and ensuring policies are in place for medication management.

From a safe design perspective, the pharmacy department and organization has thoughtfully made significant advances in technology and equipment including adding automated dispensing cabinets, anesthesia workstations, CII Safe System to improve controlled substances, PACMED and PACVISION, which is a new unit dose packager and automatic verification system, Fluidose machine and tabletop packager in addition Epic EPR in oncology. Other important safety changes since the last survey include controlled substances documentation and strong audits, computerized eMARs (electronic medication administration record) and bedside medication verification in all units except the emergency department (ED). Additionally, the teams have updated the IV monographs particularly to enhance safety for neonates and pediatric patients. BCHS is noted for their exceptional performance with medication reconciliation processes demonstrating a clear organizational strategic imperative and accountability within the pharmacy and physician groups. At this time 92 per cent of patients admitted to BCHS have their medications reconciled on admission (72 per cent in the ED).

The culture of patient safety is particularly evident with the pharmacy team, and the overall physician and administrative leadership. BCHS has made great strides to eliminate the use of acronyms and symbols found in the ISMP (Institute for Safe Medical Practices) Do-Not-Use list within all medication orders. To that end, BCHS has implemented pre-typed order sets where possible, has the ISMP Do-Not-Use list printed at the top of order sheets, completes audits of all medication orders and follows up with physicians as part of the credentialling process to provide feedback to them about continued use of acronyms and symbols in the medication orders.

Nonetheless, it is an exceptionally unsafe practice to continue to transcribe paper orders (both medication and other orders) that are at times illegible and continue to use acronyms and symbols understood to be risky practices. Audits demonstrate that over 1,900 instances of this practice have occurred within the past six months. It is noted that multiple efforts have been put in place to decrease the use of acronyms and symbols and the pharmacy team has latitude to contact the ordering physician when clarification is required. It cannot be over emphasized that this practice mitigates some risk however given the frequency of errors, it remains an organizational safety issue that has a high residual risk. Of particular risk is the medication management process within the ED where there is use of cMARS which have the potential for delays in information transfer.

Leaders build systems that keep patients safe. The process of transcribing orders places staff and physicians at the sharp end of being expected to remember to avoid using acronyms and symbols and to mitigate unsafe practices rather than rely on automated systems that could systematically eliminate many of these types of risks. The people at the sharp end are encouraged to continue their work to be vigilant and aware that this is a safety risk. They are commended for their efforts to continue to advance patient safety as is the entire team focused on finding ways to eliminate and mitigate the risk. At best transcribing of orders is inefficient for the staff expected to re-enter paper orders and at worst creates an unsafe system. BCHS is on the path towards moving to Meditech Expanse and a fully computerized physician order entry system. BCHS must not delay in moving forward with this. Funding must be prioritized. Given both the physician and administrative leadership's strong understanding of safety systems and culture, this survey team is confident that an ultimate solution to eliminating the need for routine transcription of orders and continued efforts to adopt CPOE, which should be a best practice standard across all hospitals in Canada, will be present by the next onsite survey cycle.

Table 6: Unmet Criteria for Medication Management

Criteria Number	Criteria Text	Criteria Type
3.2.2	Teams can readily access accurate and up-to-date medication information specific to the populations served.	NORMAL

Leadership

Standard Rating: 98.9% Met Criteria

1.1% of criteria were unmet. For further details please review the following table.

Assessment Results

Brant Community Healthcare System (BCHS) Patient and Family Advisors (PFAs) are embedded within much of the organization's fabric, from the Quality Committee of the Board (QCB) all the way through to many of the program councils. The implementation of resources, structures and practices to support the engagement and collaboration of patients and families in the organization's internally developed Patient and Family Centred-Care Framework has shifted the culture of care experienced.

Patients and their families have reported their care as compassionate, where staff are willing to take the time to explain everything they are doing even when things have had to change. They have noticed and appreciated the moments when staff have gone over and above to ensure their care needs are met because it was the small things at that moment that mattered most - that made me feel cared for.

Planning and Service Design

Brantford Community Healthcare System leaders communicate and model the values of the organization. The annual planning cycle begins in the fall of each year. The planning cycle provides an opportunity to 1) review progress on the strategic plan, 2) consider community needs, 3) review performance and patient survey results, 4) consider provincial priorities, and 5) engage team members and patients/caregivers. An annual plan is developed to support the achievement of the strategic plan, which includes goals and objectives, and helps guide day-to-day operations.

BCHS plans for program and service development are well thought out, and the organization is involving appropriate parties to ensure they achieve their vision. Community input and needs are identified through a number of venues. The organization engages in formal evaluation of many of its programs and services. Communication between levels of the organization is open and transparent. There are opportunities and methods for staff, physicians, service providers and the community to provide input into service planning. Strategies to engage hard-to-reach populations have been developed. The organization has identified that additional initiatives could be pursued to reach hard-to-reach populations. BCHS is working hard to develop trust with the Indigenous community and to provide culturally sensitive care. The organization is actively involved and participates in ongoing community initiatives to support and promote health and prevent disease and is actively involved with its Ontario Health Team partners.

The organization’s response to COVID-19 was tremendous and was a great success both locally and regionally. The organization is very engaged in health system transformation and health system capacity planning.

Leadership aligns their activities to the strategic priorities of the organization. Policies and procedures are in place. The organization's teams have worked hard to review their policies and help them remain current, but it has been a challenge during the pandemic. BCHS is currently working on a plan to ensure that they reach 100 per cent and move forward in a way that will stay at that level. At present, staff indicate that approximately 77 per cent of policies have been reviewed and are up to date. Leadership demonstrates accountability for safety and quality of care, as well as a commitment to quality improvement.

Resource Management

Systems for financial planning and controls are in place. The budgeting process is integrated into the planning process, as well as into clinical service planning. The strategic plan guides the decision making around spending and resource allocation. There is appropriate oversight and planning in place to allow for both capital and operational budgets. A multiyear capital plan is maintained. Variance reporting is in place to review performance against the operating budget. The board provides appropriate oversight of resource management and ensures the viability of the organization.

The staff of the finance, procurement and other related departments are well qualified to manage the finances of this organization and are not only committed to financial sustainability for BCHS, but also to ensuring health services are available to meet the needs of the population served both today and into the future. These staff have implemented processes to ensure accountability for resources as well as compliance with applicable legislation. External audits are conducted, and appropriate financial controls appear to be in place including applicable segregation of duties. The team is looking to standardize work further and support every leader in the same way, such as for budget reports.

The group uses utilization data to identify opportunities for improvement and to monitor performance. Relationships with departmental leaders are built. As such, a collaborative approach exists between the finance and clinical and support services. It appears that the Fiscal Advisory Committee is used and makes recommendations to the board with respect to the operation, use and staffing of BCHS. Input is gathered from the staff members regarding purchases and when making resource allocation decisions. Staff advised that infection prevention and control and occupational health are routinely involved in making resource allocation decisions. Inventory management is currently in-house. There are plans to change this model in the near future (stockless inventory system).

Long-term planning for community needs is completed to respond to emerging demands. There is a history of strong financial stewardship, and a multi-year recovery from COVID-19. The organization is moving to a hosted version of Meditech and is looking to optimize operations, quality and performance through this tool. Business process transformation should be planned for people and financial information systems and clearly communicated across the organization.

Physical Environment

At BCHS, patients, families, staff and physicians experience the impact of the aging infrastructure, with limited space that has very little opportunity to support growth. The clinical teams are overcapacity with patients, in addition to carts and equipment being in hallways. The organization's leadership team has made proactive efforts to move forward with the initial phases of master planning, namely the proposal development phase, for a new building. In addition, interim activity to support a significant emergency department renovation improvement project is currently in the early construction phase and will likely take eighteen months for completion. This will lead to continued overcrowding of the ED, challenges for ambulance offloading, and difficulty in managing patient privacy, experience, and potentially safety, as the community surrounding BCHS sees an increase in patients with respiratory conditions over the fall and winter, and negative pressure isolation rooms are limited in the current ED space.

Challenging the leadership and facilities team is the balance of necessary investments to maintain the existing infrastructure while moving forward with master planning efforts that are likely to be ten plus years away for a new facility. The facilities team is congratulated on their proactive maintenance approach. Their work requires a skilled and often phased approach to infrastructure replacement with limited capital funding. The team is faced with unexpected issues such as the recent large sink hole development that has major impact on their underground tunnel housing critical pipes and lines. The main hospital entrance was urgently relocated and the teams have had to partner rapidly, externally with the city and paramedics and internally to enable safe entry for patients. This has led to unexpected further construction and changes in workflow. Regularly the teams at BCHS face Code Greys, Browns and Aqua due to unexpected leaks and challenges with unsophisticated monitoring capabilities due to the age of the infrastructure. Leak detection, checklists and dehumidifiers are used to mitigate contingency situations.

