ACCREDITATION AGRÉMENT CANADA
Qmentum

Accreditation Report

Brant Community Healthcare System

Brantford, ON

On-site survey dates: November 17, 2019 - November 21, 2019

Report issued: December 10, 2019

About the Accreditation Report

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

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

Confidentiality

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

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

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

A Message from Accreditation Canada

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

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

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

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

We look forward to our continued partnership.

Sincerely,

Leslee Thompson
Chief Executive Officer

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Executive Summary

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

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

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

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

Accreditation Decision

Brant Community Healthcare System's accreditation decision is:

Accredited (Report)

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

About the On-site Survey

- **On-site survey dates: November 17, 2019 to November 21, 2019**

- **Locations**

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

  1. The Brantford General Hospital
  2. The Willett Hospital

- **Standards**

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

  System-Wide Standards

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

  Service Excellence Standards

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

- **Instruments**

  The organization administered:

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

Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
 Population Focus (Work with my community to anticipate and meet our needs)	49	1	0	50
 Accessibility (Give me timely and equitable services)	90	3	0	93
 Safety (Keep me safe)	618	9	15	642
 Worklife (Take care of those who take care of me)	120	12	1	133
 Client-centred Services (Partner with me and my family in our care)	357	12	3	372
 Continuity (Coordinate my care across the continuum)	71	0	2	73
 Appropriateness (Do the right thing to achieve the best results)	986	38	9	1033
 Efficiency (Make the best use of resources)	57	3	0	60
Total	**2348**	**78**	**30**	**2456**

Overview by Standards

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

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

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

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

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	48 (96.0%)	2 (4.0%)	0	36 (100.0%)	0 (0.0%)	0	84 (97.7%)	2 (2.3%)	0
Leadership	46 (92.0%)	4 (8.0%)	0	95 (99.0%)	1 (1.0%)	0	141 (96.6%)	5 (3.4%)	0
Infection Prevention and Control Standards	40 (100.0%)	0 (0.0%)	0	29 (100.0%)	0 (0.0%)	2	69 (100.0%)	0 (0.0%)	2
Medication Management Standards	70 (95.9%)	3 (4.1%)	5	56 (98.2%)	1 (1.8%)	7	126 (96.9%)	4 (3.1%)	12
Ambulatory Care Services	43 (93.5%)	3 (6.5%)	1	76 (97.4%)	2 (2.6%)	0	119 (96.0%)	5 (4.0%)	1
Biomedical Laboratory Services **	72 (100.0%)	0 (0.0%)	0	105 (100.0%)	0 (0.0%)	0	177 (100.0%)	0 (0.0%)	0
Critical Care Services	60 (100.0%)	0 (0.0%)	0	105 (100.0%)	0 (0.0%)	0	165 (100.0%)	0 (0.0%)	0
Diagnostic Imaging Services	67 (98.5%)	1 (1.5%)	0	66 (97.1%)	2 (2.9%)	1	133 (97.8%)	3 (2.2%)	1

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Emergency Department	71 (98.6%)	1 (1.4%)	0	104 (97.2%)	3 (2.8%)	0	175 (97.8%)	4 (2.2%)	0
Inpatient Services	51 (85.0%)	9 (15.0%)	0	77 (90.6%)	8 (9.4%)	0	128 (88.3%)	17 (11.7%)	0
Mental Health Services	49 (98.0%)	1 (2.0%)	0	91 (100.0%)	0 (0.0%)	1	140 (99.3%)	1 (0.7%)	1
Obstetrics Services	71 (100.0%)	0 (0.0%)	2	87 (100.0%)	0 (0.0%)	1	158 (100.0%)	0 (0.0%)	3
Perioperative Services and Invasive Procedures	107 (93.0%)	8 (7.0%)	0	94 (86.2%)	15 (13.8%)	0	201 (89.7%)	23 (10.3%)	0
Point-of-Care Testing **	38 (100.0%)	0 (0.0%)	0	46 (100.0%)	0 (0.0%)	2	84 (100.0%)	0 (0.0%)	2
Rehabilitation Services	44 (97.8%)	1 (2.2%)	0	70 (87.5%)	10 (12.5%)	0	114 (91.2%)	11 (8.8%)	0
Reprocessing of Reusable Medical Devices	86 (100.0%)	0 (0.0%)	2	40 (100.0%)	0 (0.0%)	0	126 (100.0%)	0 (0.0%)	2
Transfusion Services **	71 (100.0%)	0 (0.0%)	5	68 (100.0%)	0 (0.0%)	1	139 (100.0%)	0 (0.0%)	6
Total	**1034 (96.9%)**	33 (3.1%)	15	1245 (96.7%)	42 (3.3%)	15	2279 (96.8%)	75 (3.2%)	30

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

Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

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

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

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

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

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

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

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

Summary of Surveyor Team Observations

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

Brant Community Healthcare System (BCHS) recently transitioned from having a supervisor acting as a board to a newly appointed board. Over the last year the board has moved through its orientation and into being a functioning board with delegated board responsibilities from the supervisor. The supervisor role is anticipated to end in January 2020 with full responsibilities and accountability for governance transferred to the BCHS board.

In 2019, decision-making authority was delegated to the board from the supervisor. The board consists of experienced and dedicated members, with representation from ethnic and Indigenous groups, who are knowledgeable about the community. It is a skills-based board with appropriate gender and ethnic representation. Adequate board processes are in place to meet good governance practices. The board is encouraged to formally document these practices. The board is enthusiastic and committed to moving the organization forward to enhance service quality and community, staff, and physician engagement.

The organization has implemented an ethics framework that is based on the IDEA framework, and uses it for clinical and non-clinical decision making. Principle-based decision making is supported by the Niagara Regional Ethics Network. BCHS has developed in-house capacity by training ethics coordinators and through online training modules for staff. Board members, physicians, and staff know how to access consultation services and use the ethics framework. BCHS is encouraged to continue to raise awareness of and provide training on how to access and use the ethics framework.

BCHS recently initiated a robust strategic planning process to build on the strategic map initiated by the government supervisor. A diverse 33-member steering committee oversaw the process as delegated and monitored by the board. The formal strategic plan is anticipated to be approved by the board in early 2020. The organization is using the strategic map and draft strategic plan to guide its operating, resource allocation, and quality initiatives. Strategic goals have been cascaded through the organization and are being addressed at relevant levels, with a particular focus on quality, patient safety, and utilization initiatives.

BCHS has developed a fundamental human resources plan that identifies eight goals. The workplace success plan has the support of the board and senior leadership and is being implemented organization-wide. The organization is encouraged to continue to automate its e-learning systems, performance reviews, and tracking of employee performance and professional development.

The resources team has implemented several significant changes to enhance the service it provides to the organization. It has enhanced relevant reporting and engaged various levels of management in their accountabilities for managing operating and capital budgets. The board has responded with better quality and more frequent reporting to fulfill its fiduciary duties. BCHS is encouraged to be diligent about addressing its working capital and capital reserve deficits internally with continued system efficiencies, and to advocate with

government for the appropriate funding for the service volume it is providing to the community.

BCHS has initiated a functional quality management program using the accreditation standards as the framework. Plans are being developed to introduce the Institute for Healthcare Improvement framework in early 2020.

The board is fully engaged in its accountability for monitoring quality improvement and risk management activities. It receives regular reports and ensures that quality improvement and risk management are key strategic directions.

The Quality and Risk Management Committee is fully engaged, with strong representation from physicians and hospital staff. The co-leadership model of physician and management leads for clinical programs reinforces engagement at the clinical level.

BCHS departments and units make effective use of quality boards and huddles. The organization is encouraged to continue to develop the program through continued training on the use of quality and risk management methods, tools, and techniques.

The organization has set a priority goal of empowering and supporting its staff. Using physician and staff input from the transformation survey, rounding, and town halls, the organization has implemented initiatives to be more supportive of staff in their work life, and adjusted the models of care to be more supportive of staff in their working environments. Dedicated staffing positions and resources have been created to support physicians and staff and to enhance the working environment and worklife balance. The organization is encouraged to continue to develop and implement of these types of initiatives and to evaluate and monitor the effectiveness of this support.

BCHS is being significantly impacted by steadily increasing patient volumes and acuity. Managing these challenges within the existing aged infrastructure presents numerous challenges. Working with community partners, BCHS has dedicated resources to improve flow at every step of the patient journey through the organization. Admission avoidance in conjunction with partners and community resources helps identify frequent emergency department (ED) users to develop care plans to prevent crisis. For those in the ED, community support is maximized to assist with outpatient management.

Despite these challenges, the interdisciplinary teams live the mission of putting patients first. Patients and families recognize the exemplary care provided and speak highly of the BCHS physicians and staff. The teams embrace the vision of high-quality and safe patient- and family-centred care.

Care plans and associated goals for patients are established by the teams in consultation with patients and families. Falls prevention and pressure ulcer risk programs have been implemented but the effectiveness of these programs is not regularly evaluated. The organization is encouraged to undertake regular evaluation of these programs and share the findings with the other clinical programs.

The SBAR (situation, background, assessment, recommendation) communication strategy is used for nursing

shift handover, with more shift-to-shift transitions happening at the bedside. Patients and families report being well informed about the various aspects of their care. In particular, team rounding is identified by patients and staff as a valuable part of positive patient experience.

Information provided to patients at admission includes the scope of the services, the effectiveness and outcomes of the services, and other services available to address their specific needs. Also, various patient educational materials such as pamphlets are provided and these are easy to understand.

Patients and family members note that messaging from staff conveys respect for the needs of the patient, and reflects a patient-centred approach. They trust their service providers, have a good rapport with them, and feel able to ask questions and make decisions about their own care. They feel engaged in their care. They also indicate that they are informed about how to make a complaint or express a concern if necessary. Complaints and compliments are tracked and reported to the board. Informed consent is obtained from patients. Patients are satisfied with the cleanliness of the surroundings and note that staff consistently wash their hands.

The Patient and Family Advisory Committee has been reactivated since the appointment of the CEO in December 2018, and it has been fully engaged with planning and patient experience activities. Specialty areas such as the ED, critical care, mental health, and infection prevention and control have benefited from the role of the patient advisor while other areas need to engage this valuable resource. The CEO and leadership team appreciate the value that patient and family experience brings to their planning and decision-making process.

Community partners, families, and patients note a renewed engagement with partners and external community stakeholders in planning, integrating, and delivering services. Patients and families participated in the transformation survey, town halls, and engagement sessions to provide input into the organization’s strategic and program planning process. The patient relations office and communications group work to enhance connections with patients and families and their continued engagement at the service delivery level.

