ACCREDITATION AGRÉMENT CANADA
Qmentum

Accreditation Report

The Scarborough Hospital

Scarborough, ON

On-site survey dates: October 2, 2016 - October 7, 2016

Report issued: October 31, 2016

About the Accreditation Report

The Scarborough Hospital (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 October 2016. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

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

Confidentiality

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

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

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

A Message from Accreditation Canada

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

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

Your 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,

Leslee Thompson
Chief Executive Officer

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Executive Summary

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

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

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

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

Accreditation Decision

The Scarborough Hospital's accreditation decision is:

Accredited (Report)

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

About the On-site Survey

- **On-site survey dates: October 2, 2016 to October 7, 2016**

- **Locations**

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

  1. The Scarborough Hospital, Birchmount Campus
  2. The Scarborough Hospital, General Campus

- **Standards**

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

  System-Wide Standards

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

  Service Excellence Standards

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

- **Instruments**

  The organization administered:

  1. Governance Functioning Tool (2011 - 2015)
  2. Canadian Patient Safety Culture Survey Tool
  3. Worklife Pulse
  4. Client Experience Tool

Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
 Population Focus (Work with my community to anticipate and meet our needs)	51	0	0	51
 Accessibility (Give me timely and equitable services)	90	0	0	90
 Safety (Keep me safe)	634	6	10	650
 Worklife (Take care of those who take care of me)	124	1	1	126
 Client-centred Services (Partner with me and my family in our care)	369	3	0	372
 Continuity of Services (Coordinate my care across the continuum)	71	0	2	73
 Appropriateness (Do the right thing to achieve the best results)	1022	7	6	1035
 Efficiency (Make the best use of resources)	56	0	0	56
Total	**2417**	**17**	**19**	**2453**

Overview by Standards

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

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

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

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

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	50 (100.0%)	0 (0.0%)	0	36 (100.0%)	0 (0.0%)	0	86 (100.0%)	0 (0.0%)	0
Leadership	48 (98.0%)	1 (2.0%)	0	94 (97.9%)	2 (2.1%)	0	142 (97.9%)	3 (2.1%)	0
Infection Prevention and Control Standards	41 (100.0%)	0 (0.0%)	0	30 (100.0%)	0 (0.0%)	1	71 (100.0%)	0 (0.0%)	1
Medication Management Standards	73 (100.0%)	0 (0.0%)	5	62 (100.0%)	0 (0.0%)	2	135 (100.0%)	0 (0.0%)	7
Ambulatory Care Services	46 (100.0%)	0 (0.0%)	0	77 (98.7%)	1 (1.3%)	0	123 (99.2%)	1 (0.8%)	0
Ambulatory Systemic Cancer Therapy Services	65 (98.5%)	1 (1.5%)	0	91 (98.9%)	1 (1.1%)	0	156 (98.7%)	2 (1.3%)	0
Biomedical Laboratory Services **	71 (100.0%)	0 (0.0%)	0	105 (100.0%)	0 (0.0%)	0	176 (100.0%)	0 (0.0%)	0
Critical Care	48 (96.0%)	2 (4.0%)	0	114 (100.0%)	0 (0.0%)	1	162 (98.8%)	2 (1.2%)	1

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Diagnostic Imaging Services	67 (100.0%)	0 (0.0%)	0	69 (100.0%)	0 (0.0%)	0	136 (100.0%)	0 (0.0%)	0
Emergency Department	70 (98.6%)	1 (1.4%)	0	106 (99.1%)	1 (0.9%)	0	176 (98.9%)	2 (1.1%)	0
Medicine Services	44 (97.8%)	1 (2.2%)	0	77 (100.0%)	0 (0.0%)	0	121 (99.2%)	1 (0.8%)	0
Mental Health Services	50 (100.0%)	0 (0.0%)	0	92 (100.0%)	0 (0.0%)	0	142 (100.0%)	0 (0.0%)	0
Obstetrics Services	71 (100.0%)	0 (0.0%)	2	88 (100.0%)	0 (0.0%)	0	159 (100.0%)	0 (0.0%)	2
Perioperative Services and Invasive Procedures	111 (96.5%)	4 (3.5%)	0	109 (100.0%)	0 (0.0%)	0	220 (98.2%)	4 (1.8%)	0
Point-of-Care Testing **	38 (100.0%)	0 (0.0%)	0	46 (100.0%)	0 (0.0%)	2	84 (100.0%)	0 (0.0%)	2
Reprocessing and Sterilization of Reusable Medical Devices	53 (100.0%)	0 (0.0%)	0	63 (100.0%)	0 (0.0%)	0	116 (100.0%)	0 (0.0%)	0
Transfusion Services **	70 (100.0%)	0 (0.0%)	5	68 (100.0%)	0 (0.0%)	1	138 (100.0%)	0 (0.0%)	6
Total	**1016 (99.0%)**	10 (1.0%)	12	1327 (99.6%)	5 (0.4%)	7	2343 (99.4%)	15 (0.6%)	19

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

Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Safety Culture			
Accountability for quality (Governance)	Met	4 of 4	2 of 2
Patient safety incident disclosure (Leadership)	Met	4 of 4	2 of 2
Patient safety incident management (Leadership)	Met	6 of 6	1 of 1
Patient safety quarterly reports (Leadership)	Met	1 of 1	2 of 2
Patient safety-related prospective analysis (Leadership)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Communication			
Client Identification (Ambulatory Care Services)	Met	1 of 1	0 of 0
Client Identification (Ambulatory Systemic Cancer Therapy Services)	Met	1 of 1	0 of 0
Client Identification (Biomedical Laboratory Services)	Met	1 of 1	0 of 0
Client Identification (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: Communication			
Client Identification (Diagnostic Imaging Services)	Met	1 of 1	0 of 0
Client Identification (Emergency Department)	Met	1 of 1	0 of 0
Client Identification (Medicine Services)	Met	1 of 1	0 of 0
Client Identification (Mental Health Services)	Met	1 of 1	0 of 0
Client Identification (Obstetrics Services)	Met	1 of 1	0 of 0
Client Identification (Perioperative Services and Invasive Procedures)	Met	1 of 1	0 of 0
Client Identification (Point-of-Care Testing)	Met	1 of 1	0 of 0
Client Identification (Transfusion Services)	Met	1 of 1	0 of 0
Information transfer at care transitions (Ambulatory Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Ambulatory Systemic Cancer Therapy Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Critical Care)	Met	4 of 4	1 of 1
Information transfer at care transitions (Emergency Department)	Met	4 of 4	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information transfer at care transitions (Medicine Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Mental Health Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Obstetrics Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Perioperative Services and Invasive Procedures)	Met	4 of 4	1 of 1
Medication reconciliation as a strategic priority (Leadership)	Met	4 of 4	2 of 2
Medication reconciliation at care transitions (Ambulatory Care Services)	Met	7 of 7	0 of 0
Medication reconciliation at care transitions (Ambulatory Systemic Cancer Therapy Services)	Met	7 of 7	0 of 0
Medication reconciliation at care transitions (Critical Care)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Emergency Department)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Medicine Services)	Met	5 of 5	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Mental Health Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures)	Met	8 of 8	0 of 0
Safe surgery checklist (Obstetrics Services)	Met	3 of 3	2 of 2
Safe surgery checklist (Perioperative Services and Invasive Procedures)	Unmet	2 of 3	2 of 2
The “Do Not Use” list of abbreviations (Medication Management Standards)	Met	4 of 4	3 of 3
Patient Safety Goal Area: Medication Use			
Antimicrobial stewardship (Medication Management Standards)	Met	4 of 4	1 of 1
Concentrated electrolytes (Medication Management Standards)	Met	3 of 3	0 of 0
Heparin safety (Medication Management Standards)	Met	4 of 4	0 of 0
High-alert medications (Medication Management Standards)	Met	5 of 5	3 of 3
Infusion pump safety (Ambulatory Care Services)	Met	4 of 4	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Infusion pump safety (Ambulatory Systemic Cancer Therapy Services)	Met	4 of 4	2 of 2
Infusion pump safety (Critical Care)	Met	4 of 4	2 of 2
Infusion pump safety (Emergency Department)	Met	4 of 4	2 of 2
Infusion pump safety (Medicine Services)	Met	4 of 4	2 of 2
Infusion pump safety (Mental Health Services)	Met	4 of 4	2 of 2
Infusion pump safety (Obstetrics Services)	Met	4 of 4	2 of 2
Infusion pump safety (Perioperative Services and Invasive Procedures)	Met	4 of 4	2 of 2
Narcotics safety (Medication Management Standards)	Met	3 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Client Flow (Leadership)	Met	7 of 7	1 of 1
Patient safety plan (Leadership)	Met	2 of 2	2 of 2
Patient safety: education and training (Leadership)	Met	1 of 1	0 of 0
Preventive maintenance program (Leadership)	Met	3 of 3	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Worklife/Workforce			
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
Hand-hygiene education and training (Infection Prevention and Control Standards)	Met	1 of 1	0 of 0
Infection rates (Infection Prevention and Control Standards)	Unmet	0 of 1	2 of 2
Patient Safety Goal Area: Risk Assessment			
Falls prevention (Ambulatory Care Services)	Met	3 of 3	2 of 2
Falls prevention (Ambulatory Systemic Cancer Therapy Services)	Met	3 of 3	2 of 2
Falls prevention (Critical Care)	Met	3 of 3	2 of 2
Falls prevention (Diagnostic Imaging Services)	Met	3 of 3	2 of 2
Falls prevention (Emergency Department)	Met	3 of 3	2 of 2
Falls 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			
Falls prevention (Mental Health Services)	Met	3 of 3	2 of 2
Falls prevention (Obstetrics Services)	Met	3 of 3	2 of 2
Falls prevention (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
Pressure ulcer prevention (Critical Care)	Met	3 of 3	2 of 2
Pressure ulcer prevention (Medicine Services)	Met	3 of 3	2 of 2
Pressure ulcer prevention (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
Suicide prevention (Emergency Department)	Met	5 of 5	0 of 0
Suicide prevention (Mental Health Services)	Met	5 of 5	0 of 0
Venous thromboembolism prophylaxis (Critical Care)	Met	3 of 3	2 of 2
Venous thromboembolism prophylaxis (Medicine Services)	Met	3 of 3	2 of 2
Venous thromboembolism prophylaxis (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2