The BCHS team is committed to environmental sustainability and green programs. Their activities include waste diversion, education of clinical teams (recycling - reusable sharps), energy conservation activities and the cogeneration plant. The built environment and signage incorporate AODA best practices however, opportunity to fully support accessibility remains. Ramps have been installed to offer access to buildings, however these are not matched with automatic door openers which create barriers to access. Patient and family advisors are engaged in redevelopment activity and examples of changes include the number of parking spots that will be available. There will be many opportunities to partner with patients and families with the ED construction and BCHS master planning. Meaningful engagement to design accessibility up front with master planning will be an important opportunity for BCHS.

Patient Flow

There is a highly functional and enthusiastic Patient Flow Team at Brantford General Hospital (BGH). All appropriate policies are in place and up to date. Data are collected on flow, from the minute of patient arrival in the emergency department, through all intervals of care in the ED, transfer to other units of the hospital or other facilities, right through to discharge. Comparison is made to historical data for BGH and other comparator facilities, and to internal and external benchmarks. Targets for improvement are set, and plans developed for reaching those targets. Monitoring progress towards target is carried out regularly. Surge plans are in place for use during particularly busy periods, in which space is created for patients in other parts of the facility by discharging all possible patients and using space in areas not traditionally used for patient care. There is close collaboration with both internal and external partners, including tertiary care facilities in Hamilton. Transfers of care are arranged and documented through standardized SBAR forms, which are currently printed and faxed to the receiving units. Once the new cloud based Meditech IMS is in place, these forms will be part of the digital chart. The Urgent Care Centre at the Willett site is under the leadership of the BGH ED, and transfers of patients who require ED services are seamlessly arranged. The Willett site serves as an ALC unit for BGH, and patients are readily transferred as appropriate.

Surgical bookings are done via OR blocks assigned to each service. In orthopedics and some other surgical services, there are centrally managed waiting lists as mandated by the QBP system. For other services, each surgeon manages their own bookings. All patients waiting for surgery are added to the hospital waiting list, so the hospital is aware of diagnosis-specific waiting times and can take action to expedite surgery when necessary. There is close attention to the effort to meet the appropriate waiting list benchmarks. There is a very impressive computerized system that allows tracking of all surgical wait times, both Wait 1 and Wait 2, that provides real-time monitoring of all patients referred to surgeons. This allows staff to ensure that patients receive care in a timely fashion consistent with provincial benchmarks.

The Willett Urgent Care Centre sees roughly 100 patients per day, who write their name on a list on arrival and then wait for the staff to call them for triage. This is not an optimal system for either patient privacy or optimizing patient flow. The staff have plans to convert this to a computerized system in the near future. The design of the facility is not ideal for seeing the volume and the acuity level of the patients.

Principled Based Decision Making

The Ethics Committee oversees principle-based decision making for BCHS. To help build capacity and to advance ethics and ethical decision making across the organization, an interdisciplinary group is in place. The organization uses the IDEA ethical decision-making framework. Anyone may directly contact the Clinical Ethics Consultation Team (including patients).

Access to ethicist support is readily available through a regional program. The ethicist provides ethics consultation, education and in-services, as well as assists in policy development and review. The ethicist is widely used by the clinical teams for complex clinical ethical decision making, as well as by the senior team for other ethical challenges.

In general, staff are aware of ethics and the supports that are available. Several examples were discussed highlighting when and how the ethical decision-making framework was used to guide Decision making.

Some examples included: operational decisions related to COVID-19, and patient care delivery considerations. A patient advisor is a member of the committee and provides a much-appreciated patient lens to discussions and initiatives.

Information regarding trends is gathered. The ethicist provides support and education based on identified trends, issues, challenges and situations. The organization does focus its efforts on promotion, communication and such things as benchmarking, research and evidence informed decision making to improve quality of services. Education sessions are designed based on types of ethical issues and challenges facing BCHS. Education related to principled-based decision making is provided on hire. Given the significant number of new staff that have been hired, the organization could consider more active continuous education regarding ethics including how to identify, report and act on any questions or concerns. The team wants to build capacity and train more internal ethics consultants. There are currently eight staff members who are completing the Regional Healthcare Ethics Basics course. As a quality improvement activity, the group is looking at how they might track the use of local ethics consultants.

BCHS supports and promotes research. The ethics framework includes a process for reviewing the ethical implications of any research activity that the organization leads or participates in. Formalized processes could be considered to describe how issues related to physician and organizational relationships with the pharmaceutical industry (and other corporate partners) are handled.

The organization has Patient Rights and Responsibilities defined, well communicated to staff and patients, and widely posted across the organization. The group is extremely proud of the work they have completed related to principle-based decision making. Staff members report that users of this program have been thankful and appreciative of the support.

Communication

The Brant Community Healthcare System (BCHS) serves a rapidly growing community using a range of tools for internal and external communications. The various approaches to communication have helped to strengthen the organization’s reputation since the last on-site survey in 2019.

External communication is led by the biweekly Hospital Insider, a regular column in the Brantford Expositor that also runs in the Paris Star and is linked to the organization’s website and various social media accounts, such as Instagram and Facebook. The team also uses the BCHS website and social media effectively to communicate with the community. For example, a recent Code Beige (phone system failure) issued an alert to the community, and provided an alternative phone number to use, and an update when the phone system resumed normal operations.

The team is commended for their philosophy of not assuming everyone has internet access. For example, they collaborated with partners on the Ontario Health Team for a mobile navigator app. This is an app all people in the community can use on their smartphones to obtain information about care they have received, such as their health records, and other local resources related to health care, such as housing and primary care. In addition, the team has developed print materials which are shared with partners in the community, such asw primary care offices and public health. BCHS is encouraged to pursue and implement a navigator position, which will assist patients and families to identify and access care and is being developed by the Ontario Health Team of which BCHS is a member.

The team has done well to use the organization website as a valuable tool for communicating. The website is intuitive and easy to navigate with helpful information that is easy to find, such as a red-coloured bar highlights important information, and emergency department and urgent care wait times are prominent at the top and accompanied by helpful videos which were developed in collaboration with ED physicians.

The BCHS has several newsletters for internal communication, such as The Pulse, Leaders Digest which consolidates non-urgent emails to decrease workload of administrative emails, and Erin's Update which is written by the acting CEO to answer questions and personally link with staff. Many of these were started in 2023 in response to internal feedback and to strengthen organizational culture. BCHS is commended for recognizing and supporting the value of communication to increase staff engagement.

However, the organization and the team are encouraged to formally evaluate the effectiveness of this many initiatives. Doing evaluations will help to know which activities should continue and which resources could be deployed to better effect. This may be particularly important if capacity issues arise as BCHS expands its communications in response to the changing size, health needs, and diversity of the community it serves.

The team monitors performance of online communications with selected metrics. Monitoring indicated that posts in 2021 were not being widely read. In response the team changed the content to have more stories and be people-specific by telling stories related to BCHS staff and volunteers. Results show this has been more successful and resonated with the community, leading to increased readers.

Policies are well managed using a comprehensive electronic system holding all policies. There are procedures for reviewing and updating policies.

At BCHS there is still a mix of paper and electronic records. The teams are very aware of the risks and limitations of this approach. BCHS is commended for initiating the project of electronic health records (EHR) but is also strongly encouraged to develop robust change management and project plans. These will be critical in facilitating the success of the EHR project so teams can realize the potential of electronic health records to increase the quality and safety of services for patients and families, such as greater continuity of care, strengthened communication among partners, enhanced data quality for improvement projects, and reduced risk of errors.

Human Capital

The organization is supported by staff and physicians who are knowledgeable, professional, and committed to providing patient and family centric services. They are enthusiastic towards the accreditation process and how the quality journey can help them ensure care is delivered within the context of their strategic priorities.

The Human Resources (HR) team represents a broad range of services to support a healthy, competent workforce. Many effective strategies have been employed to improve recruitment and retention. There are a significant number of student and medical placements across the organization. The HR team works respectfully and collaboratively with their union partners and equally as well with non unionized staff members. Internally, the HR team strategically partners with the leaders of the organization to provide support with employment legislation compliance, employee and labour relations, talent acquisition, retaining top talent, performance management and training. HR also provides strategic support to the organization regarding diversity, equity, inclusion and belonging (DEI-B) with the recent addition of a director, DEI-B, to the team. HR has identified goals with objectives, and these are monitored to track progress. Human Resources has recently moved from paper to software solution to track applicants and onboarding. Staff files are predominately in paper format.

A comprehensive Human Resources Plan has been developed that identifies actions to support organizational priorities including ensuring supports for quality of work life, a safe work environment, and improvement activities. Similarly, a Professional Staff Human Resources Plan is developed to provide insight and inform future planning. Medical ffairs works in collaboration with the chief of staff and the department chiefs to ensure effective management of physician human resources.