Detailed Required Organizational Practices

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

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

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Communication	
The Do Not Use list of abbreviations A list of abbreviations, symbols, and dose designations that are not to be used have been identified and implemented.	· Medication Management Standards 14.6
Medication reconciliation as a strategic priority A documented and coordinated medication reconciliation process is used to communicate complete and accurate information about medications across care transitions.	· Leadership 15.7
Medication reconciliation at care transitions Inpatient care only: Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions.	· Perioperative Services and Invasive Procedures 11.6

Detailed On-site Survey Results

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

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

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

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

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

See Appendix B for a list of priority processes.

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

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

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

Priority Process Results for System-wide Standards

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

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

Priority Process: Governance

Meeting the demands for excellence in governance practice.

Unmet Criteria		High Priority Criteria
Standards Set: Governance		
13.3	The governing body shares the records of its activities and decisions with the organization.	!
13.7	The governing body regularly reviews the contribution of individual members and provides feedback to them.	!

Surveyor comments on the priority process(es)

BCHS recently transitioned from having a supervisor acting as a board to a newly appointed board. Over the last year the board has moved through its orientation and into being a functioning board with delegated board responsibilities from the supervisor. The supervisor role is anticipated to end in January 2020 with full responsibilities and accountability for governance transferred to the BCHS board.

The board consists of experienced and dedicated members, with representation from ethnic and Indigenous groups, who are knowledgeable about the community. It is a skills-based board with appropriate gender and ethnic representation.

Adequate board processes are in place to meet good governance practices. The board is encouraged to formally document these practices. The board is enthusiastic and committed to moving the organization forward to enhance service quality and community, staff, and physician engagement.

Priority Process: Planning and Service Design

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

BCHS has initiated a robust strategic planning process to build on the strategic map initiated by the government supervisor. A diverse 33-member steering committee oversaw the process as delegated and monitored by the board. The formal strategic plan is anticipated to be approved by the board in early 2020.

The organization is using the strategic map and draft strategic plan to guide its operating, resource allocation, and quality initiatives. Strategic goals have been cascaded through the organization and are being addressed at relevant levels, with a particular focus on quality, patient safety, and utilization initiatives. Community partners and stakeholders acknowledge the increased level of engagement in planning activities.

Priority Process: Resource Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The resources team has implemented several significant changes to enhance the service it provides to the organization. It has enhanced relevant reporting and engaged various levels of management in their accountabilities for managing operating and capital budgets. The board has responded with better quality and more frequent reporting to fulfill its fiduciary duties.

BCHS is encouraged to be diligent about addressing its working capital and capital reserve deficits internally with continued system efficiencies, and to advocate with government for the appropriate funding for the service volume it is providing to the community.

Priority Process: Human Capital

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
10.7	Position profiles are developed for each position and are updated regularly.	
10.8	Roles and responsibilities for patient safety are defined in writing.	!
10.11	Policies and procedures for monitoring team member performance align with the organization's mission, vision, and values.	!
Surveyor comments on the priority process(es)		

BCHS has developed a fundamental human resources plan that identifies eight goals. The workplace success plan has the support of the board and senior leadership and is being implemented organization-wide.

The organization is encouraged to continue to automate its e-learning systems, performance reviews, and tracking of employee performance and professional development.

Priority Process: Integrated Quality Management

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

Unmet Criteria			High Priority Criteria
Standards Set: Leadership			
12.4	The risk management approach and contingency plans are disseminated throughout the organization.		!
15.7	A documented and coordinated medication reconciliation process is used to communicate complete and accurate information about medications across care transitions.		ROP
	15.7.1	There is a medication reconciliation policy and process to collect and use accurate and complete information about clients' medication at care transition.	**MAJOR**
	15.7.5	Compliance with the medication reconciliation process is monitored and improvements are made when required.	**MINOR**
Surveyor comments on the priority process(es)			

BCHS has initiated a functional quality management program using the accreditation standards as the framework. Plans are being developed to introduce the Institute for Healthcare Improvement framework in early 2020.

The board is fully engaged in its accountability for monitoring quality improvement and risk management activities. It receives regular reports and ensures that quality improvement and risk management are key strategic directions.

The Quality and Risk Management Committee is fully engaged, with strong representation from physicians and hospital staff. The co-leadership model of physician and management leads for clinical programs reinforces engagement at the clinical level.

BCHS departments and units make effective use of quality boards and huddles. The organization is encouraged to continue to develop the program through continued training on the use of quality and risk management methods, tools, and techniques.

Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization has implemented an ethics framework that is based on the IDEA framework, and uses it for clinical and non-clinical decision making. Principle-based decision making is supported by the Niagara Regional Ethics Network.

BCHS has developed in-house capacity by training ethics coordinators and through online training modules for staff. Board members, physicians, and staff know how to access consultation services and use the ethics framework.

BCHS is encouraged to continue to raise awareness of and provide training on how to access and use the ethics framework.

Priority Process: Communication

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Effective communication is a priority for the organization. A public affairs portfolio oversees communications and media relations. Materials are proactive and well presented, and discussions throughout the organization confirm that staff access the tools available and are aware of corporate, program, and service communications. Screen savers on the unit computers are used effectively to communicate, with “Your time to shine” being an example of this.

The team is commended for its commitment to communicating outside the organization. In particular, the CEO and the board chair have held discussions with the Six Nations of the Grand River and the Mississaugas of the Credit First Nation.

The organization's philosophy is to view everyone as communicators. BCHS has a good mix of tools to ensure the right information is in the right hands at the right time. Corporate publications such as the annual report as well as This Week @ BCHS, posters in the elevators, the Hospital Insider column published every two weeks in the Brantford Expositor and the Paris Star, podcasts, and the patient and family handbook are some of the tools that are used.

The organization is commended for its approach to policy management. There are hundreds of policies in place and all are available electronically. There are clear protocols for updating and systems are in place to ensure updates are reviewed as required. Efforts related to disclosure and reporting sentinel events are noted with approval.

There is a clear and strong commitment to transparency in and outside the organization. The website is comprehensive, with significant amounts of information available. There are ongoing reviews of the website and additional information is made available on an ongoing basis.

The community stakeholders' meeting confirmed that the organization is very open with its communication, with all participants feeling they can access the information they need. The hospital uses many tools such as the intranet, internet, email, and newsletters to communicate with staff, patients, and external stakeholders. Staff appreciate the ease in obtaining the information.

The Information, Communications, and Technology Committee (ICT) guides the development of a year-over-year ICT strategy. It advises on cybersecurity and privacy programs, and is in the beginning stages of implementing a phishing campaign.

Random and selective privacy audits of the electronic medical record are done. Education on privacy and

confidentiality is in place, and there is a privacy breach management protocol.

Staff who were interviewed spoke favourably about the communication that flows from daily unit huddles, and the cascading information that is received after leadership and/or management forums.

As noted in the previous accreditation report, there continues to be a hybrid documentation system (paper and electronic), which poses a risk as staff members are required to move between two systems to chart.

Priority Process: Physical Environment

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

At BCHS, the team is committed to keeping the aging facility in safe working order to meet the needs of patients and staff. Frequent meetings between facilities staff and clinical staff allow for timely identification of required repairs. A formal program of regularly scheduled preventive maintenance is ongoing.

BCHS had roof and foundation leaks which were repaired, funded by Health Infrastructure Renewal funding. The organization is encouraged to explore prevention strategies and contingency funding for potential future events. Space is a concern, with carts and equipment stored in the hallways, specifically in the basement corridors. In addition, there is a lack of patient privacy during patient registration in the main lobby.

The patient care areas are kept clean, but the stairwells in the mechanical and boiler rooms are neglected and need to be cleaned to prevent slips and falls. In addition, the organization is encouraged to ensure that staff in the boiler room always wear the hearing protection devices that are provided, to safeguard against hearing loss due to the high noise levels in the area.

The physical environment has had several expansions and redevelopment projects over the years. Due to the age of the original building, the expansion and redevelopment projects were done at different elevations and the levels are not aligned. This structure presents challenges to wayfinding and movement throughout the facility for patients, families, visitors, and staff. In addition, the facility is undersized to support the volumes and does not meet current building codes. Redevelopment projects are underway in mental health to address some safety issues. Future projects may include the ED which is severely undersized to handle the volume and provide appropriate privacy and confidentiality for patients. Also, infection prevention and control could be enhanced by dedicating an elevator to transport soiled equipment only, as there is no clear separation for this function.

The organization is commended for its initiative to build a co-generation system that provides electricity generation and steam heating. This system will improve efficiency as the waste heat from power generation can be used in the heating plant which will result in energy savings in electrical, gas, and water. There are excellent processes in place to manage, store, and dispose of hazardous and flammable materials.

Priority Process: Emergency Preparedness

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
14.10 The business continuity plan addresses back-up systems for essential utilities and systems during and following emergency situations.	!

Surveyor comments on the priority process(es)

BCHS recently updated its emergency measures and business continuity plans by reconnecting with community partners and strengthening its internal systems, codes, and protocols. The organization is encouraged to continue with its staff training plans as well as the implementation of a comprehensive business continuity plan for its IT systems, given the growing reliance on IT systems for clinical and administrative operations and emergency response.

Priority Process: People-Centred Care

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

Unmet Criteria		High Priority Criteria
Standards Set: Ambulatory Care Services		
1.1	Services are co-designed with clients and families, partners, and the community.	!
3.11	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
15.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Inpatient Services		
1.1	Services are co-designed with clients and families, partners, and the community.	!
3.3	A comprehensive orientation is provided to new team members and client and family representatives.	
3.12	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
15.9	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.	!
16.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Perioperative Services and Invasive Procedures		
1.1	Services are co-designed with clients and families, partners, and the community.	!
1.7	Barriers that may limit clients, families, service providers, and referring organizations from accessing services are identified and removed where possible, with input from clients and families.	

2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
6.3	A comprehensive orientation is provided to new team members and client and family representatives.	
6.12	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
Standards Set: Rehabilitation Services		
2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
3.3	A comprehensive orientation is provided to new team members and client and family representatives.	
3.12	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	

Surveyor comments on the priority process(es)

The Patient and Family Advisory Committee has been reactivated since the appointment of the CEO in December 2018, and it has been fully engaged with planning and patient experience activities. Specialty areas such as the ED, critical care, mental health, and infection prevention and control have benefited from the role of the patient advisor while other areas need to engage this valuable resource.

The CEO and leadership team appreciate the value that patient and family experience brings to their planning and decision-making process.