Summary of Surveyor Team Observations

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

The residents of Scarborough came together to build two community hospitals in 1956 and 1985: The Scarborough General Hospital (Scarborough General) and The Salvation Army Scarborough Grace Hospital (Scarborough Grace). Both hospitals were innovators in providing health care services to their communities. In 1999 the two organizations merged to form The Scarborough Hospital (TSH). Today, the sites are referred to as the General campus and the Birchmount campus.

In 2015 and 2016, the Birchmount and the General campuses celebrated their 30th and 60th anniversaries, respectively. With 90 combined years of excellence in health care, TSH has changed lives, strengthened the community, and helped Scarborough grow.

TSH is situated in one of the most diverse communities in Canada and delivers a wide range of services including being a regional centre for ophthalmology and vascular surgery, operating the largest renal (kidney care) program in Canada, and being a centre of excellence for maternal, child, and newborn care; breast cancer and reconstructive surgery; and orthopedic surgery. The global community served includes a population that is 59 percent foreign born and more than 50 percent have English as a second language. In addition, 42 percent of the improvement areas in a recent Greater Toronto Area study on population needs are in the Scarborough catchment. This highlights the unique population served by the staff, physicians, and volunteers at TSH.

In August 2014, TSH launched a planning process to renew its strategic and clinical directions plans, calling this process “Forward Together: Building a Healthier Scarborough 2015-2019.” Four strategic priorities resulted from this new and refreshed direction: patients as partners, quality and sustainability, integrated care networks, and innovation and learning. Forward Together acknowledges that the hospital’s many successes are possible through a collective team effort and a collaborative spirit that defines approaches and solutions for the future.

In the spirit of ongoing engagement and collaboration, TSH reached out to all of its key stakeholders throughout the planning process – including staff, physicians, the TSH Foundation, volunteers, patients, provider partners, community residents, and various community groups including the hospital’s Community Advisory Council (now called the Community and Patient Advisory Council or CPAC) – to ensure there were multiple opportunities for people to get involved and provide their input and feedback.

In addition to the strategic priorities, TSH's mission is to provide an outstanding care experience that meets the unique needs of each and every patient, with a vision of being recognized as Canada’s leader in providing the best health care for a global community. Its values, expressed as ICARE (integrity, compassion, accountability, respect, excellence), are engrained in everything it does.

The board of directors has embraced the strategic priority of patients as partners. There are now community advisors and representatives on board committees. The directors are caring, passionate, and committed to patients and families and the community of Scarborough, with this being their “always front and centre” focus. Board members promote a culture of transparency, communication, and inclusiveness. They take pride in and acknowledge the resiliency of the committed staff at TSH, recognizing how they have embraced innovation and how dedicated they are to making a difference.

The Senior Management Team (SMT) models the values of TSH to improve the culture of staff and patient engagement and focus on quality improvement and patient safety. It is commended on its achievements with innovative and efficient processes as good custodians of resources. The SMT leverages multiple competing needs exceptionally well and is committed to forward thinking and innovation. In pursuit of high quality care, there is much community pride and strong trust relationships internally across programs and externally with partners. The SMT members ensure they are good communicators internally and externally and that planning is deeply socialized.

There are opportunities to continue to evolve and develop strategic partnerships, integrate programs to avoid duplication, and maximize resources for continued efficiencies. Addressing length of stay and implementing new models of care and partnerships to avoid admissions and divert to the community are in progress and the organization is encouraged to continue with these.

TSH has a long-standing history of understanding and adapting to the needs of one of Canada’s most diverse populations. Over twenty years ago, it was one the first hospitals in Ontario to dedicate a department and a director focused on diversity, to meet the changing community and patient profile needs. Recently, TSH transitioned its community council to one that now includes the patient voice. The CPAC provides guidance on overarching patient engagement activities and reports directly to the board.

In addition, patient and family advisors have been implemented across the organization, starting in the Mental Health and Addiction, Renal, and Oncology programs, and the Emergency Department. Integrating advisors with teams for planning, recruitment, and new processes is extremely well done. TSH is encouraged to continue to embed patient and family advisors into the organization as staff see tremendous value in their input and patients/families appreciate being asked. The board and the SMT are extremely committed to ensuring the culture of engagement and preserving patient- and family-centred care as a continued focus for TSH.

Community partners that were invited to participate in the on-site survey included Carefirst Seniors & Community Services Association, Centennial College, Scarborough Centre for Healthy Communities, Providence Healthcare, Yee Hong Centre for Geriatric Care, University of Toronto Scarborough campus, Toronto Paramedics, St Paul’s L'Amoreaux Centre, Alzheimer Society of Toronto, Catholic Crosscultural Services, TransCare Community Support Services, and the South Asian Autism Awareness Centre. The extensive list of invitees is evidence of TSH’s community collaboration. Community partners were very complimentary of the level of input they are asked for with respect to community planning and processes to enhance the patient experience. Some examples of community initiatives are academic partnerships with Centennial College and U of T Scarborough campus that have resulted in placements for students, process

improvements for flow with Providence and St Paul's, access to community clinic support such as the Geriatric Assessment and Intervention Network (GAIN), the renal program partnership with Yee Hong, and memoranda of understanding agreements for ethics and other support with Scarborough Centre for Healthy Communities, to name a few. Community partners described TSH as playing an anchor role for the community with the capacity to bring people together, and see the organization as responsive, committed, accountable, innovative, and a great partner for any initiative that will benefit patients.

Community partners identified a number of opportunities for improvement. These included continuing to collaborate with them to define the hospital role and the community agency role, continuing to address the diversity of the community, avoiding admissions, providing good transfer of accountability to providers through discharge practices, improving on wayfinding, and continuing to collaborate on community events such as disaster planning. Overall, partners commented on feeling appreciated by the staff as they collaborated on opportunities to improve transitions of care across the continuum.