There is a focus and commitment to staff development at BCHS. Training for staff is supported and core training needs are identified. Education and training opportunities are provided based on needs assessments. Many health promotion initiatives are available to staff. There is a workplace violence prevention program in place, and an orientation and immunization program for staff and volunteers.

New leaders have shadow schedules for the first two weeks in their role. In general, staff report that senior leaders are visible and that they receive communication regarding the aims of the organization. A Thumbs Up program is in place to recognize staff.

BCHS conducts staff and physician engagement/satisfaction surveys. Many staff report a positive work environment. There appears to be an appropriate review of staffing and skill mix against acuity, workload and job tasks. An attendance management program is in place and is used. The organization has built a culture around service and meeting patient needs. Information is communicated and shared broadly with all levels of staff. The team is working to increase diversity, equity, inclusion and belonging. The pandemic has challenged BCHS to review succession planning. The emerging leader's program is being restarted. No cost mental health benefits were offered to all staff during the pandemic. A peer support program is in place.

Recruitment and retention strategies are in place for staff and physicians. The Human Resources team has worked to develop positive working relationships. Performance (appraisals) conversations have been recently updated and reinstituted. Policies and procedures are reviewed on a regular cadence. The HR team solicits input through various means including offering exit surveys, surveys and face-to-face meetings.

The Human Resources team appears to have advanced processes in place to support staff and to ensure organizational development. Staff files are maintained in a confidential manner and are accessible only to appropriate staff. There appear to be formalized processes in place to ensure that staff are appropriately licensed (and up to date) for the work they do. Credentialing processes are in place.

HR files are stored electronically for both staff and credentialed staff.

Table 7: Unmet Criteria for Leadership

Criteria Number	Criteria Text	Criteria Type
1.3.5	The organization engages with clients and families to develop, implement, regularly review, and update as needed an open presence policy that provides families with flexibility in when they can be present.	NORMAL
2.3.7	The organization develops, implements, regularly reviews, and updates as needed policies, procedures, and plans for all its primary functions, operations, and systems.	NORMAL

Service Specific Assessment Standards

The Qmentum Global™ program has a set of service specific assessment standards that are tailored to the organization undergoing accreditation. Accreditation Canada works with the organization to identify the service specific assessment standards and criteria that are relevant to the organization's service delivery.

Transfusion Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the following table.

Assessment Results

There are well established processes in place for safe and efficient management of transfusion services at BHCS. Clear standard operating processes are in place. The team is engaged in improvements in the massive hemorrhage protocols and has recently acquired a second transfuser. They are participants in the Using Blood Wisely campaign and actively integrate data in decision making and planning. This critical service is essential for the Brantford community given the growing population and proximity to the highway and potential for trauma. All standards have been met. Full accreditation of laboratory services is expected at the end of the month.

Table 8: Unmet Criteria for Transfusion Services

There are no unmet criteria for this section.

Ambulatory Care Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the following table.

Assessment Results

The ambulatory care program provides services in the areas of endoscopy, urology, medical infusions, orthopedics, minor surgery, plastic surgery, ophthalmology, women's health, internal medicine and diabetes education among others. The outpatient program also includes an oncology clinic as a satellite of the regional Juravinksi Cancer Clinic.

The ambulatory care services have been organized as a distinct grouping in 2023, separate from peri-operative services. This is expected to increase the effectiveness of these services as their committee work and discussions will be more focused and with appropriate partnerships.

Like other programs at BCHS the ambulatory team has a renewed focus on completing performance appraisals. The team is commended for introducing new elements to enhance these evaluations for both staff and physicians.. Although not required by BCHS, a new peer-review has been added that will add valuable information for staff and managers. A physician review process was started in 2023 which will recur every three years with their re-appointment.

Currently, managers receive monthly reports which identify staff who still have outstanding evaluations. The team is encouraged to continue focusing on performance evaluations and ensuring they are completed as required. This will contribute to staff retention and the associated benefits for clients and families, such as continuity of care.

The ambulatory services team is aware of the BCHS Ethics Framework and uses the precepts of the framework when discussing ethics issues. The team has also received in-services from the regional ethicist as part of their focus on education and training. However, it is noted that the regional ethicist has not been contacted for input on any ethics issues. The team is encouraged to consider additional in-services from the ethicist and to consider ways this valuable resource can be more fully used when ethics questions arise, especially as the regional ethicist may offer insights not identified by staff in their discussions.

The ambulatory team has experience using data to track waitlists for services and make changes as needed to better serve patients. For example, endoscopy wait lists were monitored and changes made in collaboration with GI and general surgeons to mitigate wait lists, by identifying doctors willing to work additional days to meet targets. The team is encouraged to use these types of successes as a starting point for considering more effective ways of monitoring wait lists overall, such as creating a central wait list, including for other services. A central wait list is a more efficient way of monitoring how many people are waiting for a service and identifying opportunities to improve the wait times.

Table 9: Unmet Criteria for Ambulatory Care Services

There are no unmet criteria for this section.

Critical Care Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the following table.

Assessment Results

The BGH Critical Care Unit provides intensive care services to all patients over the age of fourteen. Younger patients are transferred to Hamilton for these services. There are few scheduled surgical patients requiring these services, since there is no cardiac, thoracic, neurosurgical or transplant surgery done. The physical space for the unit is spacious. There are 15 beds in the unit itself, and three in a secondary space outside the unit. The rooms are bright, with large windows and space for all appropriate machinery. The area between the nursing station and the individual patient rooms is generous, but there is a large amount of equipment and material in the hallways due to a lack of storage space.

The CCU team provides an extremely valuable service to the hospital. There is a physician-led Critical Care Response Team that provides services to patients throughout the facility that meet defined clinical criteria. This allows the team to assess patients before they deteriorate, avoiding the necessity of a CCU admission. In addition, the team regularly reassesses patients who have been transferred from the CCU to other inpatient units, to ensure they do not deteriorate and require readmission to CCU.

The team has a very detailed Surge Capacity Protocol, which has specified policies for each patient beyond the normal capacity of 18. In each patient's room there is a whiteboard that provides the patient and family with all up- to-date information about their care. The team ensures that family members play a central role in all decisions and plans for treatment and are encouraged to be present for team rounds. There is a detailed scorecard with noted performance on all performance indicators. Quality improvement initiatives are established frequently and progress towards the targets is regularly assessed. Most of the critical care services provided are based on established order sets and protocols, but the lack of a comprehensive CPOE system is an impediment to full standardization of care.

The unit has a strong collaborative relationship with Trillium Gift of Life and recently was awarded for their very high conversion rate of potential organ donors to actual donors. There are strong relationships with Toronto and London transplant teams, and those donor teams travel to BGH regularly. There are detailed and careful protocols for Neurologic Determination of Death and Donation after Cardiac Death. The CCU staff go to great lengths to honor the patients who die in the unit and are extremely sensitive to the family, religious and cultural needs of the patients and their families. For the support of the staff, there are many resources available, including the highly innovative Code Lavender, which provides immediate social, religious and psychological help to staff following tragic events.

Table 10: Unmet Criteria for Critical Care Services

There are no unmet criteria for this section.

Diagnostic Imaging Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the following table.

Assessment Results

It was a pleasure to survey the Medical Imaging Services including CT, MRI, ultrasound, nuclear medicine, mammography, X-ray, fluoroscopy/interventional radiology, bone mineral density and the cardiac diagnostics/EMG areas. The leadership team has worked on a number of collaborative initiatives including taking advantage of Innovation Fund Requests (MRI Accelerated Program) and developing a Regional MOU to support equipment downtime with neighbouring organizations.

To meet increasing demand for services, the team most recently brought in new equipment (X-ray, intervention/fluoroscopy room, CT scanner), implemented Ocean eReferral and developed an interventional radiology outreach program. To reduce unnecessary tests and ensure information sharing, the service has partnered to shape the Foreign Exam Management processes. They have participated in the Choosing Wisely Canada campaigns to reduce unnecessary testing and updated protocols to address contrast supply shortages that arose recently. Improvements to infection prevention and control measures have been put in place through partnership with MDR to support reprocessing of ultrasound probes ensuring best practices are in place. The team also works to support corporate improvement initiatives in hand hygiene, two client identifier processes and addressing issues of workplace violence including incident reporting, availability and use of Code White buttons as well as staff training.

There has been exceptional work put in place to grow the interventional radiology program and attract the specialized medical knowledge needed to offer services to the community in Brantford. Important barriers remain related to additional funding for expansion of services to meet high demand. As with other programs, staffing is lean, and it is critical that as the organization grows that capacity in areas like medical imaging and laboratory medicine are a part of the planning. Succession planning and redundancy for important roles in medical imaging informatics, given the increasing reliance on technological advances and need for integration of multiple information systems is critical, particularly as the organization moves forward with a new EPR. The team is also encouraged to continue partnering externally by contributing to provincial medical imaging repositories for sharing images and results. Finally, continued efforts to support formal medical peer review processes for quality assurance could be in place to foster communal learning.