Priority Process: Patient Flow

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

Unmet Criteria	High Priority Criteria
Standards Set: Perioperative Services and Invasive Procedures	
9.5 Scheduling strategies, such as block times, are used to achieve an optimal flow of clients.	
9.6 There is a standardized, proactive process to prioritize and schedule elective procedures.	

Surveyor comments on the priority process(es)

Patient flow is identified as a priority for the organization. All departments are involved to optimize flow and improve patient care and safety.

The surge plan has been redeveloped as a working document that provides appropriate direction and action plans for the organization. The team demonstrates close collaboration and a proactive approach to providing quality care and admitting patients to appropriate beds. Moving patients from the ED to inpatient beds during the night shift has significantly improved patient flow. Patient navigators in the ED work to identify opportunities to avoid admission, and navigators throughout the organization identify potential barriers to discharge to manage issues early in the care journey.

The organization has done great work to streamline and define the hospitalist role, with adjustments to include an evening shift to improve coverage of inpatients and streamline hospitalist admissions during evening hours. The recent implementation and increased coverage of the house-based internist has also improved support and facilitated smoother movement of high acuity patients to appropriate beds.

There are many initiatives throughout the organization to improve patient flow directly and indirectly. Staff use, such as reducing nurses accompanying patients between departments; streamlining consultations (e.g., in paediatrics); automating orders to initiate early care, such as physio consultations and delirium care pathways; and prioritizing diagnostic tests for those with pending discharges are all examples of initiatives to improve patient flow and patient care. Consolidating these processes and continuing to monitor and track indicators to ensure that initiatives continue to have the desired effect are priorities as the organization moves forward.

An initiative to admit patients from the ED deserves special mention. It uses a faxed SBAR with a 30-minute transfer of accountability. This demonstrates the excellent work of staff throughout the organization. They identified a delay in patient transition, developed and tested a plan, and then rolled the process out. Although this is a significant change for the front-line staff, their willingness to adopt this change to improve patient experience and care reflects positively on the organization.

The perioperative and surgical procedures department are encouraged to further improve operating room use. Although block bookings are used in policy, there is an under-use of operating room time in some services. Scheduling is fairly rigid and more flexibility to decrease operating room downtime and to meet targets is suggested. The organization might consider reviewing its processes to ensure operating room lists are received with adequate time for the team to review them and identify unused periods. Further, holiday periods need to be identified well in advance so these blocks can be used by other surgeons. Allocation of operating room time may need to be reviewed to align schedules with both organizational and discipline requirements and reflect actual use patterns.

Education on patient prioritization is being provided to surgeons and their external staff. Auditing operating room lists to identify specialty areas that would benefit from further education and direction may help physicians appropriately prioritize and schedule patients to meet hospital targets, smooth fluctuations in operating room use, and help with inpatient bed management.

The orthopaedic service provides a wide range of services including hip and knee replacement. The organization is not meeting its targets on wait times or volumes for these services. To maximize the program, it is suggested that the physicians, staff, and leadership develop a clear plan to prioritize operating room time, in line with hospital priorities, to meet these targets.

Priority Process: Medical Devices and Equipment

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Medical devices reprocessing (MDR) has an electronic procedure manual that displays directions and photos to guide staff in the set up of surgical trays.

MDR staff are qualified through the Central Service Association of Ontario (CSAO) or a college course in reprocessing. The manager of the department is CSAO certified. Staff education and their knowledge of medical device reprocessing requirements are excellent and staff are proud of their jobs.

Biomedical engineering keeps ongoing preventive maintenance records and tracking systems. Reports are produced and circulated to appropriate departments and committees on a regular basis. There is a well-established system to report problems with instruments and equipment in the operating room and MDR.

The main MDR department layout is designed to segregate washing and cleaning of similar instruments and equipment. Large equipment and trays are washed, soaked, and rinsed in large stainless steel sinks. Smaller and more fragile equipment are cleaned and washed in an area that is undersized and would benefit from a similar set up as the large equipment sink to improve efficiency and be more ergonomically beneficial for staff.

There are hands-free handwashing stations and sinks in MDR.

The organization is encouraged to consider purchasing height-adjustable sinks and tables for the area, to facilitate washing and cleaning small equipment.

MDR receives daily temperature and humidity reports for all areas of the department and the operating room sterile storage area. Ongoing quality audits are performed by the MDR manager. The department is commended on the set up of the scope cleaning and sterilization area which allows for trace-back of equipment, patient, sterilizer, and staff. An area for improvement would be to replace the scope dryer cabinets with HEPA filters to prevent any possible contamination of the scopes.

There is no flash sterilization performed in any of the hospital departments. The organization uses a number of acceptable visible external sterilization/reprocessing test indicators and follows manufacturers' instructions to clean, disinfect, and reprocess diagnostic devices and equipment.

The team keeps a record of staff training for all devices and equipment.

Life cycle maintenance is in place for all types of equipment. Each piece of equipment has a documented

maintenance log. The team recognizes that much of the equipment and devices exceed expected life cycles, due to limited budget, and they do not meet the programmed replacement cycle of all equipment.

Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Point-of-care Testing Services

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

Clinical Leadership

- Providing leadership and direction to teams providing services.

Competency

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

Episode of Care

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

Decision Support

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

Impact on Outcomes

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

Medication Management

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

Organ and Tissue Donation

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

Infection Prevention and Control

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

Diagnostic Services: Imaging

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

Diagnostic Services: Laboratory

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

Transfusion Services

- Transfusion Services

Standards Set: Ambulatory Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
3.10	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
Priority Process: Episode of Care		
6.6	The length of time clients wait for services beyond the time the appointment was scheduled to begin is monitored and work is done to reduce that time as much as possible.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)
Priority Process: Clinical Leadership
The ambulatory care program consists of a diabetes education program, oncology clinic, fracture room, pulmonary function testing, women's health, vascular access, infusion room, electromyography, and surgical clinics. Surgical clinics provide services in plastics, eyes, urology, endoscopy, and orthopaedics, to mention a few. Experienced and well-trained staff work in the ambulatory care program. Clinical leadership in the oncology suite is knowledgeable and there are good working relationships with Hamilton Health Sciences and Cancer Care Ontario.

There is good physician support and coverage for the ambulatory care programs. Oncology coverage from the oncologists is based on provider schedules and can result in significant variances in daily census.

Instruments requiring sterilization have been centralized in the sterile reprocessing department. Endoscopy reprocessing takes place in ambulatory care with only trained personnel undertaking cleaning and disinfecting of the scopes in a manner that clean and dirty are always geographically separated.

Priority Process: Competency

The interdisciplinary teams in the areas that were visited are all engaged, competent, and committed to patient-centered care. Members respect each other's input, dialogue is collegial, and physician engagement is strong.

All teams demonstrate a high degree of collaboration and a strong focus on caring about the clients and families.

There is a centralized education fund available to all staff to apply for financial support. Nursing bursaries are also available.

There is evidence of ongoing educational activities and opportunities for professional growth. As well, all areas have effective orientation programs that vary in length depending upon the need for additional skills.

All staff who work in the oncology clinic have specialized training and certification in oncology. Educational opportunities to maintain currency on oncology topics are available and are used by the staff.

The interdisciplinary teams are cohesive, knowledgeable, experienced, and responsive to individual client situations.

There is good case coordination for client care and this also helps manage provider workload.

Front-line staff report that performance reviews are not completed consistently. A working group has been established to refresh the process for formal reviews.

Priority Process: Episode of Care

Clients and families are encouraged to be engaged in their care to the degree that they wish to be. Clients express their appreciation for the level of information that they receive and the open and transparent communication.

Standardized information is transferred at transitions, using SBAR and ambulatory care checklists.

Wait times for oncology are included in the Oncology Quality Council scorecard. Wait time for fecal occult blood test to colonoscopy is also monitored. For the rest of the ambulatory care services, the physicians and surgeons monitor their own wait times in their own practices. If there are concerns with wait times, the physicians bring these to the Perioperative Committee for assessment.

Storage of medications in the IV infusion room and the endoscopy recovery area requires review. Look-alike medications and high-alert medications are not identified are such, and various doses of the same medication are kept in the same area. Pharmacy has been notified and is going to remedy the situation.

The time that clients wait for service beyond the time the appointment was scheduled to begin is not monitored. A patient in the fracture clinic who was interviewed had waited two hours for her appointment to start. The organization is encouraged to monitor this wait time.

The health record is a hybrid model of paper and electronic. Documentation is essentially paper-based. An electronic medical record would greatly enhance client care and data collection for quality initiatives. The organization is encouraged to implement the electronic medical record in ambulatory care.

Priority Process: Decision Support

Team members use the incident management system. Leaders review incidents and make changes as appropriate. The team fosters disclosure of client safety incidents.

Client satisfaction surveys are completed. The team is responsive to client feedback and has made improvements based on survey results. The organization is encouraged to include such learnings on the quality boards to enable team members, clients, and families to see quality improvement activities and data in a transparent way.

Priority Process: Impact on Outcomes

The team is beginning to use benchmarking and evidence-based data to look at service planning. Leadership acknowledges that goal setting, planning, and evaluation of the service is reactive rather than proactive and systematic, and that physicians and physician leaders need to be actively engaged in service planning. It is suggested that the team consider a structure where the use of clinic resources is monitored, adjusted, and reallocated as needed, based on the corporate clinical priorities identified by the organization and within available financial resources.

There is a good understanding of the processes that need to be undertaken when there is an adverse event and the processes around disclosure.

Clients are satisfied with the services. Good follow-up arrangements are made if required with other providers.

The IV infusion room is becoming space constrained and volumes are projected to increase. This may

require an increase or change in the hours of operation.

The program may need to pay more attention to client privacy and confidentiality in the registration and waiting area as program volumes continue to grow.

Standards Set: Biomedical Laboratory Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Episode of Care

The biomedical laboratory service uses the organization's falls prevention program.

Priority Process: Diagnostic Services: Laboratory

The laboratory underwent an Institute for Quality Management in Healthcare peer assessment prior to the Accreditation Canada on-site survey.

The program collects and reviews data about volumes on a regular basis. The laboratory is encouraged to establish a formal utilization policy to review and monitor inappropriate and high-volume test ordering.

The staff participate in continuing education provided by the laboratory medical staff and vendors, and through web-based education. In addition, staff participate in self-learning on topics such as hand hygiene, Workplace Hazardous Materials Information System, and emergency preparedness. Laboratory staff conduct ongoing audits for hand-hygiene compliance.

The team collects and analyzes data on a regular basis and monitors indicators such as turnaround time. Turnaround time for specific tests and referring location is determined in consultation with key stakeholders using clinical requirements. There are processes to allow priority testing for patient care areas, such as the ED and the critical care unit.