Numerous improvements to support staff and work-life wellness have been implemented since the last on-site survey. Actions to address the outcomes from the recent Metrics@Work survey have been implemented, with support to teams that had lower engagement scores. Of note, the employee engagement score for 2010 was 42.7 percent, rising to 62.7 percent in 2016, a steady climb and a tremendous improvement. Key initiatives have been implemented, including the Rising Star program, a new talent management program for leaders; wellness programs like Exhale; and a fitness centre at both sites with personalized programs. Staff are recognized through annual service awards, a summer BBQ, and bursary programs for continuing education which are much appreciated by all.

At the front line, an enhanced model of interprofessional care based on key patient-centred principles has been rolled out, with a goal of developing better perspectives by learning with, from, and about each other, both providers and patients. Other deliverables being pursued that engage patients and caregivers and span the organization are the development of shared care plans, shift change reports at the patient bedside, a review of the hospital's visitor policy, patient involvement in new staff orientation, and improvements in hospital wayfinding, to name just a few initiatives have been implemented.

Employees conveyed their appreciation for the support in the workplace and expressed pride in the care they provide to the diversity of patients who present for service. Many staff members have contributed for a number of years as long-standing employees.

Through the clinical action plan, standardizing and eliminating clinical practice variation has put the quality of patient care at the forefront. Changes have been implemented and more are in progress through communicating the value of standardized practices from the "voice of the patient." Examples include oncology, renal, vascular, and orthopedic inpatient care at the General campus; and ophthalmology, mental health, and day surgery programs at the Birchmount campus. Through strong clinician engagement and leadership TSH continues to forge the way toward clinical service planning that considers critical mass and expertise, has a positive impact on patient care and quality, and achieves the best patient outcomes. Through service integration, opportunities to improve efficiency and use of capital and reduce duplication will result.

It was a pleasure as a survey team to be part of this highly engaged organization that is focused on patients as partners first and foremost and that keeps this front and centre at all times.

Detailed Required Organizational Practices

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

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

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Communication	
Safe surgery checklist A safe surgery checklist is used to confirm that safety steps are completed for a surgical procedure performed in the operating room.	· Perioperative Services and Invasive Procedures 14.3
Patient Safety Goal Area: Infection Control	
Infection rates The organization tracks health care-associated infections, analyzes the information to identify outbreaks and trends, and shares this information throughout the organization.NOTE: This ROP only applies to locations that have beds and provide nursing care.	· Infection Prevention and Control Standards 12.2

Detailed On-site Survey Results

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

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

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

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

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

See Appendix B for a list of priority processes.

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

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

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

Priority Process Results for System-wide Standards

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

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

Priority Process: Governance

Meeting the demands for excellence in governance practice.

The organization has met all criteria for this priority process.
Surveyor comments on the priority process(es)

The Scarborough Hospital Board of Directors is a compassionate group that is committed to doing the right thing by focusing on patients, families, and the community of Scarborough; keeping these groups front and centre in all decisions; and listening to what the community, through patients, staff and advisors, has to say. Board members have used the ethical framework to work through challenging situations. They are highly supportive of the future integration of acute care services in Scarborough and advocate for their communities and staff.

Approximately three to four years ago some turnover on the board resulted in a fairly new team being the one to forge the way for the future of the community. However, there is a very good balance of corporate memory on the board. The board made a conscious decision to reshape itself to develop into a high-performing team. The board is proud of the staff innovation in care delivery models emerging from the clinical action plan to optimize quality of care at both sites.

The board undertakes a self-evaluation annually and reviews the skill sets each member brings to the committee, to plan for the recruitment of new members. The current board is highly skilled and represents the multidimensional needs of a high-performing board of directors. The nominating and recruitment process is innovative. Everyone who applies is invited to the organization and presented with an overview of the organization, time commitment, etc. to determine if this is the right fit for the individual and if the applicant is informed and aware of what they are getting into and the commitment they are making. It also allows the Nominating Committee to screen potential candidates.

The board, in collaboration with the SMT, establishes the strategic direction for the organization with the aim of achieving four strategic pillars, one of which is patients as partners. Expectations are established from the top to integrate the voice of the community and patients in all matters of the organization.

All board committees have a workplan and review scorecard performance. Quality performance is also monitored through the integrated risk management tool, quality improvement plan updates, adverse

events, good catch/near misses, and patient safety updates. In addition, the board hears stories about the patient experience at both Quality and Safety Committee and at the full board meeting. The board understands the importance of not only resolving concerns brought forward by patients and families but also being able to sustain improvements that are made.

Three board committees, Audit and Accountability, Directors Nominating, and Members Nominating, include community members in their membership. In addition, members of the Community and Patient Advisory Council participate at board meetings and provide updates twice a year.

The board is extremely proud of the innovation, caring, and resiliency of TSH staff and the ongoing collaborative partnerships with patients, families, and the community.

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)

At TSH, annual planning is aligned with the strategic plan, with a comprehensive review of the overall budget and forecasting as a starting point. The management team starts the process, engages the clinical action plan, and ensures patient safety is top of mind. An action that resulted from this year's annual operating plan was to gain efficiency in beds, model of care and a bed mapping which resulted in transition beds becoming operational.

The annual report is a review of how the organization did against its established objectives. In addition, the clinical action plan was planned and aligned with the new strategic plan, with recommendations for service planning and integration over four years. Some service integrations that have resulted as a result of quality of care were orthopedics, ENT, TIA stroke care, MH and A programming etc.

To assist with planning TSH conducts an environmental scan and reviews current performance and future forecasting by monitoring performance score cards, ensuring process and outcomes measures are tied directly to strategic goals and objectives, using financial reporting tools such as forecast and actual budgets, and using project management tools. Key partners are engaged, as evidenced at the community partners meeting where community agencies and programs felt welcomed and were openly engaged for feedback and participation in program planning and improvements with the hospital.

The leadership team is very proud of what has been achieved with the resources available. The leaders are true custodians of the resources they receive. They leverage opportunities well and ensure the focus is always on the communities (patients, families, partners, and staff), and ensure their plans are deeply socialized and communicated broadly. TSH leaders are transparent, resilient, fiscally responsible, innovative, and dedicated to caring for patients and building trusting relationships.

The Scarborough Hospital provides a full array of non-denominational spiritual care services at the General and Birchmount campuses. The spiritual care space is easily identifiable and fully accessible, and is located near the main entrance at both sites.

Opportunities for the leadership team are to continue to advocate for the capital infrastructure that is needed, find efficiencies even when it appears there are few left, and preserve the culture they have established for their community and staff while maintaining the values that have enabled them to be successful through the integration with RVHS. In addition, the journey of embedding patient- and family-centred care has really taken off in the past year. The leadership team is encouraged to continue to find opportunities to develop patient- and family-centred care for specific programs and integrate advisors into daily work.

Priority Process: Resource Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The Financial Services and Performance and Decision Support Departments are knowledgeable and aligned with their customer's needs to ensure excellent financial management and controls. A target of $8 million in efficiencies is on target to be realized this year. Last year (2015/2016), as in previous years, TSH had a balanced budget. There is always a focus on finding savings in the system and doing more with less.

Financial management education for managers is available. In addition, new board members and Community and Patient Advisory Council members receive education on funding models.

The supply chain redesign, through a Six Sigma black belt 5S project, resulted in savings of $93K in 11 months. The organization is encouraged to continue to roll out this project across both organizations, as there were stocked supply rooms in some of the high-volume clinical units such as the EDs. Standardizing packs in the operating room has helped TSH stay within the quality-based procedures allocation for surgical procedures. This has taken a lot of time, effort, and commitment on the part of the surgical program leaders.

Decision support reports and case costing data have improved in recent years. There are opportunities to improve the way end users receive information. Moving toward a business intelligence system that integrates financial, utilization, and human resource performance metrics would help managers have information and analysis readily available. Currently, information needed for analysis is received promptly. More proactive program reporting, with clinical support and partners providing information and analysis, will give front-line managers time to focus on other quality work, remove barriers, and coach staff.

One of TSH's biggest challenges is to address the capital infrastructure needs. Currently the largest project is the diagnostic imaging redesign project to improve flow and the patient experience. There are also a number of ongoing Health Infrastructure Renewal Fund projects underway. "Keeping the lights open" projects have been approved to sustain the sites until a broader community master plan can be addressed post integration.

