ACCREDITATION CANADA



Driving Quality Health Services

Accreditation Report

Brant Community Healthcare System

Brantford, ON

On-site survey dates: February 23, 2015 - February 27, 2015

Report issued: March 13, 2015

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AGRÉMENT CANADA

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

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

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

Confidentiality

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

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

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

A Message from Accreditation Canada's President and CEO

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

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

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

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

We look forward to our continued partnership.

Sincerely,

Wendy Nicklin
President and Chief Executive Officer

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Section 1 Executive Summary

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.

1.1 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.

1.2 About the On-site Survey

- **On-site survey dates: February 23, 2015 to February 27, 2015**

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

  Service Excellence Standards

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

- **Instruments**

  The organization administered:

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

1.3 Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
 Population Focus (Work with my community to anticipate and meet our needs)	60	6	0	66
 Accessibility (Give me timely and equitable services)	87	4	0	91
 Safety (Keep me safe)	580	25	18	623
 Worklife (Take care of those who take care of me)	135	4	1	140
 Client-centred Services (Partner with me and my family in our care)	177	4	0	181
 Continuity of Services (Coordinate my care across the continuum)	61	1	2	64
 Appropriateness (Do the right thing to achieve the best results)	893	53	8	954
 Efficiency (Make the best use of resources)	68	1	0	69
Total	**2061**	**98**	**29**	**2188**

1.4 Overview by Standards

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

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

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

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

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	42 (100.0%)	0 (0.0%)	0	32 (100.0%)	0 (0.0%)	0	74 (100.0%)	0 (0.0%)	0
Leadership	45 (97.8%)	1 (2.2%)	0	82 (96.5%)	3 (3.5%)	0	127 (96.9%)	4 (3.1%)	0
Infection Prevention and Control Standards	39 (95.1%)	2 (4.9%)	0	26 (89.7%)	3 (10.3%)	2	65 (92.9%)	5 (7.1%)	2
Medication Management Standards	70 (97.2%)	2 (2.8%)	6	59 (100.0%)	0 (0.0%)	5	129 (98.5%)	2 (1.5%)	11
Ambulatory Care Services	37 (94.9%)	2 (5.1%)	3	67 (87.0%)	10 (13.0%)	0	104 (89.7%)	12 (10.3%)	3
Biomedical Laboratory Services **	70 (98.6%)	1 (1.4%)	0	103 (100.0%)	0 (0.0%)	0	173 (99.4%)	1 (0.6%)	0
Critical Care	34 (100.0%)	0 (0.0%)	0	91 (95.8%)	4 (4.2%)	0	125 (96.9%)	4 (3.1%)	0
Diagnostic Imaging Services	65 (97.0%)	2 (3.0%)	0	67 (100.0%)	0 (0.0%)	1	132 (98.5%)	2 (1.5%)	1
Emergency Department	43 (91.5%)	4 (8.5%)	0	78 (97.5%)	2 (2.5%)	0	121 (95.3%)	6 (4.7%)	0

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Medicine Services	24 (77.4%)	7 (22.6%)	0	54 (76.1%)	17 (23.9%)	0	78 (76.5%)	24 (23.5%)	0
Mental Health Services	31 (86.1%)	5 (13.9%)	0	77 (87.5%)	11 (12.5%)	0	108 (87.1%)	16 (12.9%)	0
Obstetrics Services	60 (98.4%)	1 (1.6%)	3	79 (98.8%)	1 (1.3%)	0	139 (98.6%)	2 (1.4%)	3
Perioperative Services and Invasive Procedures Standards	99 (99.0%)	1 (1.0%)	0	87 (98.9%)	1 (1.1%)	0	186 (98.9%)	2 (1.1%)	0
Point-of-Care Testing **	38 (100.0%)	0 (0.0%)	0	48 (100.0%)	0 (0.0%)	0	86 (100.0%)	0 (0.0%)	0
Rehabilitation Services	31 (100.0%)	0 (0.0%)	0	66 (94.3%)	4 (5.7%)	0	97 (96.0%)	4 (4.0%)	0
Reprocessing and Sterilization of Reusable Medical Devices	51 (98.1%)	1 (1.9%)	1	61 (100.0%)	0 (0.0%)	2	112 (99.1%)	1 (0.9%)	3
Transfusion Services **	70 (100.0%)	0 (0.0%)	5	66 (100.0%)	0 (0.0%)	1	136 (100.0%)	0 (0.0%)	6
Total	**849 (96.7%)**	29 (3.3%)	18	1143 (95.3%)	56 (4.7%)	11	1992 (95.9%)	85 (4.1%)	29

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

1.5 Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client And Family Role In Safety (Perioperative Services and Invasive Procedures Standards)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Rehabilitation Services)	Met	2 of 2	0 of 0
Dangerous Abbreviations (Medication Management Standards)	Met	4 of 4	3 of 3
Information Transfer (Ambulatory Care Services)	Met	2 of 2	0 of 0
Information Transfer (Critical Care)	Met	2 of 2	0 of 0
Information Transfer (Emergency Department)	Met	2 of 2	0 of 0
Information Transfer (Medicine Services)	Met	2 of 2	0 of 0
Information Transfer (Mental Health Services)	Met	2 of 2	0 of 0
Information Transfer (Obstetrics Services)	Met	2 of 2	0 of 0
Information Transfer (Rehabilitation Services)	Met	2 of 2	0 of 0
Medication reconciliation as a strategic priority (Leadership)	Unmet	4 of 4	1 of 2
Medication reconciliation at care transitions (Ambulatory Care Services)	Unmet	2 of 7	0 of 0
Medication reconciliation at care transitions (Critical Care)	Unmet	4 of 5	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Emergency Department)	Unmet	1 of 5	0 of 0
Medication reconciliation at care transitions (Medicine Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Mental Health Services)	Unmet	3 of 5	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Unmet	4 of 5	0 of 0
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures Standards)	Unmet	2 of 7	0 of 0
Medication reconciliation at care transitions (Rehabilitation Services)	Met	5 of 5	0 of 0
Safe Surgery Checklist (Obstetrics Services)	Met	3 of 3	2 of 2
Safe Surgery Checklist (Perioperative Services and Invasive Procedures Standards)	Met	3 of 3	2 of 2
Two Client Identifiers (Ambulatory Care Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Biomedical Laboratory Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Critical Care)	Met	1 of 1	0 of 0
Two Client Identifiers (Diagnostic Imaging Services)	Met	1 of 1	0 of 0

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

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

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: Falls Prevention			
Falls Prevention Strategy (Ambulatory Care Services)	Unmet	1 of 3	0 of 2
Falls Prevention Strategy (Diagnostic Imaging Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Emergency Department)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Medicine Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Mental Health Services)	Unmet	3 of 3	0 of 2
Falls Prevention Strategy (Obstetrics Services)	Unmet	0 of 3	0 of 2
Falls Prevention Strategy (Perioperative Services and Invasive Procedures Standards)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Rehabilitation Services)	Met	3 of 3	2 of 2
Patient Safety Goal Area: Risk Assessment			
Pressure Ulcer Prevention (Critical Care)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Medicine Services)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Pressure Ulcer Prevention (Perioperative Services and Invasive Procedures Standards)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Rehabilitation Services)	Met	3 of 3	2 of 2
Suicide Prevention (Mental Health Services)	Met	5 of 5	0 of 0
Venous Thromboembolism Prophylaxis (Critical Care)	Unmet	3 of 3	1 of 2
Venous Thromboembolism Prophylaxis (Medicine Services)	Unmet	3 of 3	1 of 2
Venous Thromboembolism Prophylaxis (Perioperative Services and Invasive Procedures Standards)	Unmet	3 of 3	1 of 2

1.6 Summary of Surveyor Team Observations

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

The organization, Brant Community Healthcare System is commended on preparing for and participating in the Qmentum survey program. Since the last survey visit from Accreditation Canada the Brant Community Healthcare System has embarked on a major system transformation initiative using Lean methodologies and tools. This initiative has involved a significant re-working of the organizational chart, with programs and services defined as value streams, and the management team is aligned with the value streams headed by Value Stream Leaders.

The organization has embarked on a rigorous process of defining its mission, vision, values, goals, and objectives, along with a strategic deployment plan that articulates indicators with supporting metrics for each of the value streams. There is a visual management system in place to facilitate regular reporting and discussion about performance at regular intervals throughout a reporting period. This major system transformation is fully supported by the board. The organization is early on in its transitional journey so there is still opportunity to work on facilitating meaningful dialogue at the unit level. It is suggested that huddle boards be aligned with organization-wide metrics and also display current data that resonates with point-of-care staff on a daily basis.

The system transformation is clearly focused on the development of a coordinated continuum of care that engages patients, improves quality, and assures staff members that Brant Community Healthcare System is a great place to work. All of this is summarized in plain language in the organization's True North statement.

During the on-site survey a comprehensive and well-attended community partner focus group validated that there are strong community partnerships amongst stakeholders in the catchment area. The partners define the organization as one that acknowledges and is open to improvement and strengthening of relationships for the benefit of clients. There are many specific ideas and initiatives about improved Aboriginal partnerships, police wait-times in emergency, strengthening of connections for mental health and addiction services, and shared "back-room" services to gain efficiencies of scale. Partners describe the relationships as ones that have improved exponentially in recent years. They attribute this to the open, inclusive and non-threatening approach of the current board and administration of the organization.

Noteworthy is the work that has been done on the development of a simply worded, visual, comprehensive and practical ethics framework. The framework includes a practical and well-defined consultation process for education and consultation. This good work does need more promotion and communication so that internal and external users of the system are aware of the added value it can bring to the consumer and patient experience and staff.

There is significant evidence of gains made using Lean methodologies. The implementation of Kanban inventory systems in the operating room (OR) and then spreading to other areas is one example of how cost savings can be an added benefit of a quality improvement initiative. This is a great demonstration of how waste is identified and eliminated. Other examples are in evidence including an initiative to reduce the cycle time from the close of a job competition to the time that an offer is made.

There is an online tool that can be used to organize patient and family education in a structured way. Evidence is present across the organization of efforts to provide patient-centred education that encourages individual responsibility and solid discharge planning.

Section 2 Detailed Required Organizational Practices Results

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

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

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Communication	
Medication reconciliation as a strategic priority The organization has a strategy to partner with clients/residents to collect accurate and complete information about client/resident medications and utilize this information during transitions of care. NOTE: Accreditation Canada will move towards full implementation of medication reconciliation in two phases." For on-site surveys between 2014 and 2017, medication reconciliation should be implemented in ONE service (or program) that uses a Qmentum standard containing the Medication Reconciliation at Care Transitions ROP. Medication reconciliation should be implemented as per the tests for compliance for each ROP." For on-site surveys in 2018 and beyond, medication reconciliation should be implemented in ALL services (or programs) that use Qmentum standards containing the Medication Reconciliation at Care Transitions ROP. Medication reconciliation should be implemented as per the tests for compliance for each ROP.	· Leadership 15.8
Medication reconciliation at care transitions With the involvement of the client, family, or caregiver (as appropriate), the team generates a Best Possible Medication History (BPMH) and uses it to reconcile client medications at transitions of care.	· Mental Health Services 10.6 · Critical Care 7.7 · Ambulatory Care Services 8.4 · Perioperative Services and Invasive Procedures Standards 8.4 · Emergency Department 9.3 · Obstetrics Services 9.6
Patient Safety Goal Area: Falls Prevention	
Falls Prevention Strategy The team implements and evaluates a falls prevention strategy to minimize client injury from falls.	· Mental Health Services 16.5 · Ambulatory Care Services 17.2 · Obstetrics Services 18.2

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Risk Assessment	
Venous Thromboembolism Prophylaxis The team identifies clients at risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) and provides appropriate thromboprophylaxis.	· Medicine Services 7.4 · Critical Care 7.5 · Perioperative Services and Invasive Procedures Standards 8.9

Section 3 Detailed On-site Survey Results

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

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

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

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

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

See Appendix B for a list of priority processes.

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

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

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

3.1 Priority Process Results for System-wide Standards

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

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

3.1.1 Priority Process: Governance

Meeting the demands for excellence in governance practice.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization has an engaged and active board which uses a skills matrix and a public process to support recruitment of new members. Terms are limited to three terms of three years. Board members are actively engaged in working committees that work with administrative and clinical staff to maintain currency in the business of the organization. Results and recommendations from committee work are brought to the whole board for consideration and decision making. There is evidence that this is a rigorous process whereby recommendations can be returned to committees for revision if there is no consensus at the board level.

The board is engaged in ongoing work to build and refresh the strategic plan. During the past few years the board has supported a major system transformation effort using Lean methodologies. The board was brought up to speed on Lean and other lessons learned from private industry high-performing organizations. The board is well-informed, visible, and highly supportive of the chief executive officer (CEO) and the transformation initiatives that are underway.