Staff performance appraisals are completed annually and areas for improvement are identified during this process. Ongoing education and training are provided on a regular basis and when the need arises, such as when new equipment is introduced.

Laboratory services has standard operating procedures and annual goals and objectives for the laboratory. All staff have been provided with the necessary training and education on the standard operating procedures and this has improved quality and safety and decreased risk in the laboratory and in service delivery.

The organization has a corporate-wide hand-hygiene program that includes education and compliance audits.

Standards Set: Critical Care Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The critical care services team has strong clinical and operational leadership. The team is co-led by a nurse manager and an intensivist. This team supports the critical care needs of the patients in the BCHS catchment area.

The team has benefited from standardized equipment purchases.

The critical care unit is interdisciplinary and well organized. There is very good communication with other service providers in the community and districts and this supports continuity of services for patients. There is a well-developed referral and admission system and established communication processes with other health care providers in the hospital.

The critical care team has processes to manage surge capacity to maintain patient flow. The team collects information about patient needs and uses it to identify gaps and plan critical care services.

Priority Process: Competency

The critical care unit is structured using an interdisciplinary team approach. There are 15 funded beds and the unit has a procedure to address surge issues.

The team comprises physicians, nurses, and other allied health staff such as pharmacists, dietitians, occupational therapists, and physiotherapists. Team members receive training and ongoing education to ensure they have the appropriate skills to meet the needs of the patients.

There is an evident commitment to staff education and training. Mandatory annual sessions are available through the Halogen system on topics such as workplace violence prevention, occupational health and safety, and Workplace Hazardous Materials Information System. Managers report 100 percent compliance staff completion of these sessions.

There is a well-established training program for infusion pumps.

Informal review occurs on an ongoing basis. Staff appreciate the training and education opportunities. There is good staff morale and the team is always striving to improve, and be creative and innovative.

The critical care team is a well-developed interdisciplinary team that achieves its clearly articulated goals by regularly evaluating the team's performance and making improvements when required. Effective communication between team members helps coordinate services and define roles and responsibilities

The team conducts daily beside rounds.

The interdisciplinary collaborative teams are commended for their focus on patient and family outcomes, quality, and patient safety initiatives.

Priority Process: Episode of Care

Care plans and associated goals for patients are established by the team in consultation with patients and families. Falls prevention and pressure ulcer risk programs have been implemented but the effectiveness of these programs is not regularly evaluated. The organization is encouraged to undertake regular evaluation of these programs and share the findings with the other clinical programs.

The team obtains patients' informed consent prior to providing services and two patient-specific identifiers are used during care provision. Medication reconciliation is completed at admission, transfer, and discharge. The SBAR communication strategy is used for nursing shift handover, with more shift-to-shift transitions happening at the bedside. Patients and families report being well informed about the various aspects of their care. In particular, team rounding is identified by patients and staff as a valuable part of positive patient experience.

Information provided to patients at admission includes the scope of the services, the effectiveness and

outcomes of the services, and other services available to address their specific needs. Also, various patient educational materials such as pamphlets are provided and these are easy to understand.

Patients and family members note that messaging from staff conveys respect for the needs of the patient, and reflects a patient-centred approach. They trust their service providers, have a good rapport with them, and feel able to ask questions and make decisions about their own care. They feel engaged in their care. They also indicate that they are informed about how to make a complaint or express a concern if necessary. Complaints and compliments are tracked and reported to the board.

Informed consent is obtained from patients.

Patients are satisfied with the cleanliness of the surroundings and note that staff consistently wash their hands.

The critical care response team comprises specially trained critical care providers who identify, assess, and respond to seriously ill patients across the hospital. If a patient is transferred from the critical care unit to another care unit, the patient is followed at 24 and 48 hours by a critical care response team member.

Priority Process: Decision Support

The patient record is predominantly manual. The organization is encouraged to continue to move toward implementing a computerized provider order entry (CPOE) system that is integrated with all patient care areas.

It does not appear that the team conducts audits of patient records to ensure the records are accurate. The organization is encouraged to implement regular patient record audits.

Privacy and confidentiality are maintained. Research approved by the Ethics Committee is being conducted in the critical care unit in conjunction with McMaster University Medical Centre.

Priority Process: Impact on Outcomes

Critical care services follows the organization's policy and procedure on adverse event reporting, with all adverse events being reported through the RiskPro electronic reporting system. The team manager and/or director are notified about the event and follow-up is conducted to ensure necessary action has been taken.

The team follows the organization’s verification processes and protocols to reduce the risk of harm to patients during high-risk activities such as ordering and receiving results of critical tests and performing invasive procedures. Falls prevention data are used to improve patient care and mitigate risk. Qualitative data are reported monthly and this helps drive quality improvements.

Priority Process: Organ and Tissue Donation

There is an appropriate process for organ and tissue donation. The team provides staff with education on the process, and signs that outline the process are available.

Trillium Gift of Life Network staff interact very well with the staff and families before and after the retrieval.

Standards Set: Diagnostic Imaging Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Diagnostic Services: Imaging		
17.5	The team collects, analyzes, and interprets data on the appropriateness of examinations, the accuracy of the interpretations, and the incidence of complications and patient safety incidents.	!
17.7	The team uses a utilization management or review process to monitor diagnostic imaging services.	
17.8	The team uses results of the utilization management review to educate referring medical professionals and diagnostic imaging providers on the appropriate use of diagnostic imaging services.	

Surveyor comments on the priority process(es)

Priority Process: Diagnostic Services: Imaging

Diagnostic imaging is an effective program offering a full range of services to patients and physicians at the hospital. More than 160,000 examinations are undertaken annually in seven major areas. These include general x-ray, diagnostic ultrasound, mammography including participation in the Ontario breast screening program, fluoroscopy, bone mineral densitometry, nuclear medicine, computed tomography (CT), and magnetic resonance imaging (MRI).

In addition, emergency physicians in the ED use a bedside point-of-care ultrasound unit. The organization is encouraged to ensure that the unit is properly calibrated and functioning properly, and to develop use guidelines in consultation with the diagnostic imaging department.

The staff are engaged, well trained, open, and reflect transparency. It is clear that patient-focused care is a primary concern. The medical imaging department has defined services that meet the diagnostic needs of the patients who are referred.

Staff are well trained and the services offered meet expected timelines, except for P4 CT wait time. The increased wait times for CT are a result of more stroke and oncology cases as well as normal growth in volume. The team is strongly encouraged to continue with developing a proposal to purchase a second CT scanner and also to develop a replacement strategy for the current unit.

The CT scanner is not connected to the emergency power generators. Given the high use of the scanner, it would be out of service if there is a power failure, and this would negatively impact care for stroke patients and emergency referrals. The organization is encouraged to determine the feasibility of connecting the CT scanner to emergency backup power.

The staff and service providers are educated, trained, and qualified. They participate in continuing education and their competency is assessed. Diagnostic results are interpreted as soon as possible.

The physical environment is safe, clean, and efficient. The team follows policies and procedures for the safe storage, handling, and disposal of materials and supplies. A preventive maintenance program is scheduled to ensure the quality of the equipment. Cleaning and reprocessing schedules ensure safety and optimal performance of all devices and equipment.

The team has a quality control program to assess, evaluate, and document the quality of the imaging services. The department uses the information it collects to identify successes and opportunities for improvement.

The department has developed service contracts and liaisons that ensure that down time for imaging equipment is minimal. All equipment undergoes preventive maintenance. The department works with vendors to ensure the equipment is up to date and well maintained. Quality of services is assured via the audit and safety program.

Wait times for service are carefully monitored. Priority 1, 2, and 3 are almost always completed within the recommended wait time. Priority 4 in several of the areas fluctuates, but individuals on the list are monitored to ensure that if their status or needs change, the service is offered as required. The team has established wait times and turnaround times for the various modalities and investigates and takes action when they are above benchmarks or do not meet the needs of the stakeholders.

All referrals must have a physician’s order and all CTs and MRIs are reviewed and triaged by a radiologist to ensure the appropriateness of the test requested.

All radiologists provide feedback to the technologists regarding the quality of the images produced. The picture archiving and communication system (PACS) allows radiologists and referring physicians to view images once the images are captured and stored in PACS. There is no formal utilization program. The team is encouraged to collect, analyze, and interpret data about the appropriateness of examinations, the accuracy of the interpretations, and the incidence of complications and patient safety incidents. A formal utilization program could reduce inappropriate referrals and reduce the wait time for certain tests.

Standards Set: Emergency Department - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.11	A universally-accessible environment is created with input from clients and families.	
Priority Process: Competency		
4.14	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
5.4	Position profiles with defined roles, responsibilities, and scope of employment or practice exist for all positions.	
Priority Process: Episode of Care		
8.8	Clients waiting in the emergency department are monitored for possible deterioration of condition and are reassessed as appropriate.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		
Priority Process: Organ and Tissue Donation		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The ED is a high-volume and high-acuity department. The department has made numerous improvements and program changes to address the increasing volumes and higher acuity levels.

The physical layout of the ED presents challenges for the team. Signage supports entry both directly into the department and through the main doors of the facility. After-hours entry is only through the ED. Recently, parking in front of the department was eliminated as it was problematic for ambulance offload. This may present a barrier to those requiring urgent care. The organization might consider engaging with partners, patients, and families to mitigate the risk and improve access.

The significant infrastructure issues in the ED are recognized by the leadership, staff, and physicians. High

patient volumes impact the inadequately sized department, forcing the team to provide hallway care for admitted patients and impacting flow. The department has narrow halls and doorways that create challenges when moving stretchers. Diagnostic imaging is not adjacent to the ED, causing transport delays and prolonging staff absences to support unstable patients during testing. The team is working to mitigate these issues, pending future redevelopment approval, and continues to develop creative solutions so it can continue to provide quality care within these limitations.

The ED team recently established a Program Council that includes a patient and family advisor. The team makes excellent use of data to identify areas of concern and direct and support new programs.

The Willett site has a beautiful and updated urgent care centre that is staffed by dedicated physicians and nurses. Considerable work in community education on scope of practice and working with partners to ensure a seamless transition to the ED when required has set the urgent care centre up for success in fulfilling its role.

Priority Process: Competency

The ED has done considerable work to ensure staff receive training in required competencies. All staff receive resuscitation training through a robust internal training program in recognized programs. Ultrasound is widely used in the department by physicians who have established competencies in this skill. Auxiliary health professionals including physician assistants benefit from extended training to increase skill levels to better enable and support their role as physician extenders.

It is suggested that auditing be done to ensure ultrasound results are appropriately documented and include image print-outs to support the decision. Having preventive maintenance schedules and calibration reports available will help ensure confidence in the accuracy of the modality.