Priority Process: Human Capital

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
10.12 Policies and procedures regarding performance monitoring include how to deal with performance issues in an objective and fair way.	

Surveyor comments on the priority process(es)

The Human Resources, Organizational Development and Diversity, and Occupational Health Departments at TSH have worked tirelessly to bring stability to people support and practices over the four years since the last on-site survey. Many improvements have been implemented to ensure a strong staffing foundation for the community at large. Relationships with the various labour relations groups have improved and recruitment and retention practices have resulted in retaining long-standing employees. In the past year over 120 people were recognized for more than 25 years of service.

Turnover rates are very low, at less than 3 percent, and strategies to recruit for hard-to-fill positions have led to innovative partnerships and models (e.g., critical care recruitment, service area roles with academic partners). There is an opportunity to expand on these relationships to partners and attract candidates to positions that continue to be hard to fill due to difficulties finding the right skill mix (e.g., ultrasound technicians).

TSH offers employees a number of options to support professional talent development, including financial assistance for continuing education, technology skills development for front-line staff, presentation skills, online e-learning modules, diversity and “bias-free” training, and an Emerging Leaders program that is entering its second cohort. More than 30 staff participated in the first cohort, following which 40 percent took on stretch and leadership positions.

In addition, the organization has invested in leadership and talent development through a unique partnership with Massachusetts Institute of Technology (MIT). Coaching and assessment of capacity and leadership skills have been implemented, all leading toward the development of leaders through the Rising Star program. As part of year 1 implementation, an opportunity to improve on the performance appraisal approach and conversations between all supervisors and their staff on assessment and development resulted in Valuing Individual Performance (VIP) chats where managers and staff are expected to have discussions about learning and development, skills, goal setting, and workplace feedback, all prompted by questions.

While this new process has improved the dialogue between leaders and staff, in discussion with stakeholders it appears there was variation in value of this tool and that the information is not currently

being used consistently as a reflective practice tool when conversations and comments are documented and submitted. The organization is encouraged to continue to highlight the value of this process and develop an approach to continue this innovative project, aligned to a leadership framework so discussions are focused on development, evaluation of progress towards stated objectives, and reflective practice. TSH leadership is committed to do so using the MIT leadership capabilities approach. The organization is encouraged to continue the journey toward the goals of staff engagement, performance management, and talent development, as it is a unique approach that other healthcare partners and industries would be very interested in.

The medical credentialing process follows standard expectations and is now online. The organization is encouraged to consider building in performance reviews with all physicians through the annual credentialing process, to provide feedback based on the CanMEDS.

The Metrics@work staff engagement score increased to 62.7 percent in 2015 and has increased year over year from 2010, when it was 42.7 percent. Organizational Development is available to work with teams to develop action plans and focused support for teams in the lower 5 percent of the engagement range.

A number of work-life wellness initiatives are in place, including fitness centres at both sites, the Exhale massage program, and employee assistance programs. As well, there are recognition awards for long-term service, a summer BBQ day with activities for staff, and the highly appreciated Spirit Awards for which staff can nominate each other.

The SAFE reporting template is available for all workplace events, including incident reports, codes, staff safety, and workplace behaviours which include four different streams for follow up. Feedback received from staff in multiple areas is that the system is very time consuming to complete (up to 20 minutes).

The online learning management system has not been operational for some time. Mandatory training is being done and tracked manually. The organization is encouraged to bring this back online soon, to give staff the opportunity to complete these programs.

TSH has been a leader for decades in responding to diverse community care needs. It has won the Best Diversity Employer award and has profiles of community and staffing demographics that enables it to plan support and programs for staff and patients. TSH is highly recognized in Canada for this approach.

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	
16.5 Action has been taken on the client experience results.	!

Surveyor comments on the priority process(es)

The annual quality improvement plan supports the organizational focus on the four strategic directions: patients as partners, quality and sustainability, integrated care networks, and innovation and learning. The guiding values are at the forefront of each improvement plan.

There has been a significant commitment to ensure patients are at the centre of care and the voice of the community is always present in any improvement projects. TSH leadership should be proud of the uptake by teams to embrace this philosophy and are congratulated on the progress in such a short time.

The organization is encouraged to continue to integrate patient and family advisors throughout the organization. All teams are committed to doing so. To ensure success and improve staff focus, it is suggested the organization select a few key “priority 1” metrics with which to align annually. Ownership is greater if teams and individuals are responsible and accountable for a select few metrics for which they know they can make a difference with respect to quality and patient safety.

The reporting structure, from front-line staff to the board, emphasizes the importance of quality and safety as a shared accountability. SMT huddles at the Tier 4 board on a weekly basis. Program directors focus on performance at the Tier 3 boards and teams review key performance indicators at the Tier 1 huddles. This was evident throughout the organization. Recognition of staff efforts and evaluation of new processes and ideas are shared daily at the unit-based huddles. The organization continues to support LEAN as the quality improvement methodology. The socialization and sustainability of LEAN is demonstrated throughout the organization by all staff and physicians encountered by the on-site survey team.

Patient declaration of values are posted in key areas across both sites. These were developed by the Community and Patient Advisory Council in consultation with community stakeholders.

Numerous redesign and improvement projects aimed at improving patient experience, flow, and overall care and safety have been implemented. These include testing new options for triage in the ED, bed mapping the organization to put patients in the right bed at the right time and first time, redesigning

limited physical space, developing strategic partnerships for community dialysis sites and home program for the largest renal program in Canada, cross-training staff across sites, standardizing operating room packs to minimize risk with multiple options and decrease costs, and introducing point-of-care testing for mental health patients. Leaders at TSH are committed to planning, implementing, and evaluating processes for the benefit of patients and the community.

In the past year the Mental Health team developed a process to proactively implement a program for patients who are started on clozapine. The process was documented and has been implemented. Outcomes are being monitored to ensure the program will be beneficial from a clinical outcomes perspective; improve inpatient length of stay, which is more efficient for the hospital; and support an improved experience for patients who enter the program as an outpatient. Ongoing monitoring is encouraged, as results will be of interest to other organizations caring for patients with schizophrenia. Sharing the results, through publication or other means, will ultimately benefit more patients.

There is an opportunity for TSH to focus on patient satisfaction survey results and implement action plans to address formal feedback through a better understanding of “Would you recommend?” or “How would you rate the quality of care you received?” and reasons why the community would not rate them as excellent, very good, or good. TSH has been collaborating with the Ontario Hospital Association to develop a new process. It is important to understand where the opportunities for improvement are at the service level and develop either unit-based or corporate action plans to address them. In addition, it was noted that at the huddle boards patient experience feedback is focused on positive feedback. This is excellent reinforcement of the great work staff are doing to ensure patients receive an excellent experience; however, the organization is encouraged to ensure that all feedback is shared with staff so they can address it.

The focus on quality and patient safety at TSH is outstanding. Keep up the excellent work toward creating the best experience for patients, in co-design with them, their families, and the community.

Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The ethical framework was developed in 2012 and was recently updated. There was no framework prior to this time. Staff, patients, and family members had input into the creation of the framework.

The ethics program is supported by the SMT.

The ethical goals and objectives align with the strategic plan and direction of the organization. The board used the ethical framework to work through the merger with Rouge Valley Health System that will take place in November 2016. The ethicist indicated that the board identified issues and worked through several areas of concern, using the framework as a tool to support decision making. Ethics is a standing item on the board agenda and the ethicist is an ad hoc guest at board meetings, depending on the topic.

All new staff are oriented to the ethical framework. A training session was held for staff who wish to become ethical facilitators or super users. Currently nine staff are trained to support other staff to help them identify and work through ethical issues. Ongoing education and tabletop practices continue. The ethics team realizes there is still much work to do.

The most common ethical trend for the organization is consent and capacity. There has been one medical assistance in dying (MAID) case. Processes were quickly and methodically put into place and the hospital was able to meet the wishes of the patient and the needs of the family. The draft MAID policy is in the final stages of approval. The hospital has surveyed staff and created a list of those who are willing to assist in the MAID processes.