By way of the committees the board is routinely informed of current and projected financials, risks, incidents, and other pertinent information. Consistent with visual management tools now being used in the organization the board has a huddle board that members routinely gather at to review metrics and discuss progress and planned corrective actions around progress toward achievement of system goals and objectives.

3.1.2 Priority Process: Planning and Service Design

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization is guided by its True North statement and a set of cascading indicators that define the initiatives that it will take to achieve the vision. The guiding statements are values based and driven by the current political and fiscal environment. These are regularly monitored using a process of visual management and supported by metrics that have been chosen to show progress. Indicators are timely and measurable. The board, senior leadership team and value stream leaders are well-versed in the province's current and future funding model for health care, and how it is tied to a set of quality indicators that are non-negotiable except in terms of how much focus the organization may choose to place on particular priorities out of a set of seven.

There is abundant evidence that the leadership team has committed to embracing change and taking bold steps to implement a structure and plans that position the organization as a key player in the service delivery model to the catchment area. This has included pro-active partnerships with other health care facilitators in the area and community based providers. Thirteen community partners that were interviewed say they experience a co-operative and productive relationship with this organization. There are partnerships designed to improve the patient experience along the continuum of care. These partnerships look to eliminate waste associated with wait times for patients and community providers such as police hung-up in emergency, to improve patient relations with specific groups such as Aboriginal health partners and to take advantage of the opportunities associated with shared services. Community partners did indicate that lines of communication are open and that opportunities for improvement are many.

The physical plant presents significant challenges to the delivery of services however, it appears to be clean and well maintained. The organization recently completed the beginning of a master development plan that can be used as a guide to take advantage of any opportunities that arise to fund replacement and renovation initiatives in a challenging fiscal environment.

Provincially driven funding initiatives such as quality-based procedures are driving the organization to be specific when defining the business that it is in and to develop its business plan accordingly. The organization is encouraged to continue to use its visibility management mechanisms to engage people at all levels across the organization in defining those services that are and are not provided, and in helping the organization to improve its metrics.

The leaders are well aware that change fatigue is a factor that may impact staff engagement scores. Nevertheless, the fiscal and political environment dictates the need for major transformational change if the Brant Community Healthcare System is to remain a key player in the catchment area, including being seen as a credible organization that demonstrates transparency and accountability. To this end, the organization has embraced Lean methods to engage in strategy deployment.

The development of value streams and a supporting organizational structure pushes leadership to make connections between episodes of care from the patients' point of view. It also challenges the organization to choose and commit resources to specific indicators that are visible inside and outside the organization. While

the demonstration of transparency, public accountability and pro-active stance on community partnerships in recent years has been unsettling for people with seniority in the organization, the ideas and initiatives enacted are viewed as the right thing to do if Brant Community Healthcare System is to be viewed as a high performing healthcare organization with a future.

3.1.3 Priority Process: Resource Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization describes a scheduled process for budget development and monitoring following an annual reporting cycle. There is evidence that consultation occurs between financial advisors and value stream Group Leaders to develop the budget and to do variance reporting on a regular basis. It is evident that there is room to improve the process by which consultation occurs with cost centre Group Leaders, particularly when targets are not clear or not being met at the unit level.

The corporate resources committee of the board is actively engaged. Financial reporting is done at the board level every two months. One of the discussions that is currently happening is around how to more accurately forecast financial target outcomes. The finance value stream leader is looking at historical information as a predictor of future outcomes which is one indicator of future outcomes. However, it is suggested that with the Lean methodologies that have been adopted, the organization needs to become more aggressive at selecting, monitoring and reporting on specific stretch targets it is trying to achieve. Then, the organization needs to require Group Leaders and staff right down to the unit level to talk about progress at their visibility walls and problem solve corrective actions where the work is being done and the money is being spent. At this time in the transition journey it is evident that the metrics on the huddle walls are too high a level to resonate with point-of-care staff. Perhaps this information is equally important to unit level metrics, but it might be more effective to show both and the alignment between all levels in the organization. There is opportunity using staff engagement to promote ownership for the organization's fiscal challenges and opportunities at the unit level.

The value stream leader model is relatively new at Brant Community Healthcare System. Leaders can benefit from education and support to build their expertise at matching indicator selection and metric monitoring to fiscal priorities. It is noted that some financial management training has been provided. Part of the challenge is to move from what one value stream leader described as: "always wanting to solve problems by throwing more resource at it", and move to gaining efficiency and realizing the benefit of identifying and eliminating waste.

The resource management participants identified a number of initiatives that the organization has undertaken to make better use of resources. These include: leave and attendance management and disability management and employing non-registered staff in areas where they have traditionally not been utilized. In the current healthcare environment where a large percentage of clients in acute care are the same clientele that might be seen in long-term care, ensuring that staff members work to their full scope of practice makes a world of good sense. Also, there was some mention of a practice of allowing staff members to accumulate lieu time as a less expensive option than paying overtime wages however, this creates a similar liability that eventually has to be paid.

3.1.4 Priority Process: Human Capital

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

There is abundant evidence that the human resources (HR) team has embraced system transformation, and has aligned the value stream to focus on service excellence to the employees of the organization. There is a robust volunteer program, employee health service, occupational health and safety service, recruitment and retention program and labour relations component. The personnel file review during the on-site survey demonstrates that records are well maintained, kept secure and confidential and contain records of essential procedures such as reference checking, standardized interviews, performance review, letters of offer, and so on.

The organization reports an 80% completion rate on performance reviews in its most recent reporting period. However, anecdotally the line group leaders and employees either do not feel that they are current or that the process is useful. There is an expectation that a number of steps occur at least every second year, including self-assessment, supervisor assessment and exchange of information. There is a designated individual in HR that monitors and reminds group leaders when appraisals are due.

The human resources team participates in the organization's strategic employment program by identifying pressures and planning work around objectives that are aligned with the priorities of the organization and its funders. The emerging leaders program is one example of the effort to build competency and do succession planning within the organization. This is also an example of an effective partnership with the Foundation.

There is evidence of a focus on a safety culture across the organization. The respectful workplace policy deals with the range of issues related to violence in the workplace. The occupational health and safety program maintains a focus on data collection and analysis that drives decision making around improvement initiatives. One notable piece of data indicated that 60% of incident reports received had identified minor injuries. This is seen as an indication that staff members understand the importance of reporting and analysis to maintain a culture of safety. There is a "hurt-line" that employees can call to report an incident 24/7.

There is a robust employee health program that new employees are introduced to upon hire and a return-to-work program that kicks in almost immediately when an incident occurs. There is an attendance management program in place to support group leaders and employees to monitor and engage employees that demonstrate a pattern of sick leave use. The program can either focus on supports the organization can offer to employees with health issues, or it can focus on corrective actions that may be in order.

There is evidence that the value stream is fully engaged in the system transformation and strategic deployment plan. There is an HR huddle board with metrics and HR staff described specific examples of their involvement in improvement initiatives. An initiative to reduce cycle time from the close of a job competition to job offer was described.

There is a current strategic people plan in place that includes planning for employee and physician human resources.

3.1.5 Priority Process: Integrated Quality Management

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
12.5	The organization's leaders evaluate the effectiveness of the integrated risk management approach and make improvements as necessary.	
15.8	The organization has a strategy to partner with clients/residents to collect accurate and complete information about client/resident medications and utilize this information during transitions of care. NOTE: Accreditation Canada will move towards full implementation of medication reconciliation in two phases. • For on-site surveys between 2014 and 2017, medication reconciliation should be implemented in ONE service (or program) that uses a Qmentum standard containing the Medication Reconciliation at Care Transitions ROP. Medication reconciliation should be implemented as per the tests for compliance for each ROP. • For on-site surveys in 2018 and beyond, medication reconciliation should be implemented in ALL services (or programs) that use Qmentum standards containing the Medication Reconciliation at Care Transitions ROP. Medication reconciliation should be implemented as per the tests for compliance for each ROP.	ROP
15.8.6	The organization monitors compliance with the medication reconciliation process, and makes improvements when required.	**MINOR**
Surveyor comments on the priority process(es)		

The organization has a robust quality improvement plan in place. The quality framework flows from the strategic deployment plan. In recent years the organization has realigned its management structure to reflect the major value streams. These are the categories of administrative and clinical work that is done.

There is a quality committee of the board and an operational quality committee that lead strategic and operational planning. The work is guided by the organization's major strategic statement referenced to as True North. The True North statement is that the Brant Community Healthcare System will put the patient first, be a great place to work, and use resources wisely.

The organization is making significant efforts to use data to support decision making. There is good capacity to collect and collate data into management reports because the organization has been pro-active in building its information technology (IT) capacity. Using a system of visual management there is evidence of efforts to make decisions based on what the data says on the huddle boards that are in place across the organization. Although there is a lot of work to be done to ensure that the information and the process resonate at the

point-of-care, progress has been made and there is messaging that this highly visible process for engagement and accountability will endure.

The surveyor team was able to see the organization's enduring and shorter term priorities posted on the senior leadership team (SLT) huddle board at the beginning of the on-site survey. It was then possible to discuss progress with group leaders and staff at huddle boards across the organization. There is variation in engagement, participation in huddles, meaningfulness of data to point-of-care staff, and updating of data in the units. This is reflective of the early stages of implementing the transformation journey. The initiative to date is commendable and should lead to improved engagement scores as units are able to take better ownership of the metrics and huddle processes in their individual units.

The organization is able to report significant progress in terms of its ability to see cost savings by way of elimination of waste leading to improved quality with its new way of doing business. One concrete example has been the implementation of Kanban to introduce just-in-time inventory and eliminate losses from expiring products. This was first applied in the operating rooms and is now spreading across the organization.

There is a quality improvement plan in place which in part is because of mandatory reporting requirements in the province of Ontario. The organization is required to choose indicators from a specific list of seven set by Health Quality Ontario. There is a 'pay at risk' component associated with this plan. There is pressure on the organization to develop metrics that resonate well with staff and physicians while also meeting the specific requirements of the Local Health Integrated Network (LHIN) and the province.
Engagement of the point-of-care staff members is critical to success however, there is a sense of change fatigue. Plus, there are challenges with implementing change from the top down. There is evidence that the Brant Community Healthcare System is embracing the challenges, making proactive changes to ensure sustainability, and seeking partnerships that improve patient care by integrating programs for patients within the catchment area. A large group of community partners spoke highly of the proactive work of the current board and administration, and welcome partnerships that improve continuity of care from the patient perspective.

There is a recently developed risk management framework that is visible and easy to understand. It outlines the four main areas of risk. The organization is preparing to use the Marsh framework as its ongoing mechanism for formally assessing risk.

3.1.6 Priority Process: Principle-based Care and Decision Making

Identifying and decision making regarding ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Principle-based care and decision making is driven by a committee of the board whose members are engaged and highly motivated. There is evidence that the organization has developed tools and mechanisms that are designed to educate people and let staff and consumers know about ethics and how ethical decision-making can be facilitated here. It is notable that the committee prints the ethics framework on the back of all board agendas to keep ethics front and centre where important decisions are being made.

The organization has engaged the services of a physician ethicist that is providing service to facilities and services in the broader catchment area. There is an ethics framework in place. It is notable that the work that has been done in this area focuses on making ethics awareness and ethical consultation both practical and accessible to people that find themselves in a potentially ethical dilemma. Specifically, the organization has come up with an "ideas framework" that is visual and invites the participant to participate in the discussion about how conflicting values and ideas can lead to practices that do not feel right to people that are looking at a situation from different perspectives. The ethicist describes it as: "how to have a conversation with a person who is not like you". One example of the practical application of the model included an intervention to support a care giver providing life prolonging intervention that may not add to the quality life of an elderly client.

There is a separate research ethics committed that specifically reviews and approves research proposals in the organization. This committee is heavily weighted with physician and legal representation because it often involves clinical trials. Feedback from staff organization-wide indicates the need for ongoing education and awareness of this work.

3.1.7 Priority Process: Communication

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Since the organization's previous survey it has refreshed both the communication and E-Health strategic plans. The most recent survey on staff engagement highlighted that Brant Community Healthcare System had a number of key areas where improvements could be made. These include: Alignment with Mission and True North, Organizational Communication, Communication in Your Value Stream, Continuous Improvements and Satisfaction with Senior Leadership. Analysis and action planning has been undertaken to address the scores. Numerous communication vehicles from huddle boards to newsletters and departmental/corporate emails and memos are in place, and have been revised to provide more value. The website has been redesigned based on feedback to provide emergency department (ED) wait times and to become more user-friendly. It is being evaluated regularly and content is changed in response. The redesign has resulted in a significant reduction in calls to both the ED and switchboard. The organization uses social media and its use appears to be increasing. It has been used to successfully influence vendor behaviour in accelerating upgrade changes at Brant Community Healthcare System (BCHS).