Following a period of limited access to educational programs, the organization has renewed opportunities for educational funding. Staff appreciation and recognition programs are also re-emphasized under the new program models.

Formal performance appraisals have not been consistently done as the organization was in a period of transition. Identifying opportunities for growth and following up on issues continues to be done less formally by the leadership during regular interactions with staff.

Priority Process: Episode of Care

The ED team manages a high volume of high-acuity patients within a sub-optimal infrastructure. Triage uses an e-Canadian Triage and Acuity Scale (CTAS) system that includes the time required for reassessment. However, the waiting room does not have good sight lines from triage and, although cameras are used, they are not ideal. While staff are fully aware of the requirement to reassess based on the CTAS score, the reality of high volumes means that reassessment is not consistently done. The organization is encouraged to consider options to meet this requirement.

A best possible medication history is consistently completed with the support of a dedicated pharmacy technician in the ED.

Recognizing that delays in specialist consultation were having an impact on patient flow in the department, the ED leadership worked with specialist partners to develop a policy for in-house and off-site response time. This policy is supported by the specialists and has improved patient care, bed use, and patient satisfaction.

The ED has a patient navigator and Local Health Integration Network coordinator in the department to work on admission avoidance and to manage discharge of patients admitted to the ED.

Priority Process: Decision Support

The ED uses a paper-based documentation system, with a computerized eCTAS system that supports triage decisions. The Oculys system greatly benefits the team by tracking patient locations, decisions, and communication.

Fully trained physicians use point-of-care ultrasound in the ED.

Documentation of results with images to support interpretation and actions is suggested, to enable complete chart reviews. Preventive maintenance and calibration of equipment needs to be completed and documented to confirm that equipment is accurate.

Priority Process: Impact on Outcomes

The ED has embraced the quality journey and has successfully used indicator data to identify areas of priority, evaluate the processes, implement trials, and use the information to evaluate programs.

Recognizing the need to better manage the high volumes presenting to the department, the team has developed a see and treat area since the last on-site survey. This has allowed the team to shift a significant proportion of patients from the high-acuity area, decreasing overall wait times, reducing left without being seen rates, and increasing overall patient and staff satisfaction. The use of physician assistants in the department has also streamlined care.

The development of care pathways and use of medical directives allows the team to provide rapid and appropriate care with minimal delay. When opportunities for improvement are identified through data analysis, the team demonstrates a willingness to review creative approaches to mitigate the issues. An example is the challenge the team recognized in meeting the code stroke timelines, due in large part to the challenges imposed by departmental infrastructure. Assigning the most responsible physician and the physician assistant as a team to expedite each stage and concurrently document the required information allows the team to meet required time parameters and frees the physician to continue providing care to others in the department. The department plans to capitalize on the success of this model for other

programs, such as STEMI.

Recognizing barriers to care and patient flow is another departmental success and the recent trial and implementation of the transfer of accountability for admission is notable. Moving patients from the ED to an inpatient bed during the night shift is another example of the teams working together to overcome a barrier to care.

Having the physician assistant review all discrepancies is a proactive solution that effectively mitigates an area of risk.

The commitment of the ED leadership and physicians to quality improvement is commendable. Monitoring bounce backs, ongoing physician peer education, metrics, and chart audit teaching and review are all notable initiatives. There may be a benefit to more formally monitoring success and opportunities in the program.

The huddle board is used to communicate trends, projects, and priorities. The team may wish to consider additional priorities as it moves forward. It is suggested that results be documented with images to support interpretation and action, to enable complete chart reviews.

Preventive maintenance and calibration of equipment needs to be completed and documented to confirm that equipment is accurate.

Priority Process: Organ and Tissue Donation

The ED works closely with the Trillium Gift of Life Network. There is training on potential organ donor identification and protocols to engage Trillium early in the process.

Trillium recently recognized BCHS for its commitment to supporting organ donation in the community.

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

Unmet Criteria	High Priority Criteria
Priority Process: Infection Prevention and Control	

The organization has met all criteria for this priority process.

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

Reducing infections and improving outcomes in infection prevention and control is corporate priority and the team is proud of its accomplishments. There is evidence of excellent collaboration between clinical programs, the sterilization and reprocessing department, food services, and occupational health and safety.

Infection prevention and control education tools for staff are accessible on the intranet and during orientation. The organization is commended for its surgical site infection tracking, which can occur up to a year following certain surgical procedures.

While the organization and specific units demonstrate improvements in hand-hygiene compliance, it will be critical to continue to be vigilant and to encourage teams to achieve results that meet or exceed the set target.

The daily surveillance report is an excellent communication tool to ensure all patients who require isolation are monitored and evaluated. The organization might also benefit from assessing the location of hand sanitizer stations across the facility, as there are many locations where hand sanitizers are difficult to locate or not easily accessible.

Staff and physicians report that antibiotic stewardship is well underway. Pharmacists identify patients on antibiotics for physicians to review, and the physicians address each case specifically by reviewing type, route and duration of antibiotics, and laboratory results. Pharmacy plays an active part in antibiotic management through enforcement of automatic stop orders.

Influenza vaccine rates for staff and patients are monitored and the organization encourages staff, volunteers, physicians, and patients to obtain the flu vaccine.

Cleaning routines and schedules are well established by housekeeping services and endorsed by infection prevention and control.

Standards Set: Inpatient Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.5	Service-specific goals and objectives are developed, with input from clients and families.	
1.6	Services are reviewed and monitored for appropriateness, with input from clients and families.	
2.4	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.	
Priority Process: Competency		
3.1	Required training and education are defined for all team members with input from clients and families.	!
3.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
5.3	Position profiles with defined roles, responsibilities, and scope of employment or practice exist for all positions.	
Priority Process: Episode of Care		
9.3	The inpatient services team works with the emergency department team to initiate the geriatric needs assessment, where appropriate, for clients who enter into the organization through the emergency department.	!
Priority Process: Decision Support		
13.2	Policies on the use of electronic communications and technologies are developed and followed, with input from clients and families.	
Priority Process: Impact on Outcomes		
14.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
14.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
14.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!

14.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The medical integrated program (MIP) at BCHS covers multiple inpatient medical floors and a telemetry unit. The hospital infrastructure is older and the spaces were not originally designed for their current use. Despite these infrastructure challenges, the hallways, staff work areas, and medication rooms are maintained with minimal clutter. Frequently, the organization has to admit patients to hallways due to high volumes and the teams are creative about providing relative privacy for these individuals. The environmental services teams do an excellent job of maintaining cleanliness despite the high acuity and turnover in these units.

Staff and physicians from multiple areas who were interviewed are knowledgeable and positive about their roles in quality and safety. The teams appear to function well and provide mutual assistance to manage patient care. The presence of the managers on the floors and the regular interaction with the front-line staff is seen as positive and the support is appreciated. The managers note they also like the new structure as it allows for more focus on one clinical area and supports mentoring and coaching on the floor, which is particularly important with the large number of new staff. It also improves their ability to provide direct support and real-time feedback to the front-line staff.

Patient and family advisors are not embedded with the MIP but there is a plan to include them in the MIP Program Council. The MIP teams have involved the Patient and Family Advisory Committee in working on specific projects such as the welcome booklet and signage, and look forward to having patient and family advisors on the council.

Priority Process: Competency

Formal performance appraisals are not consistently being done as the organization is in a period of transition. Identifying opportunities for growth and following up on issues are done less formally by the leadership during regular interactions with staff.

Position profiles are generic and lack defined roles and responsibilities specific to the position. The position profiles are being further developed.

Education and training are provided to team members. The use of the huddle board as an opportunity to educate and share learning is beneficial.

Priority Process: Episode of Care

The MIP consists of several high-acuity, high-volume, and high-turnover inpatient units. Despite the workload and logistical challenges, the teams show a continued focus on patient care and meeting the

needs of the individual.

The team recognized the need to rebuild capacity for geriatrics assessment in the ED and to support inpatient care. Access to geriatric consults has improved and the team is recruiting for geriatric support.

Pressure ulcer monitoring is underway. Initial rates of pressure ulcers on evaluation were high and the organization took steps to prioritize ulcer prevention, recognition, and treatment. To improve education and support, the organization added a professional with advanced nursing training in wound and dressing management. The front-line staff very much appreciate this resource and the teams anticipate improved pressure ulcer rates due to these interventions.

Priority Process: Decision Support

BCHS has a predominantly paper-based charting system. Some elements have been moved to a computerized system and this mixed modality presents inherent challenges for information management.

Legibility in the written record is variable. It is suggested that clinicians be encouraged to verify legibility in their documentation and orders.

Priority Process: Impact on Outcomes

The MIP has worked with other departments to develop and implement standardized order sets and care pathways based on best practice. When gaps, such as the lack of a delirium care pathway, are recognized, the team is proactive in supporting the development of a tool to address the need. The hospitalists are proactive and, individually and as a group, have championed many of these initiatives, resulting in consistency across the inpatient units.

Quality improvement programs have been reinvigorated across the organization and include the front-line staff. Technological support to better collect, consolidate, and display data would be beneficial, as current efforts are labour intensive.

The quality and use of the huddle boards varies throughout the organization. Ongoing monitoring to ensure they are relevant is suggested.

Standards Set: Medication Management Standards - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Medication Management		
8.1	There is a process for determining the type and level of alerts required by the pharmacy computer system including, at minimum: alerts for medication interactions, drug allergies, and minimum and maximum doses for high-alert medications.	!
8.4	The pharmacy computer system is regularly tested to make sure the alerts are working.	!
8.5	Alert fatigue is managed by regularly evaluating the type of alerts required by the pharmacy computer system based on best practice information and with input from teams.	
13.3	Chemotherapy medications are stored in a separate negative pressure room with adequate ventilation, and are segregated from other supplies.	!
14.6	A list of abbreviations, symbols, and dose designations that are not to be used have been identified and implemented.	ROP
14.6.7	Compliance with the Do Not Use List is audited and process changes are implemented based on identified issues.	**MINOR**
Surveyor comments on the priority process(es)		
Priority Process: Medication Management		

BCHS is commended for the progress it has made with regard to medication management since the last on-site survey. The leaders, physicians, and team members are committed to quality medication management. They are enthusiastic and work collaboratively as a part of a strong interdisciplinary team.

The clinical pharmacists and pharmacy technicians are working to their full scope of practice. The Ontario College of Pharmacists' inspection of the National Association of Pharmacy Regulatory Authorities standards took place in May 2019.