There is a code of conduct for the organization. Staff are familiar with how to report an unfavourable situation to the risk program. Once filed, this report goes to the manager for review and follow up.

The organization works closely with its community partners to identify and resolve ethical concerns. For instance, if a long-term care patient had an ethical issue at the hospital and was working with the interprofessional team, once that patient was discharged back to the long-term care facility, the hospital would continue to offer support to the organization and the patient. There are good working relationships with the police and the jail staff.

There is ongoing research and policies are current and available. An assigned administrative assistant is accountable for the paper work and signatures for studies, and ensures all protocols are met before a research study begins.

Priority Process: Communication

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
11.1 Information management systems selected for the organization meet the organization's current needs and take into consideration its future needs.	

Surveyor comments on the priority process(es)

TSH has a well thought-out and up-to-date corporate communications plan and strategy for 2016/2017. The organization has a very strong commitment to communications as evidenced by numerous communication platforms and streams targeted to internal and external stakeholders. The organization takes a proactive and transparent approach with communications to increase engagement, enhance public accountability and trust, and educate and inform stakeholders about its role and the services it provides in the community.

This is clearly evidenced in the refreshed website with a specific section dedicated to the potential upcoming integration with the Rouge Valley Health System (RVHS). This was done for all stakeholders. It includes input from the Community and Patient Advisory Council and provides real-time questions and answers to mitigate potential hostility and opposition. This clearly aligns with their new Patient as Partners strategic direction.

It is a standard expectation that all staff have email for internal communications as well as access to iConnect, the internal communications intranet. iConnect houses all policies and program information and is a central repository for the majority of documents which can be printed off in each area. iConnect is currently limited and needs some redesign, such as when staff need to find policies or documents to support best practice. When they enter in the search function similar to Google, it's a data repository and all documents with the word in come up, which can be confusing as they need to search the list for the most current and up-to-date information instead of having the most up-to-date document at the top of the list. This can be time consuming and potentially pose some risk to patient care.

As well as iConnect, there is iConnect Express that focuses on an e-newsletter format. TSH also has desktop images that showcase the mission, vision, and values. Frequent town halls and videos are also used for communication.

Although there is a very detailed 2015-2019 information management/information technology (IM/IT) plan, the majority of TSH plans and initiatives are on hold due to the impending merger with RVHS. This may put many outdated and aging platforms at risk. Following the RVHS amalgamation, the organization is strongly encouraged to enact its roadmap as a top priority to maintain strategic and clinical directions.

The organization is using a hybrid model of both paper and electronic medical records (EMR). The current SAFE reporting system is an electronic system used to report all incidents, as well as a quality management tool. Currently the system is noted by some of the clinical inpatient staff to be cumbersome. It can at times take over 20 minutes to use, which they state discourages them from reporting some events such as near misses. They also stated that there is some redundancy in the system, and for things such as “codes” the event can be charted and reported up to three times in different places. As the SAFE system is updated, the organization is encouraged to ensure a broader user group is part of project implementation, to mitigate and eliminate charting redundancies.

There are clear protocols and policies regarding privacy, confidentiality, and access of client information that align with legislation and are closely audited. Patients have a clear and easily accessible process to access their own health information. Due to the diverse patient population and community needs, there is exceptional access 24/7 to translation services. As well, translated documents and multi-language signage is clearly visible throughout both campuses, and the organization is commended on this.

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: Perioperative Services and Invasive Procedures	
3.2 The area where invasive procedures are performed has three levels of increasingly restricted access: unrestricted areas, semi-restricted areas, and restricted areas.	!

Surveyor comments on the priority process(es)

Physical plant and environmental services at both the General and Birchmount campuses are maintained by the team and include infrastructure, biomedical, and environmental services. The sites are clean and well maintained despite the aging infrastructure which presents ongoing challenges. Through capital upgrades and renovations the team has been successful in meeting legislation, codes, and regulations. Assessments have been completed for both sites by the ministry and funds are allocated based on criteria to deal with immediate pressure points. Currently, a major plumbing renovation is being completed at the General site through $5 million provided. General maintenance and upgrades are completed within the sites' operating budgets.

The General site has been identified as needing replacement; however, this is part of a larger master plan to be completed as part of the planned integration of sites. The Patient and Family Advisory Council has been consulted regarding larger capital needs and space redevelopment and design, but the team indicated it was challenging to involve them in the operational projects. There was evidence of patients being consulted in planning for the renovation and expansion of the cancer care chemotherapy space. The team is encouraged to continue to work with patients and families to get their input.

There are consistent policies and protocols at both sites. The team has identified goals and objectives that align with the organization's strategic priorities. Quality improvement initiatives are tracked and reviewed in weekly huddles with staff.

Biomedical services are provided through a contract with General Electric. The preventive maintenance program uses Angus software. A tenant request system is in place for repairs. Requests are received by a dispatcher and sent to maintenance staff members' BlackBerrys. Requests are prioritized and response times tracked. The team monitors the response time and shares it with staff, improving response times for closing work orders. The clinical teams acknowledge the responsiveness of the team to their requests for equipment repair.

There are adequate back-up systems to mitigate the impact of utilities failures on patients and the team.

Central control systems are monitored and checks completed on back-up generators to ensure proper functioning. Supplies of fuel are adequate to sustain the sites for up to five days.

A number of ongoing initiatives are in place to reduce waste. The Environmental team implemented the Green Army Team with input from staff, and it has increased the diversion of cans, bottles, and plastics from 16 to 22 percent. The Biomed team completed an initiative to cull outdated equipment and dispose of it. There is an ESCO contract focused on energy conservation at both sites. Several initiatives have been implemented with potential savings of 25 percent.

The team is acknowledged for winning the Highly Protected Risk (HPR) national award from HIROC and FM Global for their efforts to protect the physical facility from risk.

There are significant challenges with space being inadequate to meet the needs of the service areas. The operating rooms were identified as the smallest in the region and areas such as inpatient units at the General site are difficult to navigate. The team has done a lot of work to use space to maximum capacity and to involve staff and patients in how to best design areas for flow and safety. During the on-site survey, the operating room doors at the General site were malfunctioning and were left open, posing a risk of contamination. The team is encouraged to continue to work to ensure that semi-restricted and restricted areas are maintained to reduce potential risks.

There are contracts with external companies to inspect, monitor, and maintain medical gases and the HVAC system. Information is documented and maintained in the department.

Operating room cleaning schedules address cleaning between cases, daily cleaning, and 72-hour cleaning.

There were a number of quality initiatives on which the maintenance team was focused. One area they were working to improve was temperature control for the building, using input from patients and staff to address temperature and provide a comfortable climate. The team also worked with the clinical staff to create a checklist to be completed prior to reporting bed malfunctions. This was shared through team huddles and has reduced unnecessary calls as nursing staff can now troubleshoot.

Priority Process: Emergency Preparedness

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The emergency preparedness (EP) program aligns and reports within the Risk Management Department. There is one EP specialist who supports the program and who has created a comprehensive, flexible program that straddles and includes both sites. Risk Management, Facilities and Environmental Services, Infection Prevention and Control, Communications, and Security make up the core team. EP is well embedded within the organization and has representation from all areas and sites in the bi-monthly Emergency Management Advisory Committee. Both sites have the physical capacity and designated area to house the emergency operations centre or incident command post depending on the need and situation if it arises.

Well-established, standardized colour code protocols are practiced either as tabletop or mock exercises on a regular basis. Implementation of the newest colour code (silver) is being rolled out in the next couple of months. All codes have been developed using an inclusive best practice approach with input from numerous internal and external stakeholders as well as community partners.

Since the last on-site survey there is now a well-developed pandemic plan that was created in partnership with infection control leadership. It was created to be simple and functional with an intention to directly link to existing Surge protocols, making it useful for more than one type of pandemic situation. The EP specialist also has a direct link to the provincial DisasterLAN (DLAN) which is a live communication tool that supports EP for the province, linking real-time sharing of information to inform systems of incidents that may affect operations. All codes are reported on SAFE and reviewed and debriefed with the teams when necessary.