An independent firm conducted a communications audit in 2013 to assess BCHS's external communications against best practices. The organization subsequently developed documents entitled: "Large Scale Crisis Communication Plan; Short Term Crisis Considerations and Resources" which it has further refined based on actual experience in a highly public disclosure situation. The handling of the disclosure has enhanced the organization's reputation as being transparent and accountable.

The engagement and community partnership value stream has introduced the Change Leadership Toolkit and resources on the VSNet Share Point page to help with consistent and effective communication planning and execution.

Significant work has been undertaken on the E-Health front to move it from a "die or fry" approach to computer technology refresh and one-off, best-of-breed application adoption. There has been a major infrastructure upgrade since the previous survey, with new servers, new computer room, new firewall and environmental safeguards allowing for both increased capacity and redundancy. The team is aware of what the current risks and gaps are to be worked on and mitigated. Examples are firewalls; single sign-on passwords; new applications to be in introduced like computerized physician order entry (CPOE), and a suite of MD clinical applications have been purchased and are to be implemented by 2016.

Policies and procedures are in place to address security and confidentiality of information. A business intelligence application is a recent introduction in the organization, and all leaders have been trained in its use. Encouragement is offered to provide ongoing training in and monitoring of the adoption of this application and others already in use here obtain full value. The existing E-Health strategic plan requires further revision and update to reflect the current and future anticipated state of the art on priority projects to be undertaken. The teams' deliverables over the past three years has been impressive. Continued collaboration and upfront work flow planning in advance of applications being introduced by clinical and IT staff is encouraged.

The work being done to support the Brant Six Nations Health Link is noteworthy. The pilot care coordination solution that has been designed to allow for seamless handing-off of care may prove to be an innovation to be shared with the field once tested and proven.

There is access to library resources and evidence-based practice guidelines.

Switchboard staff members have been trained to multi-task on many activities including assisting with Help Desk inquiries during the off-shift hours.

Partnerships and effective working relationships are in place with organizations such as: Landsdowne Children's Centre; Grand River Community Health Centre; Brant County Health Unit; Hamilton Health Sciences; McMaster University; and Niagara Haldimand Brant Local Health Integration Network, as well as others.

Corporate communications cover both campuses and are encouraged to continue obtaining input and providing the requisite communications and public relations support to both sites. The Willet site does not have the degree of technology installed as is installed at the Brantford site campus as its paper-based systems meet the current needs. The Willet site requirements need to be assessed on an ongoing basis and reflected in any updated E-Health strategic plans.

3.1.8 Priority Process: Physical Environment

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
9.2 The organization's leaders protect client and staff health and safety at all times and particularly during periods of construction or renovation.	

Surveyor comments on the priority process(es)

The surveyor team visited both the Brantford General Hospital and Willet Community Hospital sites. During the tracer activity at Brantford environmental services, the food services and a construction area namely third floor redevelopment were visited.

Environmental staff members spoken with were familiar with codes and able to describe a recent code brown spill involving hydraulic fluid from a waste compacter. Staff members described their orientation training, occupational health assessment including vaccination and the response in the event of a needle stick injury.

Some minor deficiencies were noted during the kitchen tracer. The kitchen is inspected by Public Health and the last inspection report was reviewed. Action had been taken on the issue of pigeons roosting near a window that can be opened and which is next to the cart washing area. There was a spill or leakage in the organic waste holding area. In the frozen food cooler, food boxes were stored directly on the floor. Coolers are alarmed and monitoring records were available. Food temperature audits are carried out. The cart washing area had some debris around the drain.

The construction area was enclosed with no access by patients or the public. Negative pressure monitors were present for the ante room and the construction area. Appropriate protective equipment was observed for the contract construction workers. Construction workers receive orientation to the organization's policies and procedures including codes. For the construction area when workers are not present, security does hourly fire checks as sensors are not functional, although the sprinkler system is still operational.

The organization has an active preventive maintenance (PM) system that it will be updating after the on-site accreditation visit. Compliance with the PM schedule is tracked. The most recent data show completion at only 50%. This is because some of the equipment identified for maintenance is no longer available or in use, or maintenance staff are unable to access patient care areas to do the maintenance because of occupancy and bed demand requirements. The new PM system will allow the team to generate more accurate information by allowing the team to remove items that are no longer in use.

Overall, the Brantford General Hospital site is a challenging one with buildings constructed at different times and being located on a hill. The physical age of some areas present a significant challenge. Physical limitations represent significant patient care and infection control concerns in a number of areas.

At the Willet Community Hospital site, the urgent care clinic and physical plant were visited. The redevelopment of the urgent care clinic includes areas that provide for patient privacy and support patient assessment and work flow. There is a separate waiting area for patients with acute respiratory infection (ARI)

and a negative pressure assessment room. The site's power plant is older but maintained with the appropriate processes in place should work be required where asbestos containing materials may be present.

3.1.9 Priority Process: Emergency Preparedness

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

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

The emergency response plan development and oversight is led by an enthusiastic multidisciplinary emergency plans committee encompassing broad internal and external partnerships. An external consultant was engaged to conduct formal hazard identification and risk analysis to identify and assess potential risks from a proactive and community-based perspective. This information has been used to develop the emergency response plan and incident management system.

There is strong evidence of active engagement with external partners as the program continues to evolve. Notable recent examples include engaging the local fire department expertise to advise regarding requirements for safe patient holding areas and evacuations. Recently, the organization and emergency management services (EMS) worked to tighten alignment of their respective response plans to ensure a coordinated approach to management of potential Ebola infected patients.

Internal stakeholders from all representative areas are actively involved in the work of the committee. The pandemic plan and outbreak management policy are customized in the incident management system. Work is underway to broaden the scope of the outbreak management policy. A formal business continuity plan remains to be developed. A Code Amber is under development. Plans are underway in order to complete this work.

There is a well-developed education program available via the corporate online learning management system. Staff members spoken with during the survey were well aware of the emergency codes and demonstrated they were familiar with the steps to follow in the event of an emergency event.

3.1.10 Priority Process: Patient Flow

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The policy on patient flow and access management bed management sets out the underlying principles and responsibilities to manage patient access and flow at the Brant Community Healthcare System (BCHS). The strategy is deployed and managed on a daily basis by the Navigation department team leader and navigation team. The current focus has been on the introduction of the navigator role with a more direct proactive involvement in discharge planning and engagement of infection prevention and control in order to optimize the use of all available patient beds.

Corporate initiatives under this new direction include a meeting structure for navigators and team leaders to effectively enable real time decision making regarding bed utilization, and assignment of unit-specific navigators to work directly with patients and families and attend daily rounds and discharge action board meetings on the inpatient unit. The Community Care Access Centre (CCAC) care coordinators are also in attendance. Team members reported during the survey that this has resulted in greater engagement across value streams. It has also increased collaboration, co-operation and inter-departmental respect for one another's work. Team leaders indicated that the daily action board meetings has enhanced interdisciplinary discharge planning in some instances.

Patient flow in the emergency department (ED) is challenging owing to the age of the physical plant. The rapid assessment zone is used for the less acute patients.

Metrics which are tracked regularly are the ED metrics including time to triage, and 90th percentile time from decision-to-admit until admitted to an inpatient bed. The inpatient units track the True North 48-hour conversation target, alternative level of care (ALC), and length of stay (LOS). Several bed management tools are used including an electronic bed board and bed tracking system.

Current challenges include the ALC wait time for Complex Continuing Care placement in particular, and the need for better tools to leverage data for daily decision making, performance measurement and real time reporting. The organization has recently installed a new business intelligence system which will allow for better data to support this work. Greater involvement of physicians is also required to support the next phase of the work.

The enthusiasm of the value stream teams is evident. There are well-established external partnerships between the navigation department and the Community Care Access Centre and retirement homes in the area.

3.1.11 Priority Process: Medical Devices and Equipment

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

Unmet Criteria		High Priority Criteria
Standards Set: Perioperative Services and Invasive Procedures Standards		
22.6	The organization transports contaminated items separately from clean or sterilized items, and away from client service and high-traffic areas.	!
Standards Set: Reprocessing and Sterilization of Reusable Medical Devices		
5.2	The medical device reprocessing department's hand hygiene facilities are equipped with faucets supplied with foot-, wrist-, or knee-operated handles, or electric eye controls.	!

Surveyor comments on the priority process(es)

The group leader for the medical device reprocessing (MDR) department has overall responsibility for the reprocessing and sterilization of reusable medical devices at the Willet and Brantford sites. The reprocessing committee oversees the ongoing management, evaluation and improvement of the reprocessing function across the client support value stream. Areas reviewed during the survey included MDR, operating room (OR), endoscopy and diagnostic imaging (DI), maintenance and biomedical engineering. Overall, the program is well-developed and managed. The Canadian Standards Association (CSA) standards, and infection control standards and manufacturers' requirements are embedded in policies and procedures and standard operating procedures (SOPs).

Best practices for staff competence are followed. All the staff members involved in reprocessing have completed the Central Service Association of Ontario (CSAO) certification course. The one exception is the DI staff members that are trained by the team leader of Diagnostic Imaging and Infection Prevention and Control. All certified staff members are required to complete annual follow-up education and MDR competency tests. Additional training and competency testing is done more frequently if indicated. Records of certification and annual education are maintained by the MDR group leader.

Quality control and preventive maintenance is maintained for all reprocessing equipment and records are maintained. The physical environment is well-maintained in all areas and meets standards for physical separation of functions. Air flow, temperature and humidity levels meet CSA standards. The reprocessing committee conducts an organization-wide audit of reprocessing annually. Deficiencies are addressed immediately by the MDR leadership.

Workplace safety practices are established. Staff members have received safety training. The use of personal protective equipment is mandatory. Hand-hygiene practices are followed.

The endoscopy suite is a new state-of-the-art facility, completed in the last year. The MDR team members are enthusiastic and dedicated to excellence. Quality improvement projects are selected in alignment with True North priorities. Although the department is data rich, few metrics are formally tracked. This is an area that could be strengthened. In addition, it is recommended that the results of the annual organization-wide audit be reported to leadership.

3.2 Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Point-of-care Testing Services

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

Clinical Leadership

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

Competency

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

Episode of Care

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

Decision Support

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

Impact on Outcomes

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

Medication Management

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

Organ and Tissue Donation

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

Infection Prevention and Control

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

Surgical Procedures

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

Diagnostic Services: Imaging

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

Diagnostic Services: Laboratory

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

Transfusion Services

- Transfusion Services

3.2.1 Standards Set: Ambulatory Care Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.1	The team works together to develop goals and objectives.	
Priority Process: Competency		
3.7	The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	
Priority Process: Episode of Care		
6.2	The team receives clients at the service area in a manner that respects their privacy and confidentiality.	
7.5	The team monitors and works to reduce the length of time clients wait for services beyond the time the appointment was scheduled to begin.	
8.4	With the involvement of the client, family, or caregiver (as appropriate), the team generates a Best Possible Medication History (BPMH) and uses it to reconcile client medications at ambulatory care visits where the client is at risk of potential adverse drug events*. Organizational policy determines which type of ambulatory care visits require medication reconciliation, and the how often medication reconciliation is repeated. *Ambulatory care clients are at risk of potential adverse drug events when their care is highly dependent on medication management OR the medications typically used are known to be associated with potential adverse drug events (based on available literature and internal data).	ROP
8.4.3	During or prior to the initial ambulatory care visit, the team generates and documents the Best Possible Medication History (BPMH), with the involvement of the client, family, caregiver (as appropriate).	**MAJOR**
8.4.4	During or prior to subsequent ambulatory care visits, the team compares the Best Possible Medication History (BPMH) with the current medication list and identifies and documents any medication discrepancies. This is done as per the frequency documented by the organizational.	**MAJOR**

	8.4.5	The team works with the client to resolve medication discrepancies OR communicates medication discrepancies to the client's most responsible prescriber and documents actions taken to resolve medication discrepancies.	**MAJOR**
	8.4.6	When medication discrepancies are resolved, the team updates the current medication list and retains it in the client record.	**MAJOR**
	8.4.7	The team provides the client and the next care provider (e.g., primary care provider, community pharmacist, home care services) with a complete list of medications the client should be taking following the end of service.	**MAJOR**
10.9		The team follows up with clients and service providers to determine whether the ambulatory services provided contributed to the achievement of the client's service goals and expected results, and uses this information to identify and address barriers that are preventing clients from achieving their goals.	
12.4		The team uses a specific process for transferring information when clients do not have a regular health care provider.	!
12.6		Following transition or end of service, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning.	
Priority Process: Decision Support			
		The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes			
17.2		The team implements and evaluates a falls prevention strategy to minimize client injury from falls.	ROP
	17.2.1	The team implements a falls prevention strategy.	**MAJOR**
	17.2.2	The strategy identifies the populations at risk for falls.	**MAJOR**
	17.2.4	The team establishes measures to evaluate the falls prevention strategy on an ongoing basis.	**MINOR**
	17.2.5	The team uses the evaluation information to make improvements to its falls prevention strategy.	**MINOR**
18.1		The team collects information and feedback from clients, families, staff, service providers, organization leaders, and other organizations about the quality of its services to guide its quality improvement initiatives.	
18.2		The team uses the information and feedback it has gathered to identify opportunities for quality improvement initiatives.	
18.3		The team identifies measurable objectives for its quality improvement initiatives and specifies the timeframe in which they will be reached.	!