A comprehensive plan has been implemented for high-alert medications and the availability of certain medications. The restricted availability of concentrated electrolytes and certain concentrations of heparin and narcotics (opioids) is evident. The use of concentrated electrolytes in some areas is documented and has been approved by the Medication Utilization Committee.

To support comprehensive medication management, several interdisciplinary committees have been

established, including antimicrobial stewardship; medication utilization which pro-actively manages the medication formulary, ensures all stakeholders are included, and develops policies; medication safety; medication reconciliation; PHAMIR for medication reviews; and PDEC.

The pharmacy team participates in daily huddles in the pharmacy department and reviews, among other things, any medication errors that have been reported during the previous 24 hours.

BCHS is commended for its work in implementing a large number of electronic standard order sets that are readily available to clinical staff.

A robust incident management process is in place. The process begins at the department level and then moves to the corporate level to identify potential trends. Several improvements have been made based on the findings of incident reviews.

The decentralization of the pharmacy team to place staff on the front clinical lines has been positively received and seems to have had a positive impact on patient care through direct consultation with patients and improved discussion and collaboration with physicians, nurses, physiotherapists, and other team members. Clinical pharmacists are fully integrated in clinical areas and facilitate patient safety through patient and staff education, medication reconciliation, and monitoring the use of medications and patient response.

Medication reconciliation is supported by the pharmacy technicians in the ED to develop the best possible medication history, which initially had many errors but as the process has been developed and several fail safe steps added, the errors have decreased. Regular auditing of the compliance rate for the medication reconciliation process at admission, discharge, and transitions is evident. Audit results indicate that medication reconciliation is done well in a few areas such as medicine and critical care, and not so well in others such as surgery. The Medication Reconciliation Steering Committee meets monthly to address the issues identified as barriers to implementing a robust, consistent medication reconciliation system. The organization is aware that more work needs to be done in this area.

Much of the work to manage medications is done manually. The pharmacy could greatly benefit from automation, given that the entire dispensing and narcotic process is manual and requires oversight of over 70 narcotic sheets daily. In addition, an electronic medication reconciliation process will facilitate compliance and provide patients with a more patient-friendly report than what is currently in use.

The organization is encouraged to review the functionality of the “computer on wheels” that is used in the clinical areas for medication delivery. Many of the staff who were interviewed report difficulty in using them, as they are old, difficult to manoeuvre, and often the batteries do not hold a charge long enough during medication delivery. The pharmacy department is developing a business plan to purchase automated dispensing units to solve this problem and bring BCHS one step closer to a closed medication management system, along with implementation of CPOE. As noted in the previous accreditation report, CPOE has been purchased but has yet to be implemented.

The Do Not Use abbreviations list requires attention. The list is audited as required. However, the pharmacy is just beginning to make process changes for some things that contravene the list, such as medication abbreviations, but not for the majority of infractions which are the symbols (u) and dose designations (od and d/c). The organization is encouraged to adopt a policy, process, and procedure that indicates that prescribers will be notified when their orders contain Do Not Use abbreviations and that this must be remedied before pharmacy will fill the order.

Chemotherapy agents are prepared in the oncology unit in ambulatory care. The preparation area has a separate negative pressure area with a 100 percent externally vented biohazard hood, but does not have an anteroom to segregate chemotherapy from supplies.

Standards Set: Mental Health Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
3.14 Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The mental health and addictions program serves patients from a widespread and dispersed geographical area. All acute care mental health beds in the region are located at BCHS.

There are 5.5 FTE psychiatrists, with plans underway to recruit 2 more. Based on the volume and acuity of the patients in the programs and the size of the catchment area for mental health services, it is reported that the recommended number of psychiatrists for the community is approximately 18.

Since the last on-site survey, a psychiatrist has been assigned to the ED for in-person and virtual consults.

There are strong and engaged clinical and administrative leaders who advocate for and support service delivery based on a patient-directed, recovery-oriented framework. Physician leaders are engaged in program evaluation and development, and support program design from a best practice perspective.

The team has developed many strategic partnerships across the region and in the community to facilitate access to care and the smooth transition of patients across the continuum, and to fill recognized service gaps.

The team and patients speak highly of the respect and dignity provided for sometimes challenging and marginalized populations. The team is working hard to reduce the stigma of mental illness. It has created standardized order sets and patient education materials based on recovery-oriented care.

Priority Process: Competency

In addition to the general organizational orientation and mandatory annual recertification, staff receive additional training appropriate to the provision of safe, quality mental health services including crisis prevention and Gentle Persuasive Approach training in dementia care, for example. Staff are also trained on the appropriate use of restraints and seclusion. Opportunities for staff professional development are available in the organization.

Staff are familiar with the ethics framework and know how to access ethical support if needed. They are also familiar with the policy on and reporting of workplace violence.

Although performance appraisals are to be done at probation and every two years, completion rates need to be improved.

Staff who were interviewed report that they have not had a formal performance appraisal for quite awhile. However, leaders follow up on issues, identify opportunities for growth, and provide feedback as required.

Priority Process: Episode of Care

BCHS is a designated Schedule 1 psychiatric facility serving the region of Brant and the surrounding region of Haldimand and Norfolk.

There are 18 inpatient beds; a medication clinic; acute day treatment; outpatient services that offers crisis counselling, early intervention counselling, and early psychosis counselling; and an emergency mental health triage program that provides real-time mental health assessment in collaboration with the ED and the psychiatrist.

There are 5.5 FTE psychiatrists, which is reported to be a severe shortfall for the volume and acuity of patients that are seen. Recruitment for a sixth and possibly a seventh psychiatrist is underway.

The inpatient unit is undergoing a staged refresh, mainly to widen the doorways and improve aesthetics. The four-bed intensive observation and treatment unit is scheduled to be completed by January 2020.

The physical environment of the inpatient unit is less than ideal, with dark narrow hallways with bare walls, limited space for therapeutic activities, and inadequate bathroom facilities. A security guard is the first thing to greet patients and families when they exit the elevator onto the inpatient unit.

There have been several external reviews of the mental health program since the last on-site survey: a

facility assessment in 2017, a functional and physical assessment in 2017, and an extensive mental health and addictions review in September 2018. The reviews identified gaps that led to over 30 recommendations. The program leaders are putting action plans together to address the identified gaps.

Consistent issues that are identified relate to the physical environment of the inpatient unit, such as the lack of a secure observation area for those in restraint or seclusion, elopement risks, privacy challenges, and challenges to meet accessibility standards; program vision and culture; and models of care. Leaders are encouraged to strongly advocate for capital funds to renovate the space.

There is great collaboration with several community partners.

Documentation is still paper-based. The team is encouraged to advocate for electronic documentation to facilitate collaboration and efficiencies.

Medication reconciliation is completed at admission, transfer, and discharge. Patients, families, and community partners are engaged in the discharge planning process as appropriate and with patient consent. The team follows up with patients and providers to evaluate the effectiveness of the discharge process.

The least-restraint and seclusion policies have been updated and staff report positive feedback and results thus far.

It is early days for the patient and family advisor role, which started in May 2019. There is one patient and family advisor for the mental health and addictions programs. The advisor is a member of the Quality Council and has provided input on policy and procedures, co-design, and the implementation of the IDEAS boxes on the units. The organization is encouraged to expand the advisor role to allow for more patient and family representation on all committees and working groups.

Priority Process: Decision Support

The standardized assessment completed for each patient includes risk assessments for falls, pressure ulcers, and suicide. Although the medical record remains hybrid (paper and electronic), patient records are comprehensive, up to date, and readily available to team members who require access.

Chart audits are done by clinical leaders to evaluate completeness and compliance with organizational policies and procedures related to documentation.

Priority Process: Impact on Outcomes

Quality and safety boards are located in the clinical areas. Safety rounds occur every morning and topics such as medication errors, falls, restraint use, access to care, and staff safety are discussed. The incident management system is used, along with occupational health and safety if there are incidents of violence.

Personal alarms and desk-side alarms are in place to keep staff safe. The mental health teams are encouraged to continue to maximize the spread of their knowledge and use flow charts to show trends in their quality improvement projects and initiatives.

Standards Set: Obstetrics Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The obstetrical program delivers approximately 1,500 babies annually. The program has labour, delivery, recovery, and postpartum units. In addition, the program works closely with the paediatric and neonatal program.

The program is co-led by a nurse manager and the medical chief of obstetrics. The team comprises obstetricians, registered nurses, midwives, and registered practical nurses, supported by the department of anaesthesia.

There is one operating delivery room and, when necessary, the main operating rooms are used for deliveries.

The program is investigating becoming a MoreOB team. MoreOB has a proven record in positively enhancing team working dynamics and ultimately improving the quality of care and reducing adverse events. The organization is encouraged to support the application and funding for the MoreOB program.

Priority Process: Competency

The program has an extensive orientation program for new staff. Nurses have a certificate in perinatal obstetrics. In addition to the hospital orientation, there is a four-week orientation on the unit. The organization has eLearning through the Halogen program for workplace violence, Workplace Hazardous Materials Information System, emergency codes, and falls assessments. New staff are assigned a buddy on the unit.

Performance appraisals are conducted after 30 days and following the probationary period. The manager has conducted performance appraisals for all staff over the past 18 months. Mock code exercises such as code pink are conducted and debriefed, and leanings shared.

Team members are trained in advanced cardiovascular life support, paediatric advanced life support, and neonatal resuscitation program.

Priority Process: Episode of Care

Diagnostic testing is provided by the hospital diagnostic imaging and laboratory program. Access to testing and report turnaround times are within acceptable ranges. Reports are available on the hospital PACS and MediTech.

Patients are registered on the unit and then moved to the labour and delivery room. They are assessed and/or monitored and delivery may be done by the obstetrician or midwife.

At transition points, transfer of accountability is documented so all required information is available to the receiving unit.

Medication reconciliation is done at admission, transfer, and discharge. The program completes medication reconciliation at a rate greater than 70 percent. It is encouraged to set a target rate above 90 percent.

There is a well-established protocol for antepartum bleeding and pain assessment. Emotional support and counselling is provided for difficult diagnoses.

There is an ethics framework in place to guide the team members in their decision making.

Patient satisfaction surveys are used and all patients are asked to provide feedback.

There is a case cart system for sterilization and transport.

The policies and procedures for all modalities are well written and reviewed on an ongoing basis. Staff indicate that they had input into these procedures.

Priority Process: Decision Support

The program is developing dashboards and reports that require data that must be extracted manually. This process is labour intensive and can be prone to errors. The organization is encouraged to review the information technology support for the program and automate data extraction where possible.

Priority Process: Impact on Outcomes

Patients and their families are provided with educational material when they are admitted, during their stay, and at discharge. The Brantford Public Health Unit visits all patients to help with their discharge home and caring for their new baby.