Table 11: Unmet Criteria for Diagnostic Imaging Services

There are no unmet criteria for this section.

Emergency Department

Standard Rating: 99.1% Met Criteria

0.9% of criteria were unmet. For further details please review the following table.

Assessment Results

Emergency services are available 24/7 to all members of the community. The Willett site provides urgent care services, and all patients requiring emergency services are seamlessly transferred to Brantford, which has a full-service ED. Both departments are part of a joint single department. There are specific policies and procedures for the assessment and treatment of pediatric patients. Consultants in all disciplines are readily available, either locally or in Hamilton. Pharmacists are available in-house until 11 pm, and readily available by phone during the night. There are closed private rooms available for mental health assessments. However, these are not located in a quiet, separate area and are close to the ED waiting room. The ED follows all patient assessment and treatment protocols, but the lack of a complete EMR with CPOE makes fully standardized care problematic. With the assistance of a strong decision support team, excellent and complete data are collected on all important process and outcome measures. The progress of the ED on meeting established benchmarks is prominently displayed. Annual performance targets are established and monitored.

The current extreme overcrowding and inadequacy of the physical plant makes appropriate assessment problematic. Patient flow is chaotic due to the ongoing reconstruction and will hopefully soon improve as the project proceeds. The staff do an amazing job staying positive and providing excellent care in the face of a grossly inadequate physical plant. There are very detailed and effective policies and procedures in place for managing surges in patient volume. When needed, patients are housed in non-traditional areas of the hospital and transferred to other areas. The Willett site has beds specified for ALC patients, to allow patient transfer from the ED to appropriate inpatient units. A major impediment to patient flow out of the ED is that few of the inpatient beds are private. This makes isolation of patients with infectious diseases very difficult, and one infected patient can lead to the closure of many beds. Another significant issue is the lack of home care and LTC beds in the local area. The combination of an inadequate ED physical plant, inpatient bed blockage due to shortage of private rooms, and lack of community resources has led to ED overcrowding that is not acceptable or sustainable.

The Willett Urgent Care Centre provides care to roughly 100 patients per day. On arrival patients sign their names on a list and are then called in for triage. This is not an ideal practice, and the staff will soon be implementing a more appropriate computerized system. All in all, both the Brantford and Willett sites are hindered by inadequate and poorly designed spaces that make patient assessment and management extremely difficult.

Table 12: Unmet Criteria for Emergency Department

Criteria Number	Criteria Text	Criteria Type
2.2.1	Entrance(s) to the emergency department are clearly marked and accessible.	HIGH

Inpatient Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the following table.

Assessment Results

Inpatient services at BCHS includes a number of medical floors (B6, B7, B8), a surgical unit (B5) and cardiology (telemetry unit – C5). Other inpatient areas include transitional care, palliative care, medically complex, rehabilitation, integrated stroke and pediatrics. The inpatient medicine floors total 90 funded beds that have adopted a hospitalist model caring for patients with a range of diagnostic conditions including COPD, CHF, pneumonia and lower urinary tract infections. Key organizational quality improvement initiatives that have been adopted at the program and unit level include activities to improve compliance with hand hygiene, bedside medication verification scan rates, and pressure injuries.

A priority focus for the inpatient service includes initiatives to support timely access to care for patients, particularly given the increased demand for admitted patients from the emergency department. The occupancy rate for these inpatient areas often exceeds 100 per cent. Challenges include a high ALC rate (medicine: 18-21% per cent and physical building structural limitations of many shared, small patient spaces yielding a high number of patients in isolation (currently 117). Staff and physicians are focused on improving ALOS:ELOS (acute length of stay compared to expected length of stay) ratios, activating patients through a mobility program, ensuring patients and their families have a “48-hour conversation” to understand early barriers to discharge and the patient’s goals. The organization is commended for their strong adoption of Oculys the digital bed management system that offers teams real time information to plan for patient flow and the addition of transitional care planners.

Coupled with the challenge of increased patient demand, resulting from higher patient acuity, increased surrounding population growth, lack of chronic disease management in the community with limitations on family physicians, is BCHS’s inpatient service health human resource concerns. As with organizations throughout the country, the BCHS inpatient medical and surgical service has experienced a high turnover of staff. Efforts to recruit and stabilize the turnover have been effective with decreased turnover in 2023/24 YTD. These efforts have included the addition of a charge nurse model, where charge nurses have been added to the teams. These valuable unit leaders, support mentorship of new and novice staff, clinical coordination, patient safety, improved patient experience and timely discharge of patients. The organization has also made maximal use of the Nursing Graduate Guarantee, preceptor preparation programs, partnered with OH, CNO to create a supervised practice experience partnership (SPEP) to help internationally educated nurses develop the knowledge needed to work in Canada, and enabled the clinical extern program. Many new recruits are noted to have come from these programs. As with staff, the physician complement is also challenged, particularly with building redundant support in geriatrics and additional hospitalists to support the medical services during surge. BCHS is working to recruit additional hospitalists to enable better workload balance for its physician group.

From a patient experience perspective, BCHS has resumed collection of patient experience surveys and adopted the provincial Qualtrics platform. Results are readily available on unit quality boards. The service is growing their patient and family advisor engagement efforts in hopes of meaningful partnership. Patients commented on their appreciation of the room whiteboards used across the hospital helping them to know who is providing them care, along with the use of structured communication tool AIDET (acknowledge, introduce, duration, explanation and thank you) to encourage dialogue with patients. One area of concern highlighted by the patients themselves and acknowledged by the bedside staff is the limit of the hospital’s visiting policy. Families are asked to leave at 8 pm. Full family presence is a best practice across the country and allowing 24-hour access by family caregivers as designated by patients

themselves, improves patient experience and patient safety through information sharing and supporting vulnerable patients.

Table 13: Unmet Criteria for Inpatient Services

There are no unmet criteria for this section.

Mental Health Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the following table.

Assessment Results

Brant Community Health System (BCHS) is the schedule 1 facility serving Brant County and surrounding areas. There are inpatient mental health services in an 18-bed unit of which four beds are an intensive care unit. BCHS also provides outpatient mental health care which is closely linked with the inpatient services.

Mental health services are provided by a staff team who are very committed to the program. There is a full complement of staff, associated psychiatrists, and a full-time educator who supports the team. The quality of mental health services is reflected in feedback from discussions with clients who had very positive comments on the care they received. However, clients did note the infrastructure as an area for improvement, in particular the bathroom facilities and limited space for family visits.

The team is commended for their attention to quality, measurement, and initiatives that improve care and services. An example is wait times, which is an organization Quality Improvement Plan indicator. The team addressed wait times by educating clinical staff on a new treatment approach, solution focused brief therapy. which is equally effective with clients but of shorter duration. Staff report enjoying the new approach and their continued success in assisting clients and families. In addition to wait times the team also tracks metrics of inpatient services length of stay. Both indicators are achieving targets and reflect the success of the team in providing services to the community.

The team and managers are actively focusing on completing performance appraisals to meet BCHS targets of all staff having a completed appraisal once every two years. Managers receive monthly progress reports on appraisals still outstanding. The team is encouraged to continue focusing on having all appraisals completed as planned, as this will contribute to the ongoing high level of staff retention, satisfaction, and quality of care.

The team is commended for their attention to best practices as part of ongoing education. An example is recent work to revise the restraint policy into two complementary policies. The first focuses on steps leading to restraints with the view that restraints are only the final option not the first choice. The second policy outlines practices when restraints are used including when they can be stopped. The team is strongly encouraged to continue collecting and monitoring data to see if updating the policy has led to a decrease in the frequency or duration of restraints.

Mental Health services currently use a mix of paper and electronic charting. The team is aware of the risks and limitations of this approach. The Mental Health programs teams are encouraged to be active participants in the project where possible. Providing input and feedback will allow the EHR project to be successful for staff, clients and families, with such things as increased continuity of care, strengthened communication among partners, and enhanced data quality for improvement projects.

Table 14: Unmet Criteria for Mental Health Services

There are no unmet criteria for this section.

Obstetrics Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the following table.

Assessment Results

The obstetrical services were surveyed in partnership with NICU and pediatric services. The enthusiastic and truly passionate administrative and medical leadership was found to be highly engaged in quality improvement and thoughtful planning of their services. All standards were met within these excellent services.

Of note, the physical space of the program was exceptional along with the numerous quality improvement initiatives being undertaken including safe management of oxytocin administration, completion of MORE OB simulations, the addition of induction and labour order sets, continued contribution and review of BORN data, improvements in bedside medication verification scanning, hand hygiene, implementation of the Eat, Sleep, and Console Model to support at risk neonates (NAS).