18.10	The team shares information about its quality improvement activities, results, and learnings with clients, families, staff, service providers, organization leaders, and other organizations, as appropriate.	
18.11	The team regularly reviews and evaluates its quality improvement initiatives for feasibility, relevance and usefulness.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Brant Community Healthcare System (BCHS) surgical clinics are providing services in plastics, ophthalmology, urology, endoscopy and orthopedics and operate within the ambulatory care unit (ACU). There is also an oncology clinic associated with Hamilton Health Sciences. A diabetes education program is also offered. The on-site dialysis program has just recently become a satellite of St. Joseph's Hospital in Hamilton but is still staffed by BCHS staff.

Roles and responsibilities of individuals working in the ACU have been adjusted to provide leadership in light of the absence due to illness of the individual responsible for the portfolio of services. As well, challenges have recently emerged owing to retirements and unanticipated illness of experienced senior staff. Those stepping up to provide leadership are hitting the ground running without the luxury of historical understanding for some of the operational components of ambulatory care services.

Metrics are available in the ambulatory care program, with some components having more than others due to the nature of their association with other entities like Cancer Care Ontario, the Local Health Integrated Network (LHIN) provincial process improvement process (PIP) for diabetes education and their reporting requirements. Indicators are tracked and posted on huddle boards. A review of the use and robustness of the huddle board visual management system is required. Currently, the board is used to convey the ACU goals and objectives for front-line staff, and as mentioned earlier in the report the organization needs to assess if this is meeting the needs of front-line staff.

The oncology clinic is experiencing growth. It is suggested service planning be undertaken to determine future requirements as it appears that the clinic is already outgrowing its current location both for patient volumes as well as for chemotherapy preparation.

Two required organization practices (ROPs) require attention in the ACU: implementation of medication reconciliation with best possible medication history (BPMH) and falls prevention. Some staff members are doing these activities but these practices need to be implemented consistently in accordance with the policy framework adopted by the organization.

The team is at the beginning stages of formalizing its quality improvement (QI) programming in a way that resonates for front-line staff. Formal mechanisms for obtaining client and other stakeholder data to help inform quality initiatives require work.

At this time there is no formal, consistent follow-up process for evaluating the experience of discharged patients to help evaluate the services provided and to inform future planning. The team is encouraged to consider strategies to be able to elicit this type of data on an ongoing basis.

The team members have demonstrated they can rise to any occasion given the many changes implemented in the past year. Their record of accomplishment will serve them well in considering the feedback from this accreditation survey experience.

Priority Process: Competency

The workforce in the ambulatory care unit (ACU) is experienced. Staff members are dedicated and knowledgeable.

Specialty qualifications, as required by the specific work areas, are in place. During the survey staff members indicated that they have opportunity to access staff development activities.

A number of areas are experiencing staffing challenges and different scheduling or staffing arrangements given the vacancies have materialized. Leadership is encouraged to continue to monitor the impact this is having on the front-line staff and engage them in work redesign as appropriate.

Priority Process: Episode of Care

The ambulatory care unit (ACU) is located in the newest part and despite having a contemporary design, it is noted that registration to the ACU is in a public traffic area. This is made more public by the location of the Tim Horton's store which is popular for both patients and staff alike. Individuals presenting to registration are in an open area and despite floor demarcations to help facilitate better privacy and confidentiality, it remains both an issue and a challenge.

Major review and transformation of processes has and continues to take place in the surgical clinic component of the ACU. All scope work done in the area has been reviewed and multiple changes were made to enhance patient safety as well as improve the patient experience. Medication practices, storage, inventory, and quality control were scrutinized, with changes made. A '5S' of rooms was undertaken to ensure standardized clinical space, which could be easily used by more than one clinical specialty, and this has been instituted. The consent process has been revised and collaboration between ACU and diagnostic imaging (DI) has resulted in new protocols to manage patients that may require invasive procedures and monitoring.

The diabetes education clinic has recently altered its model of care delivery. Canadian diabetes standards of care are being followed. The program is responding to direction at the provincial and Local Health Integrated Network (LHIN) level to increase its access and volumes. The program is in the early stages of responding with its revised team model of appointment assessments which are being also offered in the community on an outreach basis in primary care settings to increase access.

Scheduling is an issue in ACU. Some improvements have been made but more are indicated in order to ensure wait times for booked appointments are minimized and the patient experience for clients is optimized. The oncology clinic is efficient in accommodating patients and having all preparatory work done for their chemotherapy treatment done on the same day. This will become more of a challenge as volumes grow, and will also contribute to a congested and potentially unsafe patient environment if volumes continue to grow.

The fracture clinic presents opportunity to see if 'workload levelling' can be employed with the anticipated result being better patient flow and experience of waiting for these patients, as well as realignment of DI resources to support inpatients to help with emergency department (ED) and medical patient flow.

Priority Process: Decision Support

The ambulatory care unit services are more paper-based compared to the rest of the organization. The diabetes education program is totally paper based and stores its records within its own area. The recent program changes made in the diabetes education program are based on the Canadian Diabetes Society standards.

A review of the medication record in the oncology clinic is warranted. The surveyor found that just nursing documentation/entry of medications was documented on three different paper records, and on two computer systems namely Opis and Mosaic. A review of this is suggested for the purpose of streamlining work, as well as to avoid potential chances for making documentation errors. The oncology clinic follows evidence-based guidelines and protocols approved by Cancer Care Ontario.

Priority Process: Impact on Outcomes

The ambulatory care unit (ACU) team could benefit from more training around falls prevention and specifically, as to what that looks like in the ambulatory setting.

The quality improvement (QI) program for the various components in the ACU is not understood well by front-line staff. Although indicators could be produced during the survey, these were not in a context to give direction as to what were the measurable targets that programs were aiming to achieve and within what time frame.

Huddle boards in some of the locations visited were sparsely populated with metrics or with other detail about specific ACU program areas and what they were trying to achieve in terms of their quality initiatives.

3.2.2 Standards Set: Biomedical Laboratory Services

Unmet Criteria	High Priority Criteria
Priority Process: Diagnostic Services: Laboratory	
28.6 The team has a process to receive, document, and follow up on medical alerts and safety notifications issued by Health Canada and provincial regulatory bodies.	!

Surveyor comments on the priority process(es)

Priority Process: Diagnostic Services: Laboratory

The laboratory is equipped with state-of-the art equipment. Laboratory services are also provided to Norfolk and West Haldimand hospitals. The laboratory has recently undergone its mid-term Ontario Laboratory Accreditation (OLA) self-assessment, and 10 minor non-conformance items were identified and are being worked on.

There is seasoned and knowledgeable clinical and medical leadership in the laboratory. Staff members are seen as helpful and co-operative. The laboratory is an accredited site for the St. Claire College of Applied Arts and Technology and student learners are welcomed. Comprehensive orientation and mentorship arrangements are in place for new staff and students.

Solid quality assurance and quality control is in evidence throughout the laboratory and the various modalities. A recent quality improvement focus looked to decrease the number of mis-labelled specimens coming to the laboratory from the ambulatory care unit. The two areas have collaborated and a major improvement has been realized. The laboratory is part of the Local Health Integrated Network's quality teams, and the current focus is on troponin time, and turn around time (TAT) improvement. It is suggested that TAT performance in the laboratory can be further enhanced with the installation of visual management, which could be accomplished with television screens. This way, all staff members would know exactly what the TAT performance is for tests being processed and could mobilize to ensure that TAT performance continues to improve.

Laboratory utilization is being addressed via the operations committee as part of the: "Choosing Wisely Campaign". To date, the removal of Creatine Kinase (CK) from order sets has resulted in a notable decrease in ordering of the test. It is suggested that future such initiatives may yield both practice and cost benefits, but this would require decision support to enable such work to be undertaken.

Relationships with key stakeholders are good. There continues to be opportunities to improve those relationships particularly with nursing by way of training opportunities. The laboratory leadership is encouraged to continue to seek formal targeted and broader feedback from its stakeholders on a regular basis.

3.2.3 Standards Set: Critical Care

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
The organization has met all criteria for this priority process.			
Priority Process: Competency			
The organization has met all criteria for this priority process.			
Priority Process: Episode of Care			
3.2	If the team offers outreach services in the form of a rapid response or medical emergency team, it defines the role of this team and communicates it to other teams in the organization.		
6.3	When offering outreach services, such as a rapid response or medical emergency team, the team provides other organizational teams with the standardized criteria it uses to determine whether critical care services will be provided.		
7.5	The team identifies medical and surgical clients at risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) and provides appropriate thromboprophylaxis.		ROP
	7.5.3	The team establishes measures for appropriate thromboprophylaxis, audits implementation of appropriate thromboprophylaxis, and uses this information to make improvements to their services.	**MINOR**
7.7	With the involvement of the client, family, or caregiver (as appropriate), the team generates a Best Possible Medication History (BPMH) and uses it to reconcile client medications at transitions of care.		ROP
	7.7.4	The prescriber uses the Best Possible Medication History (BPMH) and the current medication orders to generate transfer or discharge medication orders.	**MAJOR**
7.8	The team has access 24 hours a day, seven days a week, to supporting services such as laboratory testing and diagnostic imaging, including point-of-care testing.		
12.7	Following transition or end of service, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning.		
Priority Process: Decision Support			
The organization has met all criteria for this priority process.			

Priority Process: Impact on Outcomes

The organization has met all criteria for this priority process.

Priority Process: Organ and Tissue Donation

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Critical care is a 27-bed closed unit. Medical coverage is provided by four Internists and two anesthesiologists on a seven-day rotation. Internists provide medical coverage after hours, weekends and holidays. The nursing staff members are all registered nurses (RNs) and there are part-time pharmacy and dietician staff, and a dedicated respiratory therapist 24/7. This is an enthusiastic visionary team whose members are committed to excellence in patient care. The sense of a positive, cohesive and highly engaged interdisciplinary culture was evidenced in all observed interactions. Team members are encouraged to provide input to job design.

The critical care committee provides oversight for the program. The leadership is involved in the master planning for the organization. Service planning is aligned with the goals and objectives of the organization, with a future vision on how best to serve the critical care needs of the local community. Goals and objectives and improvement initiatives have targets and indicators which are trended and analyzed against available external benchmarks. The service scope has recently expanded the capacity to care for ventilated patients with the creation of the Vent Pool. This has resulted in being able to provide critical care service to more patients in the local community and has decreased the number of patients going to other centres. There are no electrocardiogram (EEG) services on-site and no neurologist on staff, which means that neurology and neurosurgery patients have to be transferred out for a diagnosis to be made.

The layout of the unit allows for ease of work flow and team communication. The medication room is locked and has adequate space. There are good resources for medical supplies and equipment.

Patients' families spoke highly of the care provided to their family members. Particularly noteworthy is the compassion and attentiveness of all team members. Families reported they were always kept fully informed and included in all decision making. They stated the work the team does is "unbelievable" and "awesome", and they were so glad their loved one was being cared for in this unit.

Priority Process: Competency

Team capacity building and continuous professional development is evident. Team members reported a high level of support for clinical practice. Selection of new initiatives is done collaboratively and introduced in a thoughtful manner. There is a notable openness to working collaboratively with colleagues on other units in the organization.

The unit orientation package has recently been revised to have a more self-directed focus. The team has built an internal pool of certified advanced cardiac life support (ACLS) instructors to provide advanced cardiac life support certification in house. The team discusses progress on current quality cycles of improvement during team Rapid Rounds. Daily interdisciplinary bedside rounds take place using the recently introduced critical care daily rounds check list and plan of care.

Priority Process: Episode of Care

The team works collaboratively with Criticall and referring organizations to facilitate access to service. Every effort is made to accommodate patients requiring critical care.

Interdisciplinary care plans are well-developed and easily accessible to all team members. Daily care plan review and development of new orders is done by the interdisciplinary team during bedside rounds using the critical care daily rounds check list and plan of care. The check list is both comprehensive and easy to use and since it was introduced the team has seen early improvements in some of the leading process indicators such as ventilator days.

There are well-established mechanisms for transfer of information at transition points. The admission report is used to receive information about a patient that is going to be admitted to the unit. All nurse-to-nurse transfer of information is done face-to-face using the tool: "Critical Care - Nursing Standards for Patient Safety during TOA". The nursing TOA at change of shift is done in the patient room with involvement from the patient and/or family if desired.

Medication management is well-maintained with the support of the pharmacist. Medication reconciliation has not been implemented at transfer or discharge. The team works with the pharmacist and infectious diseases physician to maintain best practices in the use of antibiotics. Compliance with use of independent double-checks and dangerous abbreviations are audited. During the survey the team expressed the need for an emphasis on further education on the use of dangerous abbreviations.