Extensive information and education are provided on breastfeeding, care of the baby, and other topics as deemed necessary.

The surgical checklist is used in the operating delivery room.

The program has customized the organization's falls program which it has named the Humpty Dumpty program.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.3	Service-specific goals and objectives are developed, with input from clients and families.	
1.4	Services are reviewed and monitored for appropriateness, with input from clients and families.	
2.3	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.	
2.5	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
Priority Process: Competency		
6.1	Required training and education are defined for all team members with input from clients and families.	!
6.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
7.3	Position profiles with defined roles, responsibilities, and scope of employment or practice exist for all positions.	
Priority Process: Episode of Care		
11.6	Inpatient care only: Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions.	ROP
11.6.3	The prescriber uses the BPMH and the current medication orders to generate transfer or discharge medication orders.	**MAJOR**
20.17	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support		
21.1	An accurate, up-to-date, and complete record is maintained for each client, in partnership with the client and family.	!
21.2	A standardized set of health information is collected to ensure client records are consistent and comparable.	

22.2	Policies on the use of electronic communications and technologies are developed and followed, with input from clients and families.	
Priority Process: Impact on Outcomes		
23.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
23.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
23.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
23.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
24.2	Strategies are developed and implemented to address identified safety risks, with input from clients and families.	!
Priority Process: Medication Management		

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The perioperative and invasive services teams provide a range of outpatient and inpatient services to the community. The team has set goals and objectives and uses huddle boards to communicate some of these priorities and their status to team members. Some organizational goals have not been met, such as the volume and wait time benchmarks for procedures such as hip and knee replacement surgeries. The teams are reviewing options and identifying barriers to help the organization meet these targets.

There are several areas in the preoperative clinic that would benefit from further review. Elective surgeries are booked quite late, limiting the team's ability to ensure that blocks are adequately used, verify that patients are appropriately screened, and manage complications that arise during the assessment process. It is suggested that all elective surgeries be booked at least one month prior, to enable the team to assess, prioritize, and improve efficiencies. Also, surgical booking packages are often incomplete, putting the burden of completing the medical file on the preoperative staff.

There are opportunities in the preoperative clinic to streamline and prioritize services. Anaesthesia reviews all patients in the preoperative clinic. There may be an opportunity to reduce the number of patients who require in-person consultation with specialists through surgeon direct consultation, triage by trained staff, and more use of telephone interviews. Early reviews of surgical patients may also help with early identification of those who have barriers to surgery, and provide the potential of offering pre-surgical fitness support to optimize health, nutrition, and activity to improve surgical outcomes. Involving

a patient and family advisor in reviewing options for these programs might also be considered.

The operating room teams have an appropriate mix of trained staff. Recent staffing shortages have been rectified through intensive recruitment and training, leading to a large number of new staff in the department. Those who were interviewed are satisfied with the orientation process.

Priority Process: Competency

Formal performance appraisals are not consistently completed as the organization is in a period of transition. Leadership provides informal feedback and guidance to front-line staff.

Position profiles are generic and not specific to the roles and responsibilities of specific positions in the department. Further development of the profiles is planned.

The surgical teams have a many new staff in the department. This may be an opportunity to evaluate team functioning to establish a baseline from which to evaluate future changes to team design.

Priority Process: Episode of Care

The surgeons at BCHS provide consultation services for emergency and admitted patients. The recently formalized policy on consultations better defines the expectations and timelines for specialists in-house and in the community to respond to consultation requests.

The best possible medication history is completed during the pre-op assessment, often by a pharmacy student, when one is available. Medication reconciliation has been a challenge for the perioperative team, especially at discharge. This is reflected in low rates of compliance on audits. The team recognizes this issue and has begun trialing a new procedure to improve compliance rates, combined with ongoing education and support. Initial results indicate early success with the new process.

In the operating room, the infrastructure supports the flow from non-sterile to sterile. The outer racetrack for patient movement and the inner medical device storage area work well to support the surgical services. There are a few areas with legacy signage and the organization is encouraged to update these to indicate current use and function.

The pre- and postoperative areas are appropriately sized and equipped. The nursing staff composition is a mix of experienced and novice personnel which provides different perspectives. Many of the staff are cross-trained in multiple areas and this provides staffing flexibility for the department.

Formal evaluation of the transition process has been limited. Using data on readmission rates, developing a process for discharge check-in, and using patient surveys specific to transitions may help identify gaps and direct future initiatives.

Priority Process: Decision Support

The preoperative assessment clinic recognizes that incomplete patient information is frequently submitted for surgical bookings, with the result that hospital staff resources are required to track down medical information and diagnostic testing results and obtain signed patient consent forms and other required information. Surgeries are booked before obtaining all required information and this is a patient safety risk. The incomplete submissions are also a systemic risk as they increase the likelihood of late cancellations and unfilled block times which impact the entire community.

The preoperative clinic has standardized a required information checklist to support surgical patient registration. While this is used by some clinicians, incomplete submissions continue to be a frequent occurrence.

Charts that were reviewed contained Do Not Use abbreviations and had unsigned verbal orders beyond 24 hours.

Priority Process: Impact on Outcomes

The surgical team acknowledges a tendency to be late adopters of new techniques and procedures. Patients booked for open versus laparoscopic elective procedures have a longer recovery length of stay and these numbers are becoming less frequent. Regional anaesthesia is also advancing, resulting in better pain management, lower narcotic use, and earlier mobility. Intraprofessional education and mentoring may help team members learn and integrate new skills and procedures to provide patients with a consistent standard of care in accordance with best practice guidelines.

In the preoperative clinic, used guidelines such as Choosing Wisely may help standardize requirements for consultation and investigations. The organization might consider introducing a “pre-habilitation" program for patients awaiting joint replacement, to optimize fitness prior to surgery. It is suggested that patients and families be involved in changing and developing programs.

Priority Process: Medication Management

Medication management in the operating room has been standardized. Multidose vials are minimized and medications are labelled appropriately. Information about medication use is well communicated among the operating room team members.

The anaesthesia team offers a range of sedation and pain medication modalities, as indicated by patient profile and procedure.

The pharmacy manages crash carts and uses a system of cart exchanges that standardizes carts and centrally verifies expiration dates.

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

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

The organization has met all criteria for this priority process.

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

The organization controls the use of laboratory point-of-care testing equipment by assigning each health care professional delivering point-of-care testing with unique identification numbers. The laboratory medical director oversees the program.

Standards Set: Rehabilitation Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.3	Service-specific goals and objectives are developed, with input from clients and families.	
2.3	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.	
2.5	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
Priority Process: Competency		
3.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
15.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
15.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
15.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
15.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

At the Brantford site, rehabilitation services consists of a 25-bed inpatient unit, a 21-bed stroke inpatient unit, a 25-bed complex care unit, and a 21-bed complex and palliative care unit. The physical medicine

specialist and hospitalists provide medical oversight. Neurology consults are available from the regional stroke centre at Hamilton Health Sciences. The physical space is accessible and conducive to effective delivery of rehabilitation services.

At the Willett site, there are 15 activation and restoration beds and 17 alternate level of care beds. The site opened in January 2018 in response to the need for more beds for these populations, and to alleviate some of the flow issues at Brantford General Hospital. The Willett site had not held inpatients for ten years but was selected as the infrastructure was available and the community was very supportive. Initially this expansion was for only six months but funding was extended and it is now part of the BCHS budget.

The Willett site features infrastructure from several eras. The site has been updated and a new roof, air conditioning, and windows have been installed to improve the patient care area. The inpatient unit is in an older area of the building with small patient rooms and bathrooms which present some challenges. There is only one private room. Hallways are narrow and other services such as physiotherapy and occupational therapy are primarily offered in a basement therapy area. While this area is large, bright, and well equipped, the distance from the inpatient area presents some logistical challenges.

Patients do not have access to secure outdoor spaces. The organization is encouraged to consider updating some of the available space for patient use. The unit does not have wifi and patients' access to television is limited to common areas. This limits the types of entertainment and communication that are available, especially on weekends.

The unit is nurse practitioner-led with shared responsibility for coverage and overnight call. Nursing staff comprise a suitable mix of skills with a registered nurse, registered practical nurses, and personal support workers providing direct patient care with support from recreation, occupational and physiotherapy, and pharmacy.

The clinical leaders are well partnered to deliver comprehensive and integrated rehabilitation services to patients and families. Like their teams, they are passionate about patient-focused rehabilitation services and have worked to achieve an appropriate mix of skill level and experience within the team to support safe and effective service delivery.

The team has cultivated many internal and external strategic partnerships, including community therapies, Local Health Integration Network care coordinators, community nursing, long-term care facilities, spinal cord injury services, acquired brain injury services, and mental health services. The service is encouraged to continue to connect with referring hospitals and community service providers to meet the full range of needs of patients and the community, as this is often beyond the capabilities of one team or organization. Strong community partnerships can help patients navigate services across the continuum of care to fill service gaps.

The team is encouraged to develop, in partnership with patients and families, service-specific goals and objectives that are aligned with the organization's strategic direction. These goals and objectives will help inform and focus service planning and delivery efforts.

Priority Process: Competency

The interdisciplinary rehabilitation team includes credentialled professionals in nursing, medicine, physiotherapy, occupational therapy, speech language pathology, and social work.

The team is high functioning and very collaborative in its approach to patient care. It is not unusual to hear staff saying to a colleague, in a meaningful way, “How can I help you?”

New staff are provided with a corporate and program-specific orientation, and there is orientation to the safe use and operation of equipment, devices, and supplies.

Staff report that the IDEA ethics framework and the access to a bioethicist are important resources when making difficult decisions. They also report being supported by their managers and having opportunities for professional development including in-services, research presentations, and conferences.

Strong collaboration and teamwork is a strength of the teams across BCHS. The teams work very interprofessionally with patients and families being the centre of all that they do.

All new hires have a 30-day probationary performance appraisal and leaders have an annual 360 leadership evaluation. However, staff report that they have not have a formal performance review for some time.

Priority Process: Episode of Care

Communication before and at admission is supported by dialogue between referring and receiving physicians and nurses. Ongoing communication with patients and families includes care conferences and family meetings as needed. Communication about changes in the health status of patients with their most responsible physician is effective.

The rehabilitation team actively engages with community partners to ensure seamless transfers and discharges. The team partners with patients and families to share information about their care and how to respond to changes in their medical and/or rehabilitation process.

Medication reconciliation is thorough and consistently completed at care transitions. Discrepancies are followed up and reviewed. The clinical educator works in close collaboration with the manager and team lead to ensure infusion pump training and competency.