The pediatric team readily collaborates with external organizations and is building exceptional capacity for pediatric care within the Brantford area. The addition of a rapid assessment program to support emergent pediatric issues is undoubtedly a welcome addition to the community, building needed resources with high demand respiratory seasons. The collaborative nature of the entire region to ensure workload levelling, particularly with last season’s unprecedented RSV outbreaks, yielded many new lessons learned.

Patients commented on how fortunate they felt to receive care at HBSC and how appreciative they were to have this resource in the community. The organization is encouraged to make available more tools such as the electronic patient portal and to provide full family presence via 24-hour family visiting consistently and as a matter of policy to avoid confusion about when families are allowed to come in.

Table 15: Unmet Criteria for Obstetrics Services

There are no unmet criteria for this section.

Perioperative Services and Invasive Procedures

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the following table.

Assessment Results

All surgical services for BCHCS are provided at BGH. Surgical services provided include general surgery, orthopedics, ENT, plastics, ophthalmology and gynecology. The design and layout of the surgical suite is appropriate for the services provided. There is one-way patient flow from registration, through preanesthesia to the OR, PACU and discharge. The operating rooms are centrally located, with an outer corridor through which contaminated carts are returned to the MDR. There is not a dedicated dirty elevator back to MDR. It is shared with other functions. There is a dedicated elevator bringing sterile equipment up to the central area where all clean equipment is stored. The equipment enters the OR through one door and the contaminated equipment cart exits through another door. All appropriate protocols for surgery are carried out including preop surgical site marking and the surgical safety check list. Due to construction in the hospital, there was a very recent inspection of the air flow through the OR suites, including the number of air exchanges and replacement of the filters. All areas met or exceeded standards.

Unlike most of the hospital, the major problem is not space or facilities. Staffing for both physicians and nurses is a more important issue. The number of full-time surgeons and anesthetists is dwindling, and the ones on staff tend to be older and may retire in the short to medium term. Waiting times for surgery are more of a reflection on surgeon and anesthetist availability than operating room time. With the assistance of the Decision Support Team, real time databases have been constructed of patients waiting to see surgeons, and those waiting for surgery. This allows analysis of wait times by diagnosis, and by individual surgeon. This data allows frequent reassessment of the appropriateness of operating room assignment to meet established guidelines for surgical waiting times. Also, the perioperative program has established QI initiatives, one of which has concentrated on the reduction of surgical site infections.

Table 16: Unmet Criteria for Perioperative Services and Invasive Procedures

There are no unmet criteria for this section.

Point-of-Care Testing

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the following table.

Assessment Results

All standards have been met within point-of-care testing. The small team involved oversees all organizational point-of-care testing including education and oversight of the success of the program. Visits to the perioperative area and outpatient diabetes allowed frontline staff to demonstrate solid comprehension of the processes and where to find additional support when needed.

Table 17: Unmet Criteria for Point-of-Care Testing

There are no unmet criteria for this section.

Reprocessing of Reusable Medical Devices

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the following table.

Assessment Results

The medical devices reprocessing area and endoscopy reprocessing were reviewed in this survey. All relevant standards have been met.

The MDR leadership team is exceptional and fosters a culture of collegiality and continuous quality improvement. The staffing levels have remained consistent, and turnover is low. Unfortunately, due to challenges with the building infrastructure, the autoclave became unavailable recently. As a testament to the nimbleness of the team and strong leadership, the MDR program was able to voluntarily have its unionized staff offer to support continued reprocessing services that were relocated to an alternate location in order to keep the ORs running. The commitment of the team is commendable.

All staff are qualified through the Central Service Association of Ontario (CSAO) or college level courses in reprocessing and opportunities for continuing education are in place.

The MDR leadership team has made excellent use of available business intelligence capabilities to design meaningful and usable dashboards that support data informed decision making. The leadership is recognized for their evidence informed approach and diligence in using available information to generate new knowledge. Staff enjoy relevant data on their quality boards and readily participate in quality huddles. Policies, processes and strong standard operating procedures have been developed to guide staff for both MDR and endoscopy reprocessing.

The organization is encouraged to continue to recognize the importance of MDR as an engine that enables the seamless operations of the OR without which surgical services would not be possible. Further modernization of the MDR physical space to support best practices in efficiency, patient safety including advances in IPAC measures is critical. Congratulations on building such a great team!

Table 18: Unmet Criteria for Reprocessing of Reusable Medical Devices

There are no unmet criteria for this section.

Rehabilitation Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the following table.

Assessment Results

The rehabilitation services are provided both at Brantford Hospital and the associated Willet site in nearby Paris, Ontario. Rehabilitation includes inpatient and outpatient services, an integrated stroke unit, medically complex/palliative care, and an alternate level of care (ALC) unit that is also secured.

The rehabilitation team is currently almost fully staffed with low turnover and vacancy rates. The team is also focused on completing performance appraisals in line with the organization requirement of once every two years. The recently developed physician assessment process is also completing its first iteration and is a priority for the team. Leaders report they are putting dedicated time in their calendars to complete the appraisals. The team is strongly encouraged to continue focusing on completing all performance appraisals to gain the benefits of staff engagement and learning from this process.

The rehabilitation team is very patient focused. This is seen in their strong approach to being client and family centred, e.g., quality initiatives to lower wait times so they can respond to service requests more quickly, making changes as needed to match services to client needs (adjusting the approach or timing of care if a client wants to observe religious practices), having in-depth discussions (including using the ethics framework) with clients and families to provide them with the most appropriate care such as when clients want to be discharged back to the community and families feel it’s too soon, and making improvements to services based on feedback from the PFA representative, such as developing a stroke journey map to help clients and families know the stroke continuum of care, their goals, and the associated inpatient and/or outpatient services.

The team demonstrates a commitment to measuring quality and using data to help make improvements. Falls are a recognized high risk in rehabilitation and performance indicator data reflect this. The team has used data to instigate audits of falls, signs in care areas, and to provide additional or different education to help staff identify risks and take action to prevent falls. There are data displayed on boards in units which show performance graphs for key indicators. During walkabouts on the units, it was noticed that some boards had data which were significantly outdated (from 2021) or challenging to read because text and graphs were small. The team is encouraged to review and update performance data, so it is current and. if possible. to display data in a manner that is easier for clients, families and staff to view, interpret at a glance, and engage with.

Despite the low wait times and excellent work done by the rehabilitation team, there can still be challenges for clients to move back to the community. The team identifies that a shortage of home and community supports and a lack of subsidized spaces in retirement homes creates barriers which prevent clients from being discharged. In addition, there is a lack of appropriate elder care facilities because many will not accept persons who are at risk of falls and this means clients need to be on wait lists for long term care facilities. The team is aware that working with partners in the community is necessary to help create solutions for these issues. The team is strongly encouraged to continue discussions with partners to explore initiatives or other innovative ways to help clients and families with this crucial final step of moving back to their communities.

Table 19: Unmet Criteria for Rehabilitation Services

There are no unmet criteria for this section.

Service Excellence for Ambulatory Care Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the following table.

Assessment Results

The ambulatory care program provides services in the areas of endoscopy, urology, medical infusions, orthopedics, minor surgery, plastic surgery, ophthalmology, women's health, internal medicine and diabetes education among others. The outpatient program also includes an oncology clinic as a satellite of the regional Juravinski Cancer Clinic.

The ambulatory care services were organized as a distinct grouping in 2023, separate from perioperative services. This is expected to increase the effectiveness of these services as their committee work and discussions will be more focused and with appropriate partnerships.

Like other programs at BCHS the ambulatory team has a renewed focus on completing staff performance appraisals. The team is commended for introducing new elements to performance evaluations for staff and physicians. The team has added a peer-review component to enhance the staff performance appraisals. This is not required by BCHS but will add valuable information for staff and managers. A physician review process was started in 2023 which will recur every three years with their re-appointment.

Currently, managers receive monthly reports which identify staff who still have outstanding evaluations to be completed. The team is encouraged to continue focusing on performance evaluations and ensuring they are completed as required. This will contribute to staff retention and the associated benefits for clients and families, such as continuity of care.

The ambulatory services team is aware of the BCHS Ethics Framework, and the team uses the precepts of the framework when discussing ethics issues. The team has also received in-services from the regional ethicist as part of their focus on education and training. However, it is noted that the team has not contacted the regional ethicist for input on any ethics issues. The team is encouraged to consider additional in-services from the ethicist and to consider ways this valuable resource can be more fully used when ethics questions arise, especially as the regional ethicist may offer insights not identified by staff in their discussions.

The ambulatory team has experience using data to track waitlists for services and make changes as needed to better serve patients. For example, endoscopy wait lists were monitored and changes made in collaboration with GI and general surgeons to mitigate wait lists, through doctors being willing to work additional days to meet targets. The team is encouraged to use these types of successes as a starting point for considering more effective ways of monitoring wait lists overall, such as creating a central wait list, including for other services. A central wait list is a more efficient way of monitoring how many people are waiting for a service and identifying opportunities to improve the wait times.