Priority Process: Decision Support

The diagnostic tests and nursing documentation are in electronic format. The remainder of the patient record is in paper format. The team maintains the privacy and confidentiality of patient information. The critical care committee reviews and selects practice guidelines for adoption. Research studies are approved by the research ethics committee.

There is no after-hours magnetic resonance imaging (MRI) available to the critical care service. A request for such to the Local Health Integrated Network (LHIN) for funding has been refused.

Priority Process: Impact on Outcomes

There are well-developed quality improvement initiatives underway with evidence of robust improvement work. Progress is monitored on the internal and Local Health Integrated Network (LHIN) scorecards. The well-established safety bundles which include ventilator associated pneumonia (VAP), central line infections (CLI), and hand hygiene are monitored to sustain optimum performance and good governance.

The critical care service follows the organization-wide policy and process to report and manage sentinel events, near misses and adverse events. Summary analysis is posted and reviewed with the team for review and identification of improvement opportunities.

Priority Process: Organ and Tissue Donation

The team has formally adopted the Trillium Gift of Life (TGL) program. Quarterly meetings with TGL have been established, and an internal steering committee is in place. All TGL policies and procedure have been approved by the medical advisory committee (MAC) and the operating room (OR) has adopted the policies and procedures. Early reporting rates are tracked for the inpatient units and critical care services and are showing an upward trend.

3.2.4 Standards Set: Diagnostic Imaging Services

Unmet Criteria		High Priority Criteria
Priority Process: Diagnostic Services: Imaging		
4.3	For nuclear medicine, the team designates separate waiting areas to segregate clients who have been injected with radioactive substances from other clients.	!
15.4	The team prepares for medical emergencies by participating in simulation exercises.	!
Surveyor comments on the priority process(es)		
Priority Process: Diagnostic Services: Imaging		

There is evidence of good team work within the diagnostics imaging (DI) team. The workplace environment was described as having a good culture and no hierarchy. The DI team is supportive and welcoming to a variety of student learners. There are no issues with recruitment as there is a solid feeder system of student learners who, on graduation, welcome the opportunity to be employed at the organization. This applies not only to technologists but also the radiology specialists.

Formal and informal feedback from clients and physicians to assess needs, performance and satisfaction with services has been undertaken. The team is encouraged to continue with formal surveys into the future.

The DI department is spacious and overall is well equipped. A five-year capital equipment plan is in place and regularly reviewed and updated. The DI leadership team is aware of two major equipment items that may need to be replaced soon. In the interim, work flow is being managed with the existing equipment at both the Willet site (general radiology) and at the Brantford site (Gamma Camera).

Many patient and staff safety measures are in evidence from the safety signage in the various modalities to screening procedures in place for patients that present for diagnostic testing. Although transfer lifts and ceiling lifts are present, it is suggested that additional strategies and re-education be considered in the area of back safety for staff.

Nuclear medicine has three trained radiation safety officers and robust measures are in place for the handling, disposal and monitoring of radiation safety. This includes education of staff and physicians both internal and external to the department.

Patients are well informed around radio pharmaceuticals. There is a mechanism in place for those that wish to travel across the border which makes sure they have documentation with them, which means their travel is facilitated without heightening security concerns.

The team has and continues to work on improvement projects related to managing access and wait times in all modalities. The team is encouraged to continue efforts in this area as there are more opportunities to help the organization overall with patient flow and earlier discharge. One such opportunity to consider is for admitted inpatients to have their investigations completed earlier so discharge decisions can be expedited. It is suggested a review of how inpatients, emergency (ED) patients, outpatients including orthopedic fracture

clinic patients are scheduled. As well, a review needs to be conducted of the barriers in getting patients prepared and transported to DI and back, and this may prove a fruitful quality improvement initiative as well. Decentralizing the visual management system to the modality level requires consideration to help each area focus on what it can do to help with patient flow. Building capacity at the front-line level around visual management for modality specific indicators may prove helpful for greater engagement and focused efforts in improving access and turnaround for investigations.

Although there is informal peer consultation on clinical cases, the radiology group is encouraged to formalize and implement a peer review quality assurance program.

There evidence that utilization of DI services is reviewed with feedback provided to individuals based on trending data that is collected so ordering practices are better informed. The DI team has plans to enhance its menu of clinical testing to include tomosynthesis for magnetic resonance imaging (MRI).

The DI team is encouraged to more regularly seek feedback from its stakeholders regarding the services it provides. Specifically, the team is encouraged to consider reviewing its scheduling and slot system to allow for inpatient bookings for MRI and other modalities earlier in the day. This way, the DI department can contribute to 'pulling' patients from the inpatient units and critical care, and ED can push its patients from the ED to assist the patient flow across the organization.

3.2.5 Standards Set: Emergency Department

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
1.8	The team collaborates with its partners to develop resource-sharing arrangements to offer safe and effective services for each client and family.		
2.2	The team has the workspace it needs to deliver effective services in the emergency department.		
Priority Process: Competency			
The organization has met all criteria for this priority process.			
Priority Process: Episode of Care			
9.1	Following triage, the team completes a timely assessment for each client.		!
9.3	With the involvement of the client, family, or caregivers (as appropriate), the team initiates medication reconciliation for clients with a decision to admit and a target group of clients without a decision to admit who are at risk for potential adverse drug events (organizational policy specifies when medication reconciliation is initiated for clients without a decision to admit).		ROP
	9.3.2	The organization identifies criteria for a target group of non-admitted clients who are eligible for medication reconciliation and documents the rationale for choosing those criteria.	**MAJOR**
	9.3.3	When medications are adjusted for non-admitted clients in the target group, the team generates and documents the BPMH with the involvement of the client, family, or caregiver.	**MAJOR**
	9.3.4	For non-admitted clients in the target group, the team communicates medication changes to the primary health care provider.	**MAJOR**
	9.3.5	For non-admitted clients identified as requiring medication reconciliation, the team provides the client and the next care provider (e.g., primary care provider, community pharmacist, home care services) with a complete list of medications the client is taking.	**MAJOR**
11.3	The team follows the organization's policy to obtain the client's informed consent to treatment and/or investigation.		!
Priority Process: Decision Support			

13.2	The team meets applicable legislation for protecting the privacy and confidentiality of client information.	!
15.1	The organization has a process to select evidence-based guidelines for emergency department services.	!

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

There is strong and engaged clinical leadership for the team. Team members are committed to using the information on their population, and this includes information that is available from their decision support system to improve patient flow by reviewing and adjusting how patients are seen and care for. They have established zones within the emergency department (ED) to direct patients based on their triage score and care needs.

The team has data to show the increase in patient visits that are being seen. The team is encouraged to explore further what the underlying drivers are for this increase in patients presenting to emergency. Discussion ensued about the impact the closure of a local walk-in clinic had on both the hospital and Willett.

There may be a need for Brant Community Healthcare System to engage with the Local Health Integrated Network (LHIN) on broader strategies to reduce the demand for emergency department (ED) services. Otherwise, there is the potential as the department improves flow that it will pull more patients into the department with no overall improvement.

The room that is used by the mental health team to assess clients is located outside the department next to the inpatient area. There is no direct line of sight to the room either from the emergency department or the waiting area. The room does have a camera that is monitored on a screen in the ED but no emergency call button is available in the room. Plus, the layout of the room has a narrow and then a wide part that could lead to a worker being trapped unless the worker is deliberate about where he/she places him/her self in relation to the patient. The emergency department in conjunction with mental health services is encouraged to reassess options for a quiet room.

Priority Process: Competency

There is a comprehensive orientation for emergency department (ED) staff. There is specific training required for nurses that are providing triage services. Staff members are rotated into the different zones to vary the type and intensity of the activity.

There is support for staff members to obtain and maintain pediatric advance life support and advanced cardiac life support and this includes support for staff to become trainers.

Priority Process: Episode of Care

The time from registration to triage, and to be seen by physician is recorded. Time for referral to consultants and response time was inconsistently recorded on the charts reviewed during the on-site survey.

Although greeting is done via a microphone and there is potential for others to hear, the actual triage assessment is done in an enclosed area and is confidential, and the registration area also provides for privacy.

Priority Process: Decision Support

Information on workload and patient flow is reviewed regularly and used to improve care processes. The emergency department (ED) has clinical care pathways and order sets. These were developed by the director and then circulated for review and sign-off by all the medical staff. The nursing staff members are then able to use these order sets to initiate treatment for patients presenting with such symptom complex.

The monitoring and review of the use of the guidelines is done for patients with stroke as part of the provincial stroke program.

Priority Process: Impact on Outcomes

The team enables family members to be with the patient and participate if appropriate in the care of family members. The team has a good working relationship with emergency medical services (EMS). The team has identified one area of improvement noting that the patient severity scale that EMS uses is opposite to the Canadian Triage Acuity Scale (CTAS) that the organization uses. This was revealed during a heads-up around a potential plane crash at a nearby airport. The team is encouraged to work with EMS on the reason for using a different rating or classification.

Priority Process: Organ and Tissue Donation

Staff members identify potential organ donation patients to Trillium Gift of Life whose trained staff then have the conversation with family members with regard to organ donation.

3.2.6 Standards Set: Infection Prevention and Control Standards

Unmet Criteria		High Priority Criteria
Priority Process: Infection Prevention and Control		
2.7	The organization seeks input from the IPC and the OHS teams to maintain optimal environmental conditions within the organization.	
4.2	The organization has policies and procedures that are in line with applicable regulations, evidence and best practices, and organizational priorities.	!
9.5	The organization regularly evaluates compliance with its policies and procedures for cleaning and disinfecting the physical environment and makes improvements as needed.	
12.5	The organization identifies who is responsible for receiving and responding to information about suspected health care-associated infections.	
12.7	The organization has policies and procedures to contain and prevent the transmission of microorganisms by applying routine practices to all clients and additional precautions as necessary.	!
Surveyor comments on the priority process(es)		
Priority Process: Infection Prevention and Control		

A comprehensive infection prevention and control (IPAC) program and strong multidisciplinary team are in place. The team has a broad range of skills and experience and the team includes two infectious disease specialists with dedicated time for their infection prevention and control responsibilities. The team's recent focus has been more reactive, responding to issues arising from changes being implemented to improve bed flow and efficiency.

The IPAC committee and program is in a transition phase as a result of the organizational change that is occurring. The IPAC committee had initially been disbanded when the value stream structure was introduced into the Brant Community Healthcare System (BCHS). The committee was re-established following two cases of hepatitis C infection linked to healthcare services. At the time of survey the accountability and reporting for infection control at the leadership and governance level was unclear for members of the infection prevention and control committee. Previously, the committee had reported via the MAC to the board. The BCHS is encouraged to clarify the leadership and governance accountability for IPAC. The IPAC committee includes key external partners such as Brant County Health Unit.

Single patient isolation rooms that had been established as recommended for patients either confirmed or under investigation were converted back to shared units with co-horting of patients with similar infections. This has created new challenges for how to manage the supplies and equipment that are required for the patients. An example was given and also observed during a tracer where previously, a blood pressure machine would have been dedicated in the room for a patient with IPAC precautions. This machine is now stored in the hallway and further, it was not labelled as to whether it was clean or dirty.

Infection prevention and control (IPAC) had introduced a system of tags to identify clean and dirty equipment however, this system is not being used on the units. Another area of concern identified was the timing and extent of involvement of IPAC in construction activities. While BCHS policies indicate that IPAC will be involved in the planning and oversight of construction activities, IPAC is not always informed and indeed with one current project, the IPAC oversight is being provided externally and BCHS IPAC has had no involvement in the selection. Other examples were given and observed where changes had been implemented without a full understanding of the potential infection prevention and control issues. Overall, there is need for stronger linkages between IPAC and maintenance/construction and process improvement activities.

Numerous routine surveillance activities are carried out and reported, and the information is effectively used for program planning and activities. For example, BCHS collects information on the vaccination status of employees, volunteers and students. There is a high rate of vaccination amongst staff.

Infection prevention and control (IPAC) has worked with the emergency department (ED) to implement an acute respiratory Illness screening tool for use with all patients presenting in ED to identify those patients requiring contact or droplet precautions. There are regular ongoing audits on the use of the tool as the target is 100%. Other regular audits include to methicillin resistant staphylococcus aureus (MRSA) and vancomycin resistant enterocci (VRE) screening.

The BCHS has a system in place using PCR software that provides results in an hour which helps facilitate bed placement.

The team has worked to actively engage staff, volunteers and patients in infection control activities. Infection prevention and control (IPAC) has trained more than 100 staff member to perform hand-hygiene audits. Audits are to be done weekly, increasing to daily if an outbreak is occurring. However, IPAC is concerned that the audits have shown a decrease in compliance for 'moment one' from greater than 91% To 87%. The team is currently looking at potential factors contributing to the decrease.