There is a formal orientation to EP with all staff and one of the future goals for the EP specialist is to include personal preparedness for all staff as part of the standard EP orientation. The EP program has a well-organized, detailed page on iConnect with a direct link from the home page so it is easy for staff to find. The EP program is well organized, connected, and truly embedded throughout the organization. TSH should be proud of the progress and work that has been done over the past five years.

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 General and Birchmount sites work together on patient flow. If one ED is busy, emergency medical services can be redirected to the other organization. Physician assistants and some nursing staff work at both sites depending on patient flow and workload. Registered nurses and registered practical nurses work in the ED with expanded scopes of practice. There are no nurse practitioners working in the ED areas and this might be considered to assist with patient flow and Canadian Triage and Acuity Scale (CTAS) criteria.

The Birchmount campus has recently built a Hub section where CTAS 4 and 5 patients can be fast tracked outside of the main ED. Approximately 70 percent of its patients are fast tracked through the ED. This campus is number 1 in the area for both emergency medical services offload and wait times for non-admit patients.

The EDs collected data and trended the busiest times of the week, and changed staff schedules to match the demands of preferred patient visits. Staff may be called in to care for patients if there are holders in the ED and no inpatient beds are available. ED staff may be required to go on ambulance transfers and at times this leaves the ED short staffed.

The bed flow meeting occurs every day at 10 a.m. Staff representing all clinical units are required to attend. Discharge rounds include an interdisciplinary approach and all attendees are engaged and participate with discharge plans. Social work, occupational therapy, physical therapy, hospitalists, and pharmacy, among others, are present. Community partners (e.g., Community Care Access Centre, Providence Healthcare, Carefirst) are encouraged to attend discharge rounds. When beds are tight in the hospital, managers attend bed management meetings.

A scheduled admission process is currently underway with the intent of inpatient staff pulling admitted patients to their clinical units, even if it causes overflow and surge on the inpatient unit but keeps the flow in the ED. With this process, patients are admitted and placed in a bed two hours sooner than previous practice. If either campus has beds, patients may be sent to that hospital and vice versa. It appears that pressure is placed on Providence Healthcare to take post-acute patients from this organization, and TSH is encouraged to check in to see how Providence is managing patient flow. Open pods are implemented in various areas of the hospitals as the need arises for more beds.

There is a significant issue with the number of alternate level of care (ALC) patients and ALC days at this hospital. A 250-bed long-term care facility in the Whitby area recently burned and the hospital is feeling the effects. Care transition units were recently created so ALC patients could be moved to a specific

location and kept together. This helps with care planning for these patients. Physicians receive scorecards and use them to highlight conservable days. The organization benchmarks length of stay and estimated length of stay, etc., with other like organizations. A global plan is needed to determine how to handle ALC patients and free up acute beds. There is also a need to review chronic ventilated patient stays in the critical care area and work toward moving these patients to the community.

The bed allocator is located next to the ED at both campuses. The bed allocator has access to a computer system to monitor discharged patients and when beds are cleaned. This is a good location from which to experience the need for ED patient flow. A bed manager attends discharge rounds in the clinic programs and assists with various processes to facilitate patient flow. The bed manager sees this role as helping out wherever possible. An evening supervisor assists with bed management.

Managers receive dashboard information early each morning to inform them of the bed situations in the hospital. The average wait time for admitted patients to be placed in a bed is around 23 hours. An ED tracker system helps identify wait times, CTAS levels, number of patients, and other metrics.

CT, ultrasound, and medical Imaging (satellite) are located next to the ED at the General campus. It is felt that this helps get faster service for patients, quicker diagnostic reports, and faster discharges. A picture archiving and communication system (PACS) is used. The ED physicians bought five ultrasounds for the EDs to assist with patient flow and decrease the need for patients to return for ultrasounds.

Patient advisors are used in this program and have provided input into program projects and ongoing work.

The Geriatric Assessment and Intervention Network (GAIN) clinic assesses the frail elderly and works to prevent hospitalization. Attempts are made to deal with social visits (i.e., patients who need support with some services but do not need to be admitted) in the ED and to send these patients home with services that match their needs.

Huddle boards are used to display daily pertinent metrics and focus on quality and safety.

There are several examples of efforts to maximize patient flow and put the patient in the right bed the first time. The organization has data to show length of stay is shorter when patients are admitted to the right bed and assessed by care providers as soon as possible.

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		
4.9	Contaminated items are transported separately from clean or sterilized items, and away from client service and high-traffic areas.	!
4.13	Clean and sterile surgical equipment, medical devices, and supplies are stored separately from soiled equipment and waste, and according to manufacturers' instructions.	!

Surveyor comments on the priority process(es)

The Product Evaluation Committee meets monthly. Both hospitals participate at this joint meeting. A cross-section of pertinent staff are required to attend, and some staff are brought in ad hoc. As of yet, there are no patients on this committee. The organization is encouraged to review this possibility.

There has been success in implementing standardized products at the two hospital sites, including total joint equipment, cataract packs, and smoke evacuators. The hospitals include the corporate chiefs in the decision making and this has been successful.

The hospital works with the system Plexxus. A project was just completed to colour code and LEAN the anaesthetic room and the results were impressive. It is estimated the hospitals saved $94,000 on stock and non-stock items through

When purchasing equipment, service agreement contracts, education and training for staff, and loaner equipment are negotiated with the purchase.

Staff are required to obtain specific credentials to work in their areas of specialization. New staff receive hospital and departmental orientation. Clinical resource leaders provide education sessions for staff, based on learning needs. The resource leaders are seen as valuable resources to their programs.

VIP is a new system of addressing and speaking with staff to provide feedback. It is in the early stage of implementation and staff are gradually becoming familiar with the process. This system replaces the paper performance appraisal system and provides a method of continuous learning and development for staff. It also provides the opportunity for direct contact and communication between the manager and staff. The program will evolve as staff become more familiar with expectations and desired outcomes from both the managerial and staff perspectives.

The Biomedical Department has a computer system that highlights annual preventive maintenance checks for equipment. The department does not check equipment that falls under a service contract. When loaner equipment is brought into the organization there is a cleaning, tracking, inspecting, and return policy to follow.

The Diagnostic Imaging (DI) Department moved the cleaning of probes from its department to the Medical Device Reprocessing Department (MDRD), and there will be no further cleaning or sterilization of equipment in the DI Department. They have recently purchased more probes as well as ventilated cupboards to store the probes to accommodate the needs. This program is congratulated for this initiative and its completion.

There is the possibility to flash instruments in the operating room and the organization records the processes appropriately. The hospital is encouraged to stop this practice and invest in the appropriate number of instruments required if an instrument drops or breaks.

The MDRD spaces at both hospital sites are large and bright, and the work flows from soiled to clean. Staff were familiar with their assigned work and the purpose behind their assignments. Ventilation, humidity, and temperature are monitored on a schedule by Facilities Management. There are no designated elevators to transport soiled and sterile equipment and supplies going to the operating room or coming from the operating room to the MDRD. The hospital uses open carts with a plastic garbage-bag-like cover. The hospital is encouraged to look at this method of transportation. A hole was found in the green cover and was ready for transport to the OR. Public elevators are used for transportation to the operating room at the General campus.

The soiled room at the General campus had clean suction containers etc., stored in the soiled area. This needs to be reviewed to ensure all clean items are removed from the soiled area. With the hospital being 60 years old, there is limited storage space. At the Birchmount campus, soiled carts are placed in public hallways and near a public waiting room. The organization is encouraged to review soiled and clean space. The areas are all very clean and the Environmental Services and front-line staff are commended for their diligent work.

The endoscopy suite is located outside the operating rooms at each hospital site. There were separate cleaning rooms that housed three Olympus washers. The scopes were tested for leaks prior to soaking and brushing. Ventilated storage containers were used to house the scopes in a clean storage area. Staff were wearing appropriate personal protective equipment to clean and process the scopes.

Staff and physicians felt they generally had sufficient equipment and that it was technologically current and in good condition. Staff were familiar with their role, accountability, and how to put a ticket into the computer system to begin the repair process.

Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Point-of-care Testing Services

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

Clinical Leadership

- Providing leadership and direction to teams providing services.