Table 20: Unmet Criteria for Service Excellence for Ambulatory Care Services

There are no unmet criteria for this section.

Service Excellence for Critical Care Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the following table.

Assessment Results

The BGH Critical Care Unit provides intensive care services to all patients over the age of fourteen. Younger patients are transferred to Hamilton for these services. There are few scheduled surgical patients requiring these services, since there is no cardiac, thoracic, neurosurgical or transplant surgery done. The physical space for the unit is spacious. There are 15 beds in the unit itself, and three in a secondary space outside the unit. The rooms are bright, with large windows and space for all appropriate machinery. The area between the nursing station and the individual patient rooms is generous, but there is a large amount of equipment and material in the hallways due to a lack of storage space. The CCU team provides an extremely valuable service to the hospital. There is a physician-led Critical Care Response Team that provides services to patients throughout the facility that meet defined clinical criteria. This allows the team to assess patients before they deteriorate, avoiding the necessity of a CCU admission. In addition, the team regularly reassesses patients who have been transferred from the CCU to other inpatient units, to ensure they do not deteriorate and require readmission to CCU. The team has a very detailed Surge Capacity Protocol, which has specified policies for each patient beyond the normal capacity of 18. In each patient's room there is a whiteboard that provides the patient and family with all up-to-date information about their care. The team ensures that family members play a central role in all decisions and plans for treatment and are encouraged to be present for team rounds. There is a detailed scorecard with noted performance on all performance indicators. Quality improvement initiatives are established frequently and progress towards the targets is regularly assessed. Most of the critical care services provided are based on established order sets and protocols, but the lack of a comprehensive CPOE system is an impediment to full standardization of care.

The unit has a strong collaborative relationship with Trillium Gift of Life and recently was awarded for their very high conversion rate of potential organ donors to actual donors. There are strong relationships with Toronto and London transplant teams, and those donor teams travel to BGH regularly. There are detailed and careful protocols for Neurologic Determination of Death and Donation after Cardiac Death. The CCU staff go to great lengths to honor the patients who die in the unit and are extremely sensitive to the family, religious and cultural needs of the patients and their families. For the support of the staff, there are many resources available, including the highly innovative Code Lavender, which provides immediate social, religious and psychological help to staff following tragic events.

Table 21: Unmet Criteria for Service Excellence for Critical Care Services

There are no unmet criteria for this section.

Service Excellence for Diagnostic Imaging Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the following table.

Assessment Results

It was a pleasure to survey the Medical Imaging Services including CT, MRI, ultrasound, nuclear medicine, mammography, X-ray, fluoroscopy/interventional radiology, bone mineral density and the cardiac diagnostics/EMG areas. The leadership team has worked on a number of collaborative initiatives including taking advantage of Innovation Fund Requests (MRI Accelerated Program) and developing a Regional MOU to support equipment downtime with neighbouring organizations.

To meet increasing demand for services, the team most recently brought in new equipment (X-ray, intervention/fluoroscopy room, CT scanner), implemented Ocean eReferral and developed an interventional radiology outreach program. To reduce unnecessary tests and ensure information sharing, the service has partnered to shape the Foreign Exam Management processes. They have participated in the Choosing Wisely Canada campaigns to reduce unnecessary testing and updated protocols to address contrast supply shortages that arose recently. Improvements to infection prevention and control measures have been put in place through partnership with MDR to support reprocessing of ultrasound probes ensuring best practices are in place. The team also works to support corporate improvement initiatives in hand hygiene, two client identifier processes, and addressing issues of workplace violence including incident reporting, availability and use of Code White buttons as well as staff training.

There has been exceptional work put in place to grow the interventional radiology program and attract the specialized medical knowledge needed to offer services to the community in Brantford. Important barriers remain related to additional funding for expansion of services to meet high demand. As with other programs, staffing is lean, and it is critical that as the organization grows that capacity to areas like medical imaging and laboratory medicine are a part of the planning. Succession planning and redundancy for important roles in medical imaging informatics, given the increasing reliance on technological advances and need for integration of multiple information systems is critical, particularly as the organization moves forward with a new EPR. The team is also encouraged to continue to partner externally in contributing to provincial medical imaging repositories for sharing of images and results. Finally, continued efforts to support formal medical peer review processes for quality assurance should be in place to foster communal learning.

Table 22: Unmet Criteria for Service Excellence for Diagnostic Imaging Services

There are no unmet criteria for this section.

Service Excellence for Emergency Department

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the following table.

Assessment Results

Emergency services are available 24/7 to all members of the community. The Willett site provides urgent care services, and all patients requiring emergency services are seamlessly transferred to Brantford, which has a full-service ED. Both departments are part of a joint single department. There are specific policies and procedures for the assessment and treatment of pediatric patients. Consultants in all disciplines are readily available, either locally or in Hamilton. Pharmacists are available in-house until 11 pm, and readily available by phone during the night. There are closed private rooms available for mental health assessments. However, these are not located in a quiet, separate area and are close to the ED waiting room. The ED follows all patient assessment and treatment protocols, but the lack of a complete EMR with CPOE makes fully standardized care problematic. With the assistance of a strong Decision Support Team, excellent and complete data are collected on all important process and outcome measures. The progress of the ED on meeting established benchmarks is prominently displayed. Annual performance targets are established and monitored.

The current extreme overcrowding and inadequacy of the physical plant makes appropriate assessment problematic. Patient flow is chaotic due to the ongoing reconstruction and will hopefully soon improve as the project proceeds. The staff do an amazing job staying positive and providing excellent care in the face of a grossly inadequate physical plant. There are very detailed and effective policies and procedures in place for managing surges in patient volume. When needed, patients are housed in non-traditional areas of the hospital and transferred to other areas. The Willett site has beds specified for ALC patients, to allow patient transfer from the ED to appropriate inpatient units. A major impediment to patient flow out of the ED is that few of the inpatient beds are private. This makes isolation of patients with infectious diseases very difficult, and one infected patient can lead to the closure of many beds. Another significant issue is the lack of home care and LTC beds in the local area. The combination of an inadequate ED physical plant, inpatient bed blockage due to shortage of private rooms, and lack of community resources has led to ED overcrowding that is not acceptable or sustainable.

The Willett Urgent Care Centre provides care to roughly 100 patients per day. On arrival patients sign their names on a list and are then called in for triage. This is not an ideal practice, and the staff will soon be implementing a more appropriate computerized system. All in all, both the Brantford and Willett sites are hindered by inadequate and poorly designed spaces that make patient assessment and management extremely difficult.

Table 23: Unmet Criteria for Service Excellence for Emergency Department

There are no unmet criteria for this section.

Service Excellence for Inpatient Services

Standard Rating: 97.5% Met Criteria

2.5% of criteria were unmet. For further details please review the following table.

Assessment Results

Inpatient services at BCHS includes a number of medical floors (B6, B7, B8), a surgical unit (B5) and cardiology (telemetry unit – C5). Other inpatient areas include transitional care, palliative care, medically complex, rehabilitation, integrated stroke and pediatrics. Inpatient medicine floors total 90 funded beds that have adopted a hospitalist model caring for patients with a range of diagnostic conditions including COPD, CHF, pneumonia and lower urinary tract infections. Key organizational quality improvement initiatives that have been adopted at the program and unit level include activities to improve compliance with hand hygiene, bedside medication verification scan rates, and pressure injuries.

A priority focus for the inpatient services includes initiatives to support timely access to care for patients, particularly given the increased demand for admitted patients from the emergency department. The occupancy rate for these inpatient areas often exceeds 100 per cent. Challenges include a high ALC rate (medicine: 18-21 per cent) and physical building structural limitations of many shared, small patient spaces yielding a high number of patients in isolation (currently 117). Staff and physicians are focused on improving ALOS:ELOS ratios, activating patients through a mobility program, ensuring patients and their families have a 48-hour conversation to understand early barriers to discharge and the patient's goals. The organization is also commended for their strong adoption of Oculys the digital bed management system that offers teams real time information to plan for patient flow, and the addition of transitional care planners.

Coupled with the challenge of increased patient demand, resulting from higher patient acuity, increased surrounding population growth, lack of chronic disease management in the community with limitations on family physicians, is BCHS's inpatient service health human resource concerns. As with organizations throughout the country, the BCHS inpatient medical and surgical service has experienced a high turnover of staff. Efforts to recruit and stabilize the turnover have been effective with decreased turnover in 2023/24 YTD. These efforts have been through the addition of a charge nurse model, where charge nurses have been added to the teams. These valuable unit leaders, support mentorship of new and novice staff, clinical coordination, patient safety, improved patient experience and timely discharge of patients. The organization has also made maximal use of the Nursing Graduate Guarantee, Preceptor Preparation programs, partnered with OH, CNO to create a supervised practice experience partnership (SPEP) to help internationally educated nurses develop the knowledge needed to work in Canada and enabled the clinical extern program. Many new recruits are noted to have come from these programs. As with staff, the physician complement is also challenged, particularly with building redundant support in geriatrics and additional hospitalists to support the medical services during surge. BCHS is working to recruit additional hospitalists to enable better workload balance for its physician group.