Hand-hygiene products and information are widely available for both the public and staff.

3.2.7 Standards Set: Medication Management Standards

Unmet Criteria		High Priority Criteria
Priority Process: Medication Management		
8.2	The organization has a policy for when and how to override alerts by the pharmacy computer system.	!
11.2	The organization has a policy for when and how to override smart infusion pump alerts.	!
Surveyor comments on the priority process(es)		
Priority Process: Medication Management		

Medication management is well-organized at the organization. The pharmacy team is passionate and committed to making medication safety a reality in concert with patients and clinicians. The approach taken by the pharmacy is one of: "Quality of Work" and "First time Quality at every point". This is reflected in the deeper dive and auditing that the team is doing on a number of required organizational practices (ROPs) to ensure that things are not only done but that they are being done accurately. Specifically, the team has noted that although best medication histories (BMH) are being completed audits reveal that 90% of the time a rework is required by a pharmacist as a significant percentage of the histories being audited have one or multiple inaccuracies. The team recognizes that there will need to be an ongoing and continued push to improve performance in this area. As well, audit results reveal that there are still challenges in the do-not-use abbreviations being used, as well as the roll-out and hard wiring of medication reconciliation in all clinical areas of the organization.

The pharmacy team is acknowledged for the significant work that has been undertaken to address the ROPs which has necessitated multiple work process changes. A recent accomplishment has been the standardization of code blue carts and the medication trays. The operating room (OR) trays are a future project to consider. The sexual assault order set has been introduced at both Willet and Brantford sites.

Major investments in enabling technology are in evidence to support medication management at the Brantford site. This is allowing staff members there to innovate processes so that work flow is tightened concurrent with forcing stricter safety checks on medications prepared in the pharmacy such as for total parenteral nutrition (TPN). Some of the process improvements have come as a direct result of reviewing adverse events/near misses that have stimulated thinking of how to prevent future such events. It is suggested that some of the improvements being made be more broadly communicated in an effort to share the lessons learned. The team is noted for its work on bar coding a patient's own medications that are taken when in hospital.

The bar coding system and electronic medication administration records (eMAR) are appreciated by front-line nurses and pharmacists.

A computerized physician order entry (CPOE) has been purchased and is planned for implementation in 2016. Opportunities for improvement exist in the areas of better inventory management with automation as well as moving from paper to electronic management of narcotics/controlled substances, as currently this is a labour intensive process for both nursing and pharmacy.

It is suggested that consideration be given to reviewing the existing area for chemotherapy preparation and storage. This space is small and does not have an anteroom as required by USP797.

Policies dealing with over ride of smart infusion pumps, the pharmacy system, and the CPOE once introduced, need to be developed.

Although intensive efforts have made to implement medication reconciliation organization wide more work needs to be done to hardwire the practice. Specifically, medication reconciliation is not in place in the ambulatory care unit areas, outpatient areas such as outpatient mental health and for surgical day patients. Medication reconciliation needs expansion for obstetrics, surgery and at a number of transition points.

Training around do-not-use-abbreviations would be welcomed by the clinical community.

3.2.8 Standards Set: Medicine Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.2	The team uses the information it collects about clients and the community to define the scope of its services and set priorities when multiple service needs are identified.	
2.1	The team works together to develop goals and objectives.	
2.2	The team's goals and objectives for its medicine services are measurable and specific.	
5.2	Team members have input on work and job design, including the definition of roles and responsibilities, and case assignments, where appropriate.	
Priority Process: Competency		
3.5	The organization provides sufficient workspace to support interdisciplinary team functioning and interaction.	
3.6	The interdisciplinary team communicates regularly to coordinate services, roles, and responsibilities.	!
3.7	The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	
4.2	The team orients new team members about their roles and responsibilities, the team goals and objectives, and the organization as a whole.	
4.7	The team monitors and meets each team member's ongoing education, training, and development needs.	
4.8	Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	
5.3	Team leaders regularly evaluate the effectiveness of staffing and use the information to make improvements.	
Priority Process: Episode of Care		
7.4	The team identifies medical and surgical clients at risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) and provides appropriate thromboprophylaxis.	ROP
7.4.3	The team establishes measures for appropriate thromboprophylaxis, audits implementation of appropriate thromboprophylaxis, and uses this information to make improvements to their services.	**MINOR**

7.7	The team has access to the necessary diagnostic services, results, and expert consultation or advice to complete a proper assessment.	
Priority Process: Decision Support		
13.2	Team members receive education and training on information systems and other technology.	
14.1	The organization has a process to select evidence-based guidelines for medicine services.	!
14.2	The team reviews its guidelines to make sure they are up-to-date and reflect current research and best practice information.	!
14.3	The team's guideline review process includes seeking input from staff and service providers about the applicability of the guidelines and their ease of use.	
Priority Process: Impact on Outcomes		
16.3	The team identifies measurable objectives for its quality improvement initiatives and specifies the timeframe in which they will be reached.	!
16.5	The team designs and tests quality improvement activities to meet its objectives.	!
16.6	The team collects new or uses existing data to establish a baseline for each indicator.	
16.7	The team follows a process to regularly collect indicator data to track its progress.	
16.8	The team regularly analyzes and evaluates its indicator data to determine the effectiveness of its quality improvement activities.	!
16.9	The team implements effective quality improvement activities broadly.	!
16.10	The team shares information about its quality improvement activities, results, and learnings with clients, families, staff, service providers, organization leaders, and other organizations, as appropriate.	
16.11	The team regularly reviews and evaluates its quality improvement initiatives for feasibility, relevance and usefulness.	
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

The medicine team needs to make more effective use of information on clients and patients in the planning and development of its services. The use of information is inconsistent across the medicine services, with the stroke program and coronary care recovery demonstrating increased use of data in the service delivery and quality improvement initiatives.

There is a need to clearly transfer accountability during the discharge planning discussions, and this necessitates active physician involvement in discharge planning. The current approach without direct physician involvement is of limited value and may in fact generate additional work and distract discharge planners from tasks that would have a greater impact on patient flow

There is a need for training for all levels of management in the use of the decision support tools. For this to be successful relief will need to be provided to managers while they receive the training, and it should not be seen and done as one more add on, or it will be a negative introduction to the potential benefits that the decision support could provide them.

Priority Process: Competency

There are variations across the units, within the team and with other value streams on the approach to support of professional education including ongoing requirements for professional certification. There is a lack of clarity between what the individual is accountable for and what the organization will support. This appears to have become more of an issue due to changes in the amount of funding available to support continuing education. The medicine team is encouraged to look at a standardized approach across value streams.

There is support from the Foundation for individuals in the form of scholarships for which they can apply.

There is a need to support and facilitate the change management process. In the discussions during the survey there was a theme with health care workers that when concerns were raised about potential impacts of proposed changes on patient care and safety that their concerns were discounted. Further, there was the sense that they were seen as change resistant or being obstructive and therefore, discounted. There is a need to develop a strategy to re-engage these team members as there is still a commitment to provision of quality care and responding to the needs of patients.

Priority Process: Episode of Care

During the survey clients spoke highly of the care that they or family members had received. They expressed that they were informed of treatment plans. Clients felt there was good exchange of information between health care providers including for when they were transferred to other facilities for diagnostic or treatment services.

Priority Process: Decision Support

The team is encouraged to build on its experience with the implementation of the provincial stroke guidelines and look at the implementation of other evidence-based guidelines.

Priority Process: Impact on Outcomes

Impact on Outcomes is a difficult priority process to evaluate for medicine services. Certain aspects of the services have clearly identified quality improvement plans that they are measuring and reporting on and using the information to make informed changes. The provincial stroke program is an excellent example of this work. For the other medicine services, the key quality improvement initiative was identified as the 48-hour conversation. For this quality improvement initiative however, the tracking and reporting was inconsistent across the different units within the value stream. There was also wide variation in engagement around this quality improvement initiative. There is recognition of the potential benefit that this initiative could have for patient care but there is a need for engagement by key front-line staff in the initiative.

The team is encouraged to look at units where there has been effective engagement of nurses and physicians with the initiative and see how the learning might be applied to other units.

3.2.9 Standards Set: Mental Health Services

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
1.4	The team uses the information collected about clients and the community to define the scope of its services.		
2.1	The team works together to develop goals and objectives for its services.		
2.2	The team's objectives for mental health services are specific and measurable.		
2.3	The team identifies the resources needed to achieve its goals and objectives.		
Priority Process: Competency			
4.6	The team receives education on the safe and appropriate use of seclusion and restraints.		
4.12	Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and constructive manner.		
Priority Process: Episode of Care			
10.6	With the involvement of the client, family, or caregiver (as appropriate), the team generates a Best Possible Medication History (BPMH) and uses it to reconcile client medications at transitions of care.		ROP
	10.6.1	Upon or prior to admission, the team generates and documents a Best Possible Medication History (BPMH), with the involvement of the client, family, or caregiver (and others, as appropriate).	**MAJOR**
	10.6.2	The team uses the BPMH to generate admission medication orders OR compares the Best Possible Medication History (BPMH) with current medication orders and identifies, resolves, and documents any medication discrepancies.	**MAJOR**
Priority Process: Decision Support			
The organization has met all criteria for this priority process.			
Priority Process: Impact on Outcomes			
16.5	The team implements and evaluates a falls prevention strategy to minimize client injury from falls.		ROP
	16.5.4	The team establishes measures to evaluate the falls prevention strategy on an ongoing basis.	**MINOR**

16.5.5	The team uses the evaluation information to make improvements to its falls prevention strategy.	MINOR
16.6	The team participates in regular safety briefings to share information about actual and potential safety problems, reduce the risk of error, and improve the quality of service.	!
17.3	The team identifies measurable objectives for its quality improvement initiatives and specifies the timeframe in which they will be reached.	!
17.4	The team identifies the indicator(s) that will be used to monitor progress for each quality improvement objective.	
17.5	The team designs and tests quality improvement activities to meet its objectives.	!
17.6	The team collects new or uses existing data to establish a baseline for each indicator.	
17.7	The team follows a process to regularly collect indicator data to track its progress.	
17.8	The team regularly analyzes and evaluates its indicator data to determine the effectiveness of its quality improvement activities.	!
17.9	The team implements effective quality improvement activities broadly.	!
17.10	The team shares information about its quality improvement activities, results, and learnings with clients, families, staff, service providers, organization leaders, and other organizations, as appropriate.	
17.11	The team regularly reviews and evaluates its quality improvement initiatives for feasibility, relevance and usefulness.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The organization provides services in an 18-bed inpatient unit and a day hospital. The typical occupancy rate is between 81 and 85% on the inpatient unit. The average length of stay (LOS) is approximately between 6.1 and 6.5 days, and the maximum length of stay is 28 days. Twenty-four percent (24%) of inpatients remain on the unit less than twenty-four hours. Approximately 50% of inpatients stay less than three days.

Because of the location and design of the physical spaces it is not possible for the inpatient unit and the day hospital to integrate. Integration would mean that programs can be accessed easily at any point on the continuum. The primary objective of the inpatient unit is to stabilize and ensure appropriate medication usage. The primary objective of the day hospital is to provide services that support independent living.

Although the unit group leader participates in information exchange and planning opportunities with community partners, there is no evidence of an organized effort to do data collection and needs assessment that can be used to define and adjust programs accordingly. An example was provided of the development of a value stream map by this organization and its community partners but it was only current state. Without developing a corresponding future state map the opportunity to choose indicators and metrics for future success is lost.

This team does have huddle boards at the unit level however, they are not engaged in timely use of visual daily management to manage risks and opportunities. There is a perception that the metrics on the board are about high-level organizational goals that do not filter down to the point-of-care. There is opportunity to improve the engagement of staff in the development of unit level metrics and daily visual management.

Priority Process: Competency

The organization has struggled with recruitment and retention issues of the inpatient unit and attributes this to challenges and "old school practices" that conflict with the best practice knowledge and career aspirations of new staff arriving on the unit. The organization has taken steps to address these issues. One innovative approach is to bring in simulated patients from McMaster University to expose staff members to current best practices and work toward adopting standardized interventions based on these. The organization suggests that the situation is gradually improving along with improved morale on the unit.

During the survey a clear policy and procedure around use of restraints was not observed in practice. The stated policy is least restraint, but restraints are available for use, and staff members are encouraged to view a video on appropriate use. Familiarization with the use of these restraints is not mandatory. This is an area where clarity about policy and procedure require improvement and where training needs to be provided to all staff.

Unit leadership indicated that there is poor compliance with the organization's expectations about performance review and planning for staff.

Priority Process: Episode of Care

Patient and care giver education materials need to be updated and standardized. There is evidence that patient and care giver education is an aspect of the discharge planning work that begins on admission.

Priority Process: Decision Support

There is evidence that the mental health service has good mechanisms in place for decision support. The organization has made great strides toward the electronic health record with the development of information technology (IT) infrastructure.