Competency

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

Episode of Care

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

Decision Support

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

Impact on Outcomes

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

Medication Management

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

Organ and Tissue Donation

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

Infection Prevention and Control

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

Diagnostic Services: Imaging

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

Diagnostic Services: Laboratory

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

Transfusion Services

- Transfusion Services

Standards Set: Ambulatory Care Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
2.4 Space is co-designed with input from clients and families to ensure safety and permit confidential and private interactions with clients and families.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

There is a dedicated and strong leadership team in the Chronic Kidney Disease (CKD) program. Over 3,000 chronic kidney disease patients are served by this program, and approximately 220 to 230 patients receive home dialysis.

Patient and Family Advisory Council members assist with the functions of the CKD program. With a large population to serve and limited space in an older facility, there is minimal opportunity to change the way the service is provided.

Patients spoken with at the hospital and at a satellite dialysis unit (Yee Hong Centre for Geriatric Care) were extremely pleased with the services provided and the professional staff who care for them. The

physicians and clinical staff ensure there is flex time in their daily schedules to see urgent cases. Staff have employee assistance programs available to them and peer support to assist in dealing with a patient's death. Staff attend patient funerals to demonstrate support for the families and closure for themselves. An ethicist is available to patients and staff, and staff in the program were familiar with the ethical framework.

The orthopedic and plastics clinic at the General campus is spacious and provides privacy for patients. There are several sinks and hand stations to support hand hygiene.

At the Birchmount campus, there is a orthopedic clinic for outpatients. Two orthopedic technologists and a nurse were available to support the 35 visits for the shift. This space was large, clean, and very private.

The organization is encouraged to use a number system rather than calling out patients' names in the waiting areas. This was observed in all waiting areas at both hospitals and is a breach of privacy.

At the General campus, minor procedures are completed on one side of the operating room. The surgical pause occurred. Consents were completed and noted on the chart. Education and follow-up instructions are given to patients following the procedure and patients have to sign that they have received the information. Feedback from patients indicated that they felt they were provided with the necessary information to make informed decisions and understood what they were consenting to. Patients were pleased with their care.

Minor procedures were done at a Birchmount clinic outside the operating room and could also be done in the ED if necessary. Consents were obtained by the physician.

Priority Process: Competency

The VIP tool is used to provide feedback to staff on a regular basis. Managers are expected to communicate with staff and vice versa. These talks are documented and become part of the staff member's human resources file. The VIP tool replaces the hard copy performance appraisal previously used. It is hoped the compliance of completing and providing just in time feedback to front line staff will occur.

Staff have the necessary courses and credentialing to work in their areas of expertise. Registered practical nurses work to their full scope of practice and have the support of the registered nurses in the work setting. There appears to be a good working relationship among the staff and physicians in all areas of the organization.

Relevant policies go to the appropriate committees for review and approval. The Nursing Practice Committee reviews policies relevant to nursing.

Staff are encouraged to take part in ongoing learning and education. If the course is mandatory and a new requirement, the organization may pay for it. Otherwise, job descriptions outline the credentialing required to work in a specific area.

Priority Process: Episode of Care

Families are welcome to participate in the care of the CKD patient. They are invited to be part of the discussions and care planning.

Various methods are used to assist patients with interpretation issues. A translation service is available by phone and some pamphlets and instruction forms are in three or four languages. Translators are also available to assist.

For the multi-cultural community, there is a spiritual place to worship at both hospital sites and all religions are welcome to use this space. There are chaplain services available on site.

Ambulatory Services has access to social work, dietitians, pharmacy, and diagnostic testing.

At the General campus, the endoscopy suite has a good flow for patient care and is located outside but near the operating room. The endoscopy program is situated in a clinic setting at the Birchmount campus. The hospital is encouraged to remove wooden cupboards and LEAN the amount of materials in the rooms. Sheets are used to cover supplies if a patient with methicillin-resistant Staphylococcus aureus (MRSA) or vancomycin-resistant enterococci (VRE) is scoped. This is an infection prevention and control concern. Workflow and cleaning of scopes at both sites met standards.

There is a robust outpatient Cardiology Department at the Birchmount campus that meets Cardiac Care Network (CCN) accreditation standards. This program has been in place for approximately a year and already serves 300 patients. There are five cardiologists at Birchmount and eight at the General campus. The nurses work at both sites. Pacemakers are inserted at the General campus. The team is very proud of its accomplishments in the past year. They offer cardiac stress, echocardiography, transesophageal testing, Holter monitoring, etc. Based on feedback from their recent CCN accreditation, they will be creating recovery room space and purchasing an echocardiography bed. They have recently purchased a computer software program to scan Holter results and this is managed by a skilled staff member who reads the ECGs and reports the findings to the cardiologists.

The Diabetes Outpatient Clinic at the Birchmount Campus has two nursing staff and two dietitians. They see approximately 30 visits per day and include gestational diabetes patients. The team has created an algorithm to help prioritize which patients should be seen first or urgently and which ones can wait for a short period of time.

The CKD program, including the dialysis treatment centres, has reached capacity. Staff work in tight places and patients have minimal or no privacy. The organization is working diligently to provide appropriate space that meets the needs of staff and patients. Patients at the dialysis satellites would benefit from televisions to watch, to help pass the time. The ventilation system at the dialysis satellite at the Yee Hong Centre for Geriatric Care flows directly onto the patients and a patient complained of being chilled.

Excellent interaction was observed between professionals and patients. There was evidence of informed consent with treatment choices provided.

Reprocessing at both sites is thorough and processes are clear and concise. Staff know and understand their roles. The organization is encouraged to ensure the green plastic covers used during transport do not have any holes and to make all attempts to use an elevator that does not have patients or families on it.

Priority Process: Decision Support

Patients in all ambulatory clinics are registered. Those patients having a procedure have bracelets and two patient identifiers are used. Documentation is entered into a computer system and hard copies are scanned into patient charts.

Patients can request access to their charts in writing. The organization is encouraged to consider patient access with the option for the patient to include information such as recent blood sugars, weight, BPs, etc.

Huddle boards are used throughout the organization and address quality and safety topics. Metrics are used and staff are given positive feedback for a job well done. Input is received from staff on how to improve the care provided to patients.

All patients registered at this organization have an electronic chart. Health care providers can access patient charts at either hospital site.

Priority Process: Impact on Outcomes

Staff use a computerized risk program to report near misses and occurrences. Some staff report the system is slow and difficult to use while others feel it is a fast and easy way to report occurrences. Once filed, the managers and directors receive a message that an occurrence has taken place. Disclosure occurs with patients and families. VIP follow up is completed with staff.

Huddles are effectively used to discuss areas for improvement in the clinical areas. As a team, the staff work toward improving services and outcomes for patients.

The program is encouraged to obtain formalized patient feedback on their services.

High-risk falls patients were identified at registration for each program and a falls sticker was placed on the patient's chart.

Students and volunteers were seen throughout the ambulatory services. In several cases staff commented that they were hired after a student clinical placement.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
6.1	Required credentials, training, and education are defined for all team members with input from clients and families.	!
Priority Process: Episode of Care		
10.11	Clients and families are provided with opportunities to be engaged in research activities that may be appropriate to their care.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		
Priority Process: Medication Management		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The team has planned service around information gathered from the clients, families, and other services in the hospital as well as community partners. Clients and families are engaged in planning service at various levels. Client input was sought on the design of the current therapy space and in the development of the design of the planned expansion and renovation of the treatment areas. The unit space is very crowded to increase from 12 treatment chairs to 20 to respond to the increased demand and to address wait times.

The team identifies gaps in services and opportunities to address them. The Psychosocial Oncology Support Team (POST) was implemented to address a gap in service around psychosocial support for clients. The interdisciplinary team including mental health staff and psychiatry provide a variety of services including individual counselling, group sessions, meditation, and self-help apps.

Strong partnerships are evident across other service areas such as palliative care and mental health. Relationships are well established with Cancer Care Ontario and the four other hospitals in the Toronto East Health Network. When services are not available at the site clients are referred to other areas. A referral service has been established with Sunnybrook Health Sciences Centre for radiation oncology and the oncologists visit clients at the site for consults.