Care plans are individualized and goals are driven by patients. Whiteboards in patient rooms reinforce goals and time frames, and serve as an additional communication tool between staff. Care transitions are carefully planned. Individualized patient goals are developed with the patients and the team discusses and documents progress on a regular basis.

Care rounds and documentation are comprehensive.

Patients indicate that they receive excellent written information that is easy to understand.

Staff appear well supported and able to advocate for the patients. They find they have a receptive ear in management. Collectively, this supports a good work environment.

Coordination of care, although not without its challenges in specific case situations, is by and large seamless.

Priority Process: Decision Support

All staff are required to complete mandatory e-learning on privacy and confidentiality. All rehabilitation areas have a hybrid system of documentation that includes electronic and paper-based charting.

Following the circle of care, and while respecting patients' rights to privacy and with patients' consent, information is shared as required to facilitate a patient-centred approach to service delivery. Patients are also involved in sharing information such as sharing their medications list and providing a discharge summary to appropriate providers.

All documentation that was reviewed appears to follow safe abbreviations when documenting, as per the BCHS policy for documentation.

Implementing one electronic record would mitigate the inefficiencies that arise when staff need to look in two places for patient information. It would also address the risk of missing important information.

Priority Process: Impact on Outcomes

The team incorporates evidence-based practice guidelines into care delivery. Order sets, care maps, and treatment protocols are in use. Processes are in place to select and review practice guidelines with the involvement of the broader team. Daily huddles and discharge rounds provide opportunities for information exchange and discussion related to safety concerns. Team members are familiar with the incident reporting system and feel comfortable reporting.

The patient and family advisor for rehabilitation is a long-time volunteer and prior patient of the stroke program. The advisor makes rounds to speak with patients and offer hope. The advisor has not been asked to provide feedback on quality improvement initiatives, policies, procedures, or design options.

Information about quality improvement activities, results, and learnings has not been widely shared. This was also identified in the last accreditation on-site survey.

Standards Set: Transfusion Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Transfusion Services	
The organization has met all criteria for this priority process.	
Surveyor comments on the priority process(es)	
Priority Process: Episode of Care	
Transfusion services uses the organization's electronic falls prevention program.	
Priority Process: Transfusion Services	
The laboratory has a process to identify the recipient when there are urgent requests for blood and the recipient's identity is unknown. The laboratory has a well-established recall procedure for blood and blood by-products. Transfusion services has standard operating procedures and annual goals and objectives for the service. All staff have been provided with the necessary training and education on the standard operating procedures and this has improved quality and safety and decreased risk in the laboratory and in service delivery. Nursing staff are well educated on the procedure to administer blood and/or blood products to patients in the patient care areas. They are responsible for obtaining patient consent, as validated by the critical care unit.	

Instrument Results

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

Governance Functioning Tool (2016)

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

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

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

- **Data collection period: September 16, 2019 to October 22, 2019**
- **Number of responses: 10**

Governance Functioning Tool Results

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1. We regularly review and ensure compliance with applicable laws, legislation, and regulations.	0	0	100	93
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	0	0	100	94
3. Subcommittees need better defined roles and responsibilities.	70	10	20	72
4. As a governing body, we do not become directly involved in management issues.	10	0	90	88
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	96

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
6. Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	96
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	0	100	95
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	0	0	100	95
9. Our governance processes need to better ensure that everyone participates in decision making.	30	60	10	63
10. The composition of our governing body contributes to strong governance and leadership performance.	0	0	100	94
11. Individual members ask for and listen to one another's ideas and input.	0	0	100	97
12. Our ongoing education and professional development is encouraged.	0	0	100	86
13. Working relationships among individual members are positive.	0	0	100	97
14. We have a process to set bylaws and corporate policies.	0	20	80	95
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	97
16. We benchmark our performance against other similar organizations and/or national standards.	0	30	70	73
17. Contributions of individual members are reviewed regularly.	0	44	56	66
18. As a team, we regularly review how we function together and how our governance processes could be improved.	0	11	89	76
19. There is a process for improving individual effectiveness when non-performance is an issue.	10	40	50	60
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	0	10	90	82

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
21. As individual members, we need better feedback about our contribution to the governing body.	11	78	11	45
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	0	10	90	80
23. As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	96
24. As a governing body, we hear stories about clients who experienced harm during care.	0	0	100	79
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	0	10	90	89
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	0	25	75	87
27. We lack explicit criteria to recruit and select new members.	33	67	0	73
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	0	10	90	88
29. The composition of our governing body allows us to meet stakeholder and community needs.	0	0	100	90
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	91
31. We review our own structure, including size and subcommittee structure.	0	10	90	86
32. We have a process to elect or appoint our chair.	0	0	100	89

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2019 and agreed with the instrument items.

Overall, what is your assessment of the governing body's impact over the past 12 months, in terms of driving improvements to:	% Poor / Fair	% Good	% Very Good / Excellent	%Agree * Canadian Average
	Organization	Organization	Organization	
33. Patient safety	0	0	100	80
34. Quality of care	0	0	100	82

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2019 and agreed with the instrument items.

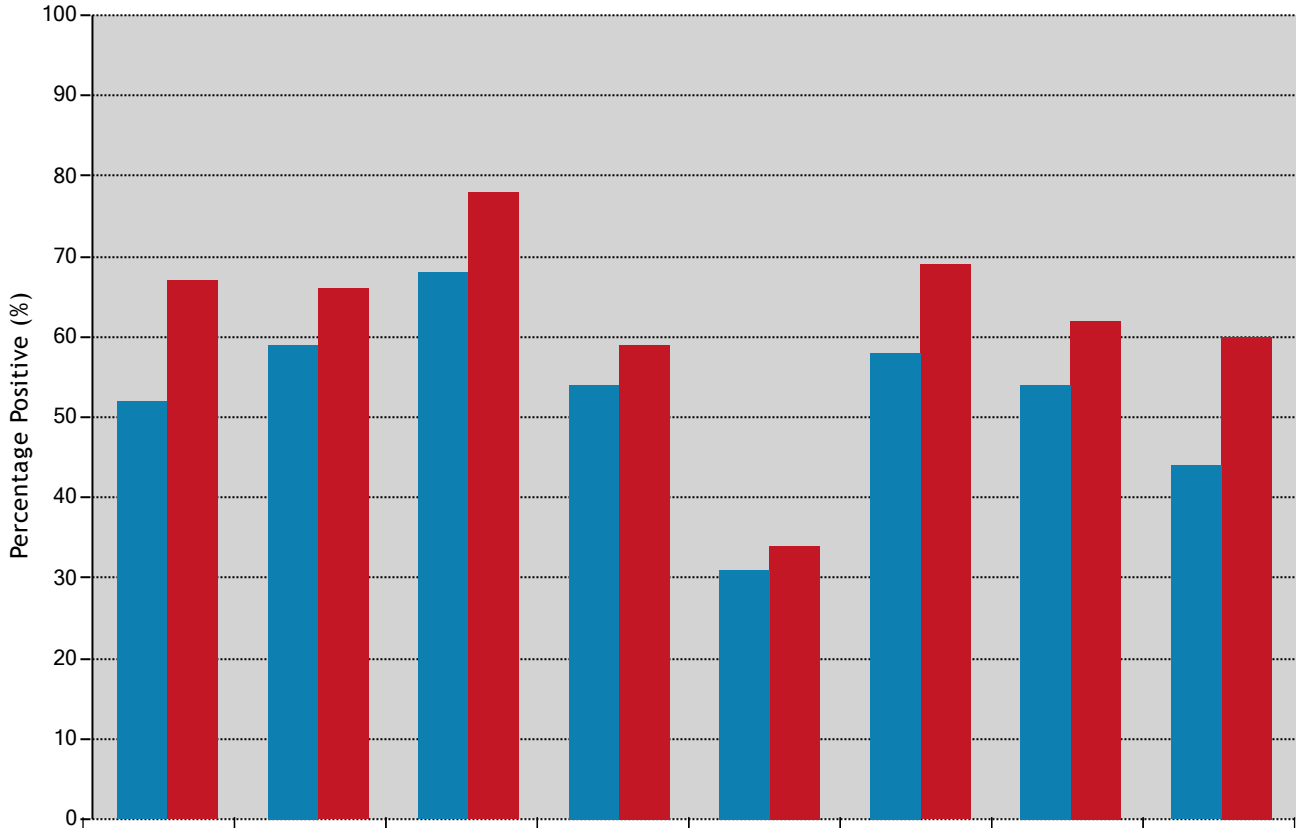
Canadian Patient Safety Culture Survey Tool

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

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

- **Data collection period: February 15, 2019 to March 4, 2019**
- **Minimum responses rate (based on the number of eligible employees): 299**
- **Number of responses: 700**

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



	Organizational (senior) leadership support for safety	Supervisory leadership for safety	Unit learning culture	Enabling Open Communication I: judgment-free environment	Enabling Open Communication II: job repercussions of error	Incident follow up	Stand-alone items	Overall Perceptions of Client Safety
	52%	59%	68%	54%	31%	58%	54%	44%
	67%	66%	78%	59%	34%	69%	62%	60%

Legend

Brant Community Healthcare System

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2019 and agreed with the instrument items.

Worklife Pulse

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

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

The organization used an approved substitute tool for measuring quality of Worklife. The organization has provided Accreditation Canada with results from its substitute tool and had the opportunity to identify strengths and address areas for improvement. During the on-site survey, surveyors reviewed actions the organization has taken.

Client Experience Tool

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

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

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

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

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

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

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

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

Organization's Commentary

After the on-site survey, the organization was invited provide comments to be included in this report about its experience with Qmentum and the accreditation process.

The Brant Community Healthcare System would like to thank the surveyors for assisting our organization in identifying what we are doing well and where we need to focus our improvement ideas. Accreditation is an important part of the BCHS quality improvement journey and will continue to be a platform we use to measure against as we move forward. As an organization we collectively demonstrated that BCHS is committed to quality and safety in our healthcare delivery, and for this we are very proud.

As an organization, our next steps will be to develop a work plan based on the recommendations within the Accreditation report that incorporate timelines and accountabilities. Through our strategic planning process, we have heard that BCHS needs to always be "Accreditation-Ready." Being Accreditation-Ready is a key outcome as we embark upon our 2020-2025 strategic plan. As an organization we are fully committed to ensuring that we do not lose this focus as we continue our hard work and dedication to improving quality and patient safety at the Brant Community Healthcare System.

Appendix A - Qmentum

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

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

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

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

Action Planning

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

Appendix B - Priority Processes

Priority processes associated with system-wide standards

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