Priority Process: Impact on Outcomes

There is some evidence of quality improvement initiatives in the service area but these are generated by unit leadership and not directly aligned with organizational indicators of quality. The unit staff members and leadership are interested in the organization's strategic deployment plan but do not feel a specific connection between the unit-level huddle board, unit activity, and the system-wide quality matrix. In the on-site discussions around quality improvement in the episode of care activities there was no evidence of a deliberate and structured effort to initiate, evaluate and share results from specific quality improvement initiatives.

The organization is able to report adverse events related to client and patient safety using corporate mechanisms but there is little evidence of proactive safety-related metrics monitoring or discussion at the unit level.

3.2.10 Standards Set: Obstetrics Services

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
The organization has met all criteria for this priority process.			
Priority Process: Competency			
The organization has met all criteria for this priority process.			
Priority Process: Episode of Care			
3.4	The team uses structured communication tools to communicate clearly and effectively.		!
9.6	With the involvement of the client, family, or caregiver (as appropriate), the team generates a Best Possible Medication History (BPMH) and uses it to reconcile client medications at transitions of care.		ROP
	9.6.4	The prescriber uses the Best Possible Medication History (BPMH) and the current medication orders to generate transfer or discharge medication orders.	**MAJOR**
12.5	Following transition or end of service, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end-of-service planning.		
Priority Process: Decision Support			
The organization has met all criteria for this priority process.			
Priority Process: Impact on Outcomes			
18.2	The team implements and evaluates a falls prevention strategy to minimize client injury from falls.		ROP
	18.2.1	The team implements a falls prevention strategy.	**MAJOR**
	18.2.2	The strategy identifies the populations at risk for falls.	**MAJOR**
	18.2.3	The strategy addresses the specific needs of the populations at risk for falls.	**MAJOR**
	18.2.4	The team establishes measures to evaluate the falls prevention strategy on an ongoing basis.	**MINOR**
	18.2.5	The team uses the evaluation information to make improvements to its falls prevention strategy.	**MINOR**
Surveyor comments on the priority process(es)			

Priority Process: Clinical Leadership

The obstetrics services uses internal historical data and comparative statistics from the Best Outcomes Registry Network (BORN) of Ontario to plan for services. This year's major focus has been strengthening the family centred care with the adoption of the World Health Organization (WHO) Baby Friendly Initiatives (BFI) and incorporating pediatrics into the family-centred care model on the new unit. The design of the new obstetrical unit will enable many of the principles of BFI, with an emphasis on the total family experience.

External partnerships are well-established and include the Public Health association for breast feeding and support, Southern Ontario Neonatal Nurses' Association and others. Participation in the BORN database allows for benchmarking at the national and international levels for the BFI initiatives. Internal goals and targets are aligned with the 'X Matrix' and focus on safety and transition home.

Nursing, midwifery, medical and paramedical students are welcomed by the obstetrical team. Opportunities to utilize volunteers on the service are currently under consideration.

This dedicated team continues to maintain the philosophy of the managing obstetrical risk efficiently (MORE ob) program including skills tests and competency-based orientation.

Priority Process: Competency

The interdisciplinary team is made up of obstetricians, registered nurses, midwives and pediatricians, anaesthesia, respiratory therapy and social work. There is an obstetrician on service 24/7. A pediatrician and an anesthetist are within easy travelling distance at all times which allows for rapid response in emergency situations after hours.

Credentials are maintained for breast feeding, fetal monitoring and neonatal resuscitation. There is an orientation program for all new staff members and it includes orientation to equipment and workplace safety practices. Staff members are trained in the use of infusion pumps.

Priority Process: Episode of Care

The obstetrical care has moved into the new labour and delivery unit, and the special care nursery is in the new birthing suite. This is supporting the family-centred approach and is recognized by the team members and families. New parents commented on the benefits of additional space and privacy in particular. The resuscitation area in the special care nursery has excellent space and privacy for resuscitation to take place and it includes features to accommodate the needs of a transport team and family.

The post partum patients are on a combined pediatric and adult medical and surgical area. The team is aware that this presents a security risk to the newborns rooming with parents. Care coordination is facilitated by the use of standardized admission assessment monitoring and care planning tools in the labour and delivery suite, the special care nursery and post partum unit. The clinical pathway is followed throughout the obstetrical episode of care. The discharge preparation and education is well done. The team has worked with the Public Health Unit to produce an excellent discharge book which has been professionally printed and bound.

Implementation of the electronic record on labour and birth is planned.

Families spoke highly of the care and attention of the staff members and the quality of information provided throughout the process.

The team is encouraged to sustain the philosophy and principles of the managing obstetrical risk efficiently (MOREob) program to support cohesive and high reliability team functioning.

Priority Process: Decision Support

The clinical record is in paper format for labour and birth, except for diagnostic test results which are available online. The nursing documentation is in electronic format on the postpartum unit.

Prenatal records are available when patients are admitted. Interdisciplinary admission assessments are comprehensive. Care pathways for the entire episode of care are initiated on admission for vaginal births and for cesarean sections.

The team uses multiple mechanisms to access evidence-based guidelines including participation on external local and provincial committees and working groups. All research studies are approved by the research ethics committee.

Priority Process: Impact on Outcomes

Benchmark indicators chosen for this year through the Better Outcomes and Registry Network (BORN) database are: newborn phenylketonuria (PKU) screening, episiotomy rate, cesarean section and formula supplementation. Performance can be trended and benchmarked with national and international rates. The internal indicators aligned with the True North priorities are: 48-hour conversation for discharge, falls and hand hygiene.

There is evidence of successful improvement initiatives. For example, there is an excellent patient discharge booklet and standardized discharge protocol on the postpartum unit and this has been implemented in partnership with the Public Health Unit. The protocol is intended to ensure all necessary discharge information and follow-up information is received and understood by the parents. The team is encouraged to design an evaluation plan for this initiative.

The team has focused primarily on developing family-centred care incorporating pediatrics in preparation for the opening of the new unit. This is the major improvement goal for the team this year which is in line with the True North priorities.

3.2.11 Standards Set: Point-of-Care Testing

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

The organization has met all criteria for this priority process.

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

The point-of-care testing (POCT) program at Brant Community Healthcare System is well established and monitored. Leadership for the program is experienced and knowledgeable. Standard operating procedures (SOPs) are in place to support POCT activities. There is education of nursing staff prior to POCT use. The POCT program is limited to glucometers, urinalysis in pregnancies and Haemoglobin in A1C1's.

During the on-sites survey a number of observations were conducted. Nursing staff members using glucometers at both the Brantford and Willet sites were observed and they consistently followed the established procedures, including obtaining consent, two client identifiers, appropriate device access and subsequent results recording.

Written agreements are in place around obligations of manufactures/suppliers to report adverse events/recalls.

3.2.12 Standards Set: Rehabilitation Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
11.5	Following transition or end of service, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
16.1	The team collects information and feedback from clients, families, staff, service providers, organization leaders, and other organizations about the quality of its services to guide its quality improvement initiatives.	
16.10	The team shares information about its quality improvement activities, results, and learnings with clients, families, staff, service providers, organization leaders, and other organizations, as appropriate.	
16.11	The team regularly reviews and evaluates its quality improvement initiatives for feasibility, relevance and usefulness.	
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

Solid, clinical and medical leadership is evident in the rehabilitation program. The physical medicine specialist and hospitalists are committed and strongly team based in their approach to care delivery. Students and volunteers are present and a welcome addition to the fabric of the unit.

There is evidence that the leadership solicits information from a variety of sources including peers and comparators as well as undertaking environmental scanning to help inform planning and decision-making around service delivery.

Good working relationships are in place with tertiary rehabilitation programs as well as other community partners to ensure smooth discharge back to the community when appropriate.

The unit has the essential space, equipment and supplies to support a rehabilitative approach to care delivery.

The unit has introduced personal support workers (PSWs) into the workforce and has integrated them into the care routines appropriate to their scope of practice.

Priority Process: Competency

The rehabilitation staff members are part of an integrated interdisciplinary team and demonstrate appreciation of one another's roles. It is noted a number of experienced clinicians have left the organization. This has created concern for the rest of the team. It is suggested that the situation be monitored to ensure that the workplace continues to attract and retain top talent.

Given the organization's role as a district stroke program with both acute and rehabilitative elements and given the feedback obtained from staff members, physicians and clients it is suggested that fact finding occur. Information needs to be obtained to determine if therapeutic time allocations are affected by the mix of patients being seen as well as on use of time for direct and indirect activities so that appropriate corrective actions can be undertaken.

Continuing education opportunities are available and staff members avail themselves of the opportunity to enhance their skill sets.

Priority Process: Episode of Care

Patients and their families contacted during the on-site tracer were complimentary of the care that they received. Staff members were described as helpful and caring. Two clients articulated that areas of improvement in the service included better communication around timing of transfer/discharge to other institutions or to home. Both these clients also commented on the need to increase therapeutic supplies as well as to ensure that enough therapeutic time was made available for them to continue to make progress to functional independence.

A comprehensive interdisciplinary assessment is completed for all patients on admission. This includes aspects of care such as risk assessment for falls, and skin integrity assessment relative to prevention of decubitus ulcer, assessment of pain and patient goals and objectives. Use of the Braden tool for pressure ulcer risk is done weekly on all patients or more often if indicated by a change in client condition. Staff members know exactly which patients on the unit have reddened areas on their skin and also know the progress that is being made in restoring skin integrity.

The use of the situation-background-assessment-recommendation (SBAR) tool to ensure timely transfer of information was in evidence.

Priority Process: Decision Support

The team benefits from its association with the Stroke Network in terms of access to best practice guidelines and information sharing. Members of the team have been involved in selected research projects and understand both the process and approvals required to participate in such activity.

There is evidence of work done on delirium and other best practice information specific to the elderly population, and it is available to the team.

The seniors' resource consultant role, clinician role and navigator roles are in place to support staff members and patients in preparing for transition back to the community.

Priority Process: Impact on Outcomes

The team consistently uses the electronic bedside medication verification (BMV) for all medical administrative practices. Hand-hygiene compliance was also observed as being consistently done by staff.

The position of a seniors' resource consultant is an organization-wide resource which is working with the team to smooth transitions back to the community. Work has re-ignited on the seniors' friendly committee which has a patient adviser from the community in its membership. A referral process is now in place for Care for the Elderly in the community.

The team is encouraged to continue refining its quality improvement program. The team is at the beginning stages of its journey using Lean methodology and is encouraged to solicit feedback from clients and others as to the impact of its efforts. The team is encouraged to look at lessons learned from the current experience and to consider positioning information in a manner that resonates with front-line staff.

3.2.13 Standards Set: Transfusion Services

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

Surveyor comments on the priority process(es)
Priority Process: Transfusion Services
Although there is evidence of a transfusion committee which is meeting quarterly the committee needs attention. Anesthesiology representation is the only consistent external representative at this forum. The Brant Community Healthcare System (BCHS) medical director sits at the Local Health Integrated Network (LHIN) laboratory medical directors' forum and also has participated in the emergency department (ED) blood working group to revamp protocols associated with triaging of blood supplies in emergency situations. The position of transfusion officer was eliminated during the organization's restructuring activities and the point-of-care testing (POCT) coordinator has now assumed responsibility for both activities. The individual will require mentorship and support to grow in the role and its specific responsibilities. As the laboratory engages in conversation with other providers there may be opportunity to look at attracting such expertise if there is sharing with other providers or through different arrangements that might be feasible. There is a formal training program for nursing staff which is administered annually through e-learning. Compliance with the training was noted as 100%. A review is suggested of the total number of registered nurses that need to be trained in light of staffing changes and full-time and part-time casual personnel. An end-to-end tracer of administrating a unit of blood was undertaken. Both laboratory and nursing staff members followed policies around blood transfusion as per policy.

3.2.14 Priority Process: Surgical Procedures

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

Unmet Criteria			High Priority Criteria
Standards Set: Perioperative Services and Invasive Procedures Standards			
8.4	With the involvement of the client, family, or caregiver (as appropriate), the team generates a Best Possible Medication History (BPMH) and uses it to reconcile client medications at transitions of care.		ROP
	8.4.1	Upon or prior to admission, the team generates and documents a Best Possible Medication History (BPMH), with the involvement of the client, family, or caregiver (and others, as appropriate).	**MAJOR**
	8.4.2	The team uses the BPMH to generate admission medication orders OR compares the Best Possible Medication History (BPMH) with current medication orders and identifies, resolves, and documents any medication discrepancies.	**MAJOR**
	8.4.3	A current medication list is retained in the client record.	**MAJOR**
	8.4.4	The prescriber uses the Best Possible Medication History (BPMH) and the current medication orders to generate transfer or discharge medication orders.	**MAJOR**
	8.4.5	The team provides the client, community-based health care provider, and community pharmacy (as appropriate) with a complete list of medications the client should be taking following discharge.	**MAJOR**
8.9	The team identifies clients at risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) and provides appropriate thromboprophylaxis.		ROP
	8.9.3	The team establishes measures for appropriate thromboprophylaxis, audits implementation of appropriate thromboprophylaxis, and uses this information to make improvements to their services.	**MINOR**
24.8	The team follows a process to follow up with discharged day surgery clients.		