The model of care was reviewed and a pod model was implemented with input from staff and clients. The nursing staff indicated that this was a positive change as it provided opportunity for them to have a say in their work assignment and improved their time to provide care.

The process for assessment and treatment was reviewed and redesigned by the team with input from clients and families. A change from one day for assessment and treatment to two days was implemented to address wait time for chairs, workload, and flow. Other initiatives such as negotiating with the PIC line insertion team and the central line team to block spots for clients has resulted in significant reductions in wait times, from six to eight weeks to two weeks.

The team worked with clients and families to address unit congestion and manage the flow of visitors to the unit by implementing an arm label to identify a visitor.

Priority Process: Competency

The team is interdisciplinary and includes nurses, oncologists, palliative care physicians, social workers, pharmacists, dietitians, drug access navigators, clerks and volunteers. There was evidence of a collaborative approach to care with the client and family involved at all points.

The team consists of staff with the required credentials to provide care. The team is encouraged to provide opportunities for clients or families to have input into the education and training requirements for staff.

The nurse educator was very involved in providing education and training to clients and staff. An education session called "Helping you prepare for your cancer treatment" was developed and provided to all clients prior to their initial treatment. The education is provided with the assistance of interpreters and planning to provide it in Chinese is ongoing.

A comprehensive orientation is provided that includes peer assignment and support. Staff are supported to complete the de Souza oncology certification course and new hires are required to complete it within a year. Staff indicated they were provided with opportunities to participate in education sessions such as drug lunch and learns, new equipment, and protocols.

Staff participate in daily huddles to share information with the team and review team goals and quality improvements. There were opportunities to celebrate individual team members for initiatives and for managers to acknowledge team members.

Staff indicated that they receive feedback on their performance though the VIP chats and felt these provided opportunity for two-way feedback.

The team indicated that complaints are dealt with in the unit by staff and managers. If a complaint goes through Patient Relations it is followed up by the manager and shared with the staff to make improvements where possible.

Staff were aware of the process to report safety incidents and reports were shared with the team to identify areas for improvement.

Priority Process: Episode of Care

Services are provided by an interdisciplinary team including nurses, physicians (oncologists, palliative care, psychiatrists), social workers, pharmacists, dietitians, and volunteers.

A comprehensive assessment is completed when a client is referred and a treatment plan is developed with input from the client and family.

Partnerships have been developed with other hospitals and community partners for services not available such as radiation oncology. A referral service has been established with Sunnybrook Health Sciences Centre and consults are provided on site. Information is shared across the sites to provide smooth transitions. A drug facilitator position is in place which provides assistance to clients regarding funding for drugs and completion of financial assessments for coverage.

The population accessing services is very culturally diverse.

Information is provided to clients about their treatment plans and they are involved in decisions about their care. An education session that provides information to clients and families on cancer and the process they will encounter is provided to all clients prior to receiving chemotherapy. Staff provide access to interpreters to ensure clients understand their treatment plans. Clients interviewed indicated they were given information and staff explained what to expect.

The addition of the mental health nurse and psychiatrist to the team for 1.5 days a week was identified by the team as a significant enhancement to client care and helps address the psychological impact of a cancer diagnosis on clients. This service has been received well by clients.

The inclusion of the palliative care physician as part of the team has improved the assessment of clients and their understanding and facilitated transition to palliative care when active treatment is no longer indicated. The team involves the client and family in exploring in-hospital or at-home palliative care. The strong partnership with the palliative care team and the access to home visits has resulted in more clients receiving palliation at home.

The team provides written and verbal information to clients. A chemotherapy wallet card is provided to clients, as well as a fever card explaining when they should to go to emergency.

The team is not involved in research such as clinical trials. Clients are referred to other centres if they wish to participate in clinical trials.

Priority Process: Decision Support

The client record consists of a dual electronic system which uses Meditech for documentation of the team assessment and treatment and OPIS for physician order entry for medications. Computers are set up side by side so staff can cross-reference the medication orders and treatment plan. Information from OPIS is scanned and entered into the Meditech system so it can be accessed by all providers.

The team involves clients and families in their treatment plans. Clients indicated they had access to their chart and information was provided by the team when they requested it.

The pharmacy provides a chemotherapy flow sheet with the treatment plan to the nursing staff. It includes the medication regime as well as treatment consideration. The treatment regime is connected to the electronic treatment scheduling system, resulting in better use of treatment chairs, increased capacity for treatment, and reduced wait times for clients.

Priority Process: Impact on Outcomes

The team has identified areas of risk and monitors indicators. Processes to mitigate risks are implemented, such as double checks, training and education, incident reporting, and follow up. Information is shared with the team on areas of risk and improvement initiatives to prevent future occurrences.

Safety incidents are disclosed to the client and family.

Feedback from clients and families is obtained through surveys and ongoing discussions. Complaints are reviewed and addressed and information is used to improve service. The team shares complaints and issues at the daily team huddles and identifies opportunities to address them.

The team has identified areas for improvement that align with the strategic priorities. These are reviewed daily at the team huddles to determine if they are on target. Areas for improvement are identified and a plan to address these is developed with input from the staff, clients, and families.

The team has implemented the Vocera communications device which is worn by staff and enables communication within the team. The team indicated that this has improved their functioning and saved time in tracking down team members.

Priority Process: Medication Management

The Pharmacy team is integral to the service and works collaboratively with all members. There was evidence of excellent communication between the pharmacist, physicians, and nursing staff.

Standardized drug protocols and pre-printed orders are used. The pharmacist prepared a treatment plan for the drug regime ordered by the oncologist. There are well-established and clear processes to order, verify, dispense, check, and administer medications.

The OPIS computerized physician order entry system was adopted. This system has been implemented and information is scanned into the Meditech system for sharing across the system.

The pharmacist has been involved with a regional team to develop a standardized spill kit. The team has developed a kit specific to the clinic with input from a mock code brown. The team is continuing to assess the appropriateness of the kit and address expiry timelines.

Infusion pumps are standardized and dedicated to the clinic. Training is provided to staff on operation of the pumps and updated annually.

The team is acknowledged for their involvement in a quality initiative with the cardiologists to identify cardiac oncology patients that are at risk of developing cardiac toxicity. These patients are referred to the cardiologist and information is shared to reduce risk to the patients. The team indicated that other areas such as nephrology are interested in partnering to identify risks.

Standards Set: Biomedical Laboratory Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Diagnostic Services: Laboratory	

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)
Priority Process: Diagnostic Services: Laboratory

The biomedical laboratory at the General site offers comprehensive lab services to the inpatient population and outpatient clinics. The lab offers state-of-the-art automation where possible to reduce errors and expedite processing of samples.

There are solid processes in place to standardize services across both sites. Turn around times are measured and quality improvements implemented to reduce wait times. Emergency room, outpatient clinic, and inpatient samples are colour coded.

Overall, high quality biomedical lab services are offered to the community at both sites.

Standards Set: Critical Care - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
3.1 Required credentials, training, and education are defined for all team members with input from clients and families.	!
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
15.5 Guidelines and protocols are regularly reviewed, with input from clients and families, to ensure they reflect current research and best practice information.	!
Priority Process: Organ and Tissue Donation	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Critical Care (CC) program is a high-functioning, respected, busy program that crosses between both sites and serves the Central East LHIN. Although they are not cited for trauma, cardiovascular surgery, neuro, or transplant they provide comprehensive services for critically ill patients and use “critical” for any patient transfers requiring services not immediately provided.

The team repatriates patients back from referral centres in a timely fashion so they can receive care closer to home. The Critical Care Response Team (CCRT) is very responsive throughout the hospital, providing assessment and support to mitigate intensive care unit (ICU) admission as well as conducting very thorough assessments 48 hours post-ICU discharge in the units on all patients. TSH was one of the founding Canadian hospitals to integrate CCRT and is commended on continuing its best practice in this area.

There is a relatively new and passionate CC leadership team that is making positive and exciting changes in the ICUs at both sites. One example, implemented with input from patients and families, is the new pet visitation policy.

All staff interviewed were committed to their CC family and noted it was like “home,” a clear indication that even