From a patient experience perspective, BCHS has resumed collection of patient experience surveys and adopted the provincial Qualtrics platform. Results are readily available on unit quality boards. The service is growing their patient and family advisor engagement efforts in hopes of meaningful partnerships. Patients commented on their appreciation of the room whiteboards used across the hospital helping them to know who is providing them care along with the use of the structured communication tool AIDET to encourage dialogue with patients. One area of concern highlighted by the patients themselves and acknowledged by the bedside staff is the limit of the hospital's visiting policy. Families are asked to leave at 8 pm. Full family presence is a best practice across the country and allowing 24-hour access by family caregivers as designated by patients themselves, improves patient experience and patient safety through information sharing and supporting vulnerable patients.

Table 24: Unmet Criteria for Service Excellence for Inpatient Services

Criteria Number	Criteria Text	Criteria Type
1.2.7	The team works with the organization to create a universally accessible service environment.	NORMAL
3.1.5	The team ensures that clients are able to actively participate in documenting information in their record.	NORMAL

Service Excellence for Mental Health Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the following table.

Assessment Results

Brant Community Health System (BCHS) is the schedule 1 facility serving Brant County and surrounding areas. There are inpatient mental health services in an 18-bed unit of which four beds are an intensive care unit. BCHS also provides outpatient mental health care which is closely linked with the inpatient services.

Mental health services are provided by a staff team who are very committed to the program. There is a full complement of staff, associated psychiatrists, and a full-time educator who supports the team. The quality of mental health services is reflected in feedback from discussions with clients who had very positive comments on the care they received. However, clients did note the infrastructure as an area for improvement, in particular the bathroom facilities and limited space for family visits.

The team is commended for their attention to quality, measurement, and initiatives that improve care and services. An example is wait times, which is an organization Quality Improvement Plan indicator. The team addressed wait times by educating clinical staff on a new treatment approach, solution focused brief therapy, which is equally effective with clients but of shorter duration. Staff report enjoying the new approach and their continued success in assisting clients and families. In addition to wait times the team also tracks metrics of inpatient services length of stay. Both indicators are achieving targets and reflect the success of the team in providing services to the community.

The team and managers are actively focusing on completing performance appraisals to meet BCHS targets of all staff having a completed appraisal once every two years. Managers receive monthly progress reports on appraisals still outstanding. The team is encouraged to continue focusing on having all appraisals completed as planned, as this will contribute to the ongoing high level of staff retention, satisfaction, and quality of care.

The team is commended for their attention to best practices as part of ongoing education. An example is recent work to revise the restraint policy into two complementary policies. The first focuses on steps leading to restraints with the view that restraints are only the final option not the first choice. The second policy outlines practices when restraints are used including when they can be stopped. The team is strongly encouraged to continue collecting and monitoring data to see if updating the policy has led to a decrease in the frequency or duration of restraints.

Mental Health services currently use a mix of paper and electronic charting. The team is aware of the risks and limitations of this approach. The Mental Health programs teams are encouraged to be active participants in the project where possible. Providing input and feedback will allow the EHR project to be successful for staff, clients and families, through such things as increased continuity of care, strengthened communication among partners, and enhanced data quality for improvement projects.

Table 25: Unmet Criteria for Service Excellence for Mental Health Services

There are no unmet criteria for this section.

Service Excellence for Obstetrics

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the following table.

Assessment Results

The obstetrical services was surveyed in partnership with NICU and pediatric services. The enthusiastic and truly passionate administrative and medical leadership was found to be highly engaged in quality improvement and thoughtful planning of their services. All standards were met within these excellent services.

Of note, the physical space of the program was exceptional along with the numerous quality improvement initiatives being undertaken including safe management of oxytocin administration, completion of MORE OB simulations, the addition of induction and labour order sets, continued contribution and review of BORN data, improvements in bedside medication verification scanning, hand hygiene, implementation of the Eat, Sleep, and Console Model to support at risk neonates (NAS).

The pediatric team readily collaborates with external organizations and is building exceptional capacity for pediatric care within the Brantford area. The addition of a rapid assessment program to support emergent pediatric issues is undoubtedly a welcome addition to the community, building needed resources within high demand respiratory seasons. The collaborative nature of the entire region to ensure workload levelling, particularly with last season’s unprecedented RSV outbreaks, yielded many new lessons learned.

Patients commented on how fortunate they felt to receive care at HBSC and how appreciative they were to have this resource in the community. The organization is encouraged to make available more tools such as the electronic patient portal and to provide full family presence via 24-hour family visiting consistently and as a matter of policy to avoid confusion about when families are allowed to come in.

Table 26: Unmet Criteria for Service Excellence for Obstetrics

There are no unmet criteria for this section.

Service Excellence for Perioperative Services and Invasive Procedures

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the following table.

Assessment Results

All surgical services for BCHS are provided at BGH. Surgical services provided include general surgery, orthopedics, ENT, plastics, ophthalmology and gynecology. The design and layout of the surgical suite is appropriate for the services provided. There is one-way patient flow from registration, through pre-anesthesia to the OR, PACU and discharge. The operating rooms are centrally located, with an outer corridor through which contaminated carts are returned to the MDR. There is not a dedicated dirty elevator back to MDR. It is shared with other functions. There is a dedicated elevator bringing sterile equipment up to the central area where all clean equipment is stored. The equipment enters the OR through one door and the contaminated equipment cart exits through another door. All appropriate protocols for surgery are carried out including preoperative surgical site marking and the surgical safety check list. Due to construction in the hospital, there was a very recent inspection of the air flow through the OR suites, including the number of air exchanges and replacement of the filters. All areas met or exceeded standards.

Unlike most of the hospital, the major problem is not space or facilities. Staffing for both physicians and nurses is a more important issue. The number of full-time surgeons and anesthetists is dwindling, and the ones on staff tend to be older and may retire in the short to medium term. Waiting times for surgery are more of a reflection on surgeon and anesthetist availability than operating room time. With the assistance of the Decision Support Team, real time databases have been constructed of patients waiting to see surgeons, and those waiting for surgery. This allows analysis of wait times by diagnosis, and by individual surgeon. This data allows frequent reassessment of the appropriateness of operating room assignment to meet established guidelines for surgical waiting times. Also, the perioperative program has established QI initiatives, one of which has concentrated on the reduction of surgical site infections.

Table 27: Unmet Criteria for Service Excellence for Perioperative Services and Invasive Procedures

There are no unmet criteria for this section.

Service Excellence for Rehabilitation Services

Standard Rating: 100.0% Met Criteria

0.0% of criteria were unmet. For further details please review the following table.

Assessment Results

The rehabilitation services are provided both at Brantford Hospital and the associated Willet site in nearby Paris, Ontario. Rehabilitation includes inpatient and outpatient services, an integrated stroke unit, medically complex/palliative care, and an alternate level of care (ALC) unit that is also secured.

The rehabilitation team is currently almost fully staffed with low turnover and vacancy rates. The team is also focused on completing performance appraisals in line with the organization requirement of once every two years. The recently developed physician assessment process is also completing its first iteration and is a priority for the team. Leaders report they are putting dedicated time in their calendars to complete the appraisals. The team is strongly encouraged to continue focusing on completing all performance appraisals to gain the benefits of staff engagement and learning from this process.

The rehabilitation team is very patient focused. This is seen in their strong approach to being client and family centred, through such things as quality initiatives to lower wait times so they can respond to service requests more quickly, making changes as needed to match services to client needs (adjusting the approach or timing of care if a client wants to observe religious practices), having in-depth discussions (including using the ethics framework) with clients and families to provide them with the most appropriate care such as when clients want to be discharged back to the community and families feel it’s too soon, and making improvements to services based on feedback from the PFA representative, such as developing a stroke journey map to help clients and families know the stroke continuum of care, their goals, and the associated inpatient and/or outpatient services.

The team demonstrates a commitment to measuring quality and using data to help make improvements. Falls are a recognized high risk in rehabilitation and performance indicator data reflect this. The team has used data to instigate audits of falls, signs in care areas, and provide additional or different education to help staff identify risks and take action to prevent falls. There are also data displayed on boards at units which show performance graphs for key indicators. During walkabouts on the units, it was noticed that some boards had data which were significantly outdated (from 2021) or challenging to read because text and graphs were small. The team is encouraged to review and update performance data, so it is current and, if possible, to display data ina manner that is easier for clients, families and staff to view, interpret at a glance, and engage with.

Despite the low wait times and excellent work done by the rehabilitation team, there can still be challenges for clients to move back to the community. The team identifies that a shortage of home and community support and a lack of subsidized spaces in retirement homes creates barriers which prevent clients from being discharged. In addition, there is a lack of appropriate elder care facilities because many will not accept persons who are at risk of falls and this means clients need to be on wait lists for long term care facilities. The team is aware that working with partners in the community is necessary to help create solutions for these issues. The team is strongly encouraged to continue discussions with partners to explore initiatives or other innovative ways to help clients and families with this crucial final step of moving back to their communities.

Table 28: Unmet Criteria for Service Excellence for Rehabilitation Services

There are no unmet criteria for this section.

Quality Improvement Overview

Exceptional Care – Exceptional People. Brant Community Healthcare System (BCHS) Brantford General Hospital (BGH) site is nestled within a hillside of a residential community. This site has six wings contained in six separate buildings. Wings A to E are mostly devoted to care services, with Wing H serving only for administrative purposes.

The BCHS website has ample information for patients and visitors about care services (with diagrams or video, if/when applicable). Wait times are posted for the emergency department at the BGH site and for Urgent Care at the Willett site. Information includes such things as electronic referral forms, information on how to access care services, a detailed explanation about who is a substitute decision maker (SDM), information on how to become a Patient and Family Advisor (PFA), and how to provide patient feedback and experience .

Along the hallway walls are information boards, art, signage and pamphlets liberally dispersed. Although each building wing is identified by a different coloured elevator, BCHS is urged to reexamine ways to improve wayfinding.

The senior leadership team is a focused group leveraging the five key goals of the current strategic plan to embed and foster a culture that values C.A.R.E. The team is deeply committed to transforming and supporting their organizational framework of Patient and Family-Centred Care (PFCC) and championing equitable safe care. Senior leadership is encouraged to operationalize, examine, and execute how to engage patients and families in developing a process to monitor, assess, and evaluate their PFCC efforts and health equity practices to identify meaningful measures of effectiveness as they continue along their journey.

BCHS has a group of highly engaged Patient Family Advisors (PFAs) who are active on the Brantford Brant Norfolk Ontario Health Team, belong to the Indigenous communities within the region, or volunteer with other regional community partners. There are currently fourteen PFAs at BCHS: one on the Quality Committee of the Board (QCB), eight on the CEO's Patient and Family Advisory Council (PFAC) who meet at least eight times yearly and also met throughout the Pandemic, and six involved in various program councils. Currently, there are PFAs on the Obstetrics Program Council, and the Ambulatory Program Council. There are plans underway to start a Mental Health and Addictions Youth Council, and a Diversity Equity Inclusion–Belonging (DEI-B) Committee. Since the last Accreditation, the role of the PFA morphed from being present at a meeting – to now being included in the team.

PFAs have been recruited through Patient Experience, Patient Relations, the newspapers, and word of mouth. They receive similar onboarding as hospital volunteers, PFA Orientation, a Patient and Family Advisor Orientation Handbook, San'Yas Indigenous Cultural Safety Training online, Unconscious Bias Training (for PFAs on hiring panels) and have a PFA peer mentor for support. As PFAs continue to partner more closely with the hospital, additional exploration about enriching their capacity (co-design, quality improvement, health equity) with BCHS as the organization commences master planning is strongly encouraged.

Collaboration with the PFAs to date has created notable deliverables like the BCHS Patient and Family-Centred Care Framework, the Patient Experience Bundle (AIDET, Communication Boards, Videos), the PFA Workplan, PFA Newsletter, and reviewing the addition of two process measures as custom questions to the Patient Experience Survey disseminated by Qualtrics 48-hours post-discharge contingent upon patient consent. PFAs receive formal recognition from Volunteer Services, and free parking when in-person. The hospital is urged to consider other ways to recognize and celebrate this group, encourage their wellness, and monitor/assess the potential for burnout.

PFAs reported "seeing the change as a result of their input" and feeling like "they listen to us, respect us, and involve us". They are excited about the role of DEI-B director being filled as they hope to collaborate to increase awareness about DEI-B, disabilities of all types, and social determinants of health. PFAs are also energized to discover ways to start conversations to build bridges with Indigenous communities within the region while keeping their finger on the pulse of the changing demographic of the population.

PFAs are hoping to “recruit PFAs with more diversity that is representative of the region”, and “break down the silos that patients and families experience (internally and externally to BCHS)” to facilitate “consistent integrated care across healthcare organizations and community partners”. Despite the challenges for PFA recruitment, BCHS can examine how to implement a fulsome recruitment strategy that incorporates different models to support PFA engagement and optimal adaptability. PFAs see themselves “as part of the solution” and hope to “see a day when we all receive care where everyone is treated respectfully regardless of who they are”.

The BCHS offers Indigenous Health Services to improve the quality of care, foster inclusivity, and promote a culturally safe environment for the surrounding Indigenous communities with access to an Indigenous Navigator whose role is in the process of being occupied. There is a dedicated Indigenous Family Space where medicines can be prepared, and ceremonies can be conducted. With the recent addition of the Director of DEI-B, activities are collaboratively underway to understand the hospital’s current state with the Indigenous Health & Medicine Team. The organization is encouraged to continue assessing how to operationalize and embed “holistic care that is culturally competent”.

Staff and volunteers at BCHS wear embroidered, colour-specific uniforms to identify their roles within the organization, except for management, senior leadership and physicians. There are Patient and Family Handbooks on Inpatient Floors that outline many topics from Your Hospital Stay, Hospital Programs & Services, Practical Information About Your Stay, and Patient Safety.

Due to the department's physical space constraints, the emergency department (ED)at the BGH site is being renovated as part of an improvement project. The PFA of the Emergency Program Council has been instrumental in providing input and advising on the ongoing project. Currently, the entrance to the ED for patients is in the B wing. A monitor in the main waiting area depicts the wait times and information is posted on the walls about how patients are triaged. Stretchers are placed in certain hallways, and there are five zones. Patients and families reported that their care experience “was with dignity and respect”, so they continue to return to BCHS because “they feel cared for, and their concerns are taken seriously”. Another patient said she feels “confident enough to self-advocate and ask as many questions - until I feel confident and satisfied”.

Surgery (B5) and Cardiology (C5) can be accessed along the same hallway. The walls are donned with information, signage and art. Patients indicated that information is shared with them and their families. They receive education on their conditions through support for self-management or resources within the community. “I feel involved in my care, and I know what’s supposed to happen when”. “Staff have been unbelievable, and it has been a two-way conversation. They have been timely and explain everything”. “They made what could be the worst thing in my life bearable because they are always smiling, kind and joking with me”. Their wish is for the “BCHS to get a brand-new facility”.

In Mental Health (MH) Inpatient, one patient reported that “the staff is very nice” and “talking with the nurses has been meaningful; everyone is doing well”. Patients in Mental Health Inpatient have access to the transition facilitator, who can help with resources within the community, and families are involved in team meetings with the physician and the patient.

OBS is housed in the D wing, which is relatively newer. Information is meticulously placed in the hallway, and the nursing unit separates patients and clients with a modest amount of Plexiglas. “I feel well taken care of… I receive constant communication and am always informed of any changes. My husband is fully involved and can ask questions and have them answered. The nurses always answer all my calls and tell me what to expect next – you would never know people were stretched thin here”.

Critical Care Unit (CCU) is spacious, with all the rooms along the walls and the nursing station situated in the center. The team is tight and supportive of each other. They have collaborated with patients and families to facilitate specialized requests for cultural, religious and three wishes when they are toward the end of life.

BCHS Willet site is in a residential area of Paris. The facility is over 100 years of age, with the walls adorned with vintage pictures throughout the building. This site has Urgent Care and Transitional Care.

Patients access the Urgent Care clinic from 9 am – 9 pm. The area has constraints for spacing; however, many members of the community and surrounding area, per one patient's account, stated that "everyone feels comfortable and confident coming here for care – it's fast, effective and very efficient". Another patient stated that the care "I have received in the past is why I am here today – I come in, they do what they do, and then I can do what I need to do".

In the Transitional Care Unit (C2), the surveyor spoke with two patients about their care experiences. Both identified that information was shared, they received explanations with resources and support and already have a goal of discharge planning as the conversations started early in the admission process. They identified that options and an individualized care plan with respect to physical therapy have been put in place and that their families are involved.

Ambulatory Care at BCHS offers a host of different care services. The patient interviewed was in Oncology receiving the last chemotherapy treatment. "The atmosphere is positive, the care is amazing, the staff is professional – All I can say is thank you for keeping a light atmosphere". The gong was rolled out, and the surveyor and a few nurses stood in anticipation while the patient's nurse said, "go ahead – and hit the gong as hard as you can because. Your. New. Life. Starts. Now". After the patient hit the gong, everyone cheered, clapped and woo-hooed. At that moment, as the echo of the gong settled, the room got quiet, and the silence was palpable - the vision of "Exceptional Care - Exceptional People" happened.