Surveyor comments on the priority process(es)

The scope of the surgical services is established and regularly evaluated by the peri-operative committee which includes all the surgical chiefs. Plans are based on government requirements which include quality-based procedures, historical utilization data and funding. The team has well-established partnerships with strategic partners including the Community Care Access Centre, Local Health Integration Network and the Regional Joint Assessment Program.

The clinical care program is well developed. Care planning is done with good evidence of the development of standard order sets and care maps based on best practices. Patient safety and experience are a priority. Considerable work has been done to implement the required organizational practices and plans are in place to finalize full implementation of the medication reconciliation and audit process to evaluate the venous thrombo embolism program. Patient education and communication are evident in the documentation and from the conversations with patients and staff. Patients spoke highly of the experience and care and attention of the staff.

The work flow is organized throughout the peri operative service areas. The space however is challenging on the inpatient unit and does not allow for easy movement and storage of equipment. Equipment resource needs appears to be adequate and utilization is a priority for the team. It is noted the inventory value stream project using Lean methodology realized more than $298,000 in savings.

The performance management system is in place and all team member credentials and training is well managed. There is evidence of a well-established workplace safety program. The program includes education, safety inspections, ergonomics assessments and infection control.

The major challenges of the service are the wait time for surgery and discharge management from the inpatient unit.

Section 4 Instrument Results

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

4.1 Governance Functioning Tool

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

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

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

- **Data collection period: October 29, 2013 to December 13, 2013**
- **Number of responses: 10**

Governance Functioning Tool Results

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1 We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations.	0	0	100	89
2 Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	0	0	100	93
3 We have sub-committees that have clearly-defined roles and responsibilities.	0	0	100	93
4 Our roles and responsibilities are clearly identified and distinguished from those delegated to the CEO and/or senior management. We do not become overly involved in management issues.	0	0	100	90
5 We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decision-making.	0	0	100	89

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
6 Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	92
7 Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	94
8 Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	0	0	100	93
9 Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	0	0	100	92
10 Our governance processes make sure that everyone participates in decision-making.	0	0	100	90
11 Individual members are actively involved in policy-making and strategic planning.	0	0	100	88
12 The composition of our governing body contributes to high governance and leadership performance.	0	0	100	89
13 Our governing body’s dynamics enable group dialogue and discussion. Individual members ask for and listen to one another’s ideas and input.	0	0	100	92
14 Our ongoing education and professional development is encouraged.	0	0	100	87
15 Working relationships among individual members and committees are positive.	0	0	100	96
16 We have a process to set bylaws and corporate policies.	0	10	90	91
17 Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	95
18 We formally evaluate our own performance on a regular basis.	0	0	100	78
19 We benchmark our performance against other similar organizations and/or national standards.	10	10	80	66
20 Contributions of individual members are reviewed regularly.	0	30	70	61

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
21 As a team, we regularly review how we function together and how our governance processes could be improved.	10	20	70	77
22 There is a process for improving individual effectiveness when nonperformance is an issue.	33	33	33	53
23 We regularly identify areas for improvement and engage in our own quality improvement activities.	10	10	80	78
24 As a governing body, we annually release a formal statement of our achievements that is shared with the organization's staff as well as external partners and the community.	10	0	90	81
25 As individual members, we receive adequate feedback about our contribution to the governing body.	20	30	50	64
26 Our chair has clear roles and responsibilities and runs the governing body effectively.	0	0	100	92
27 We receive ongoing education on how to interpret information on quality and patient safety performance.	0	0	100	78
28 As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	92
29 As a governing body, we hear stories about clients that experienced harm during care.	10	0	90	81
30 The performance measures we track as a governing body give us a good understanding of organizational performance.	0	0	100	88
31 We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	0	0	100	84
32 We have explicit criteria to recruit and select new members.	0	0	100	79
33 Our renewal cycle is appropriately managed to ensure continuity on the governing body.	0	0	100	86

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
34 The composition of our governing body allows us to meet stakeholder and community needs.	0	10	90	91
35 Clear written policies define term lengths and limits for individual members, as well as compensation.	10	0	90	92
36 We review our own structure, including size and sub-committee structure.	0	10	90	86
37 We have a process to elect or appoint our chair.	0	0	100	90

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2013 and agreed with the instrument items.

4.2 Patient Safety Culture Tool

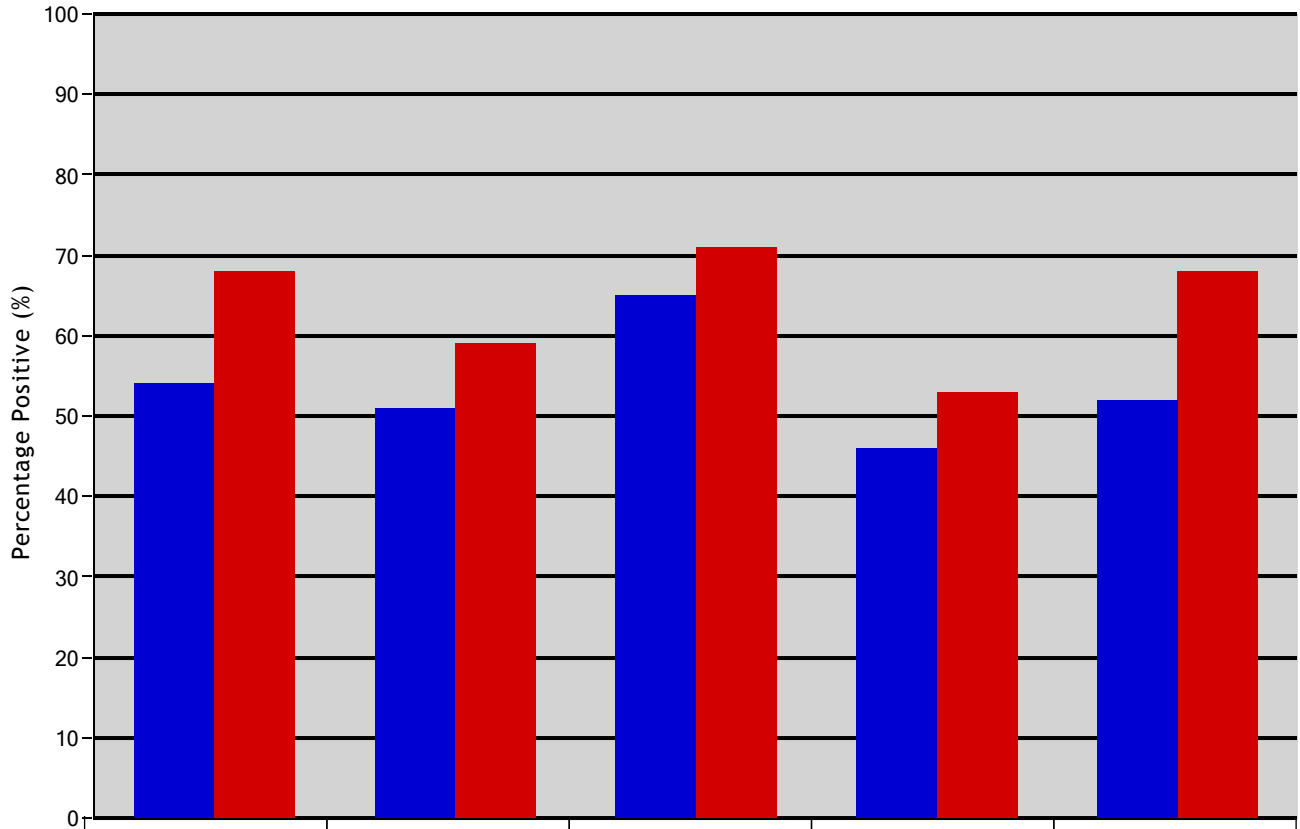
Organizational culture is widely recognized as a significant driver in changing behavior and expectations in order to increase safety within organizations. A key step in this process is the ability to measure the presence and degree of safety culture. This is why Accreditation Canada provides organizations 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: September 12, 2013 to October 7, 2013**
- **Minimum responses rate (based on the number of eligible employees): 269**
- **Number of responses: 456**

Patient Safety Culture Tool: Results by Patient Safety Culture Dimension



	Senior leadership support for safety (valuing safety)	Supervisory leadership support for safety	Patient safety learning culture	Communication barriers/talking about errors	Overall perception of patient safety
	54%	51%	65%	46%	52%
	68%	59%	71%	53%	68%

Legend

Brant Community Healthcare System

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2013 and agreed with the instrument items.

4.3 Worklife Pulse

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

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

The organization used an approved substitute tool for measuring 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.

4.4 Client Experience Tool

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

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

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

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

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

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

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

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

Section 5 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 (BCHS) serves 136,000 residents of Brantford, Brant County, and surrounding communities. Over 80% of funding required to operate the organization is provided by the Ministry of Health and Long-Term Care via the Hamilton Niagara Haldimand Brant Local Health Integration Network (LHIN) and Cancer Care Ontario. Special projects and equipment are funded by the Brant Community Healthcare System Foundation and community partners (e.g., municipalities, academic institutions).

Services are provided across two sites, the Willett in Paris, Brant County and the Brantford General Hospital in the City of Brantford. The Willett, Paris is an urgent care centre with community outreach programs.

The Brant Community Healthcare System provides outpatient (including dialysis, diabetes education, oncology, diagnostic imaging, emergency, mental health and addictions, fracture clinic, stroke, and ambulatory care) and acute inpatient services (including mental health and addictions, maternal newborn child, critical care, acute medical, complex continuing care, rehabilitation, stroke, and surgical services). Over 1,400 staff, 300 physicians and 500 volunteers provide care and service across our two sites.

The Brantford General Hospital is also home to the Grand Erie Six Nations Clinical Education Campus and Mac-CARE Program. Over 300 students, including medical students, nursing students and allied health professionals from universities and colleges across the province (and sometimes beyond) complete their placements with the BCHS annually.

BCHS is a high-performing organization, consistently winning workplace awards (e.g., Ontario Hospital Association's Silver Quality Workplace Award for 2014) and being recognized for high quality of care e.g. Canadian Institute for Health Information (CIHI) hospital standardized mortality ratio (HSMR) have been the lowest in the country for the past 5 years.

To continue to be a top performing organization, meet the multitude of challenges facing the healthcare system, and capitalize on the potential that the challenge of change brings, BCHS has made a number of transformational changes over the last two years: instituting a continuous quality improvement philosophy through adopting a LEAN management system, realigning the organization's structure to value streams and changing the model of care to ensure patients have an improved experience of care.

Such transformational change is required to meet the organization's ambitious goals set out within the new True North established in the 2013-6 Strategic Plan which include putting "Patients First", "Using our Resources Wisely", and creating a "Great Place to work".
Results noted through the surveyor commentary further supports the organization's vision of our True North and values.

The survey team assigned to the BCHS conducted a rigorous, in-depth evaluation and exploration of our processes and initiatives over the course of 4 days. Surveyors were knowledgeable, thorough and engaging. While opportunities for improvement were identified and welcomed, the positive re-iteration of our current path/direction was also validated. We appreciate the feedback provided and the experience this survey team provided to our staff, patients, community, volunteers, and physicians.

Utilizing the Qmentum process; Service Excellence Standards, Required Organizational Practices and Priority Processes is a very prescriptive and standardized approach to ensuring our level of compliance with safety and quality is adhered to. The onsite peer review process is instrumental in providing our staff with an opportunity to share the excellent work that they do, on a daily basis, to ensure optimal patient outcomes and experience.

The ongoing commitment to performance excellence, continuous quality improvement, risk identification and mitigation will be guided by our strategic directions, Quality, Patient Safety & Risk Management framework, Quality Improvement Plan and Quality Performance Roadmap.

As always, the experience of Qmentum has brought to the forefront the amazing group of individuals, both within and external to the organization, who makes up the BCHS and who will propel us to realize our True North: Patient First, Using Resources Wisely, and being a Great Place to Work. We thank Accreditation Canada staff and the volunteer surveyors who worked with us and whose insights and encouragement will guide us in the next phase of our quality improvement journey.

Appendix A Qmentum

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

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

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

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

Action Planning

Following the on-site survey, the organization uses the information in its Accreditation Report and Quality Performance Roadmap to develop action plans to address areas identified as needing improvement. The organization provides Accreditation Canada with evidence of the actions it has taken to address these required follow ups.

Evidence Review and Ongoing Improvement

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

Appendix B Priority Processes

Priority processes associated with system-wide standards

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

Priority processes associated with population-specific standards

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

Priority processes associated with service excellence standards

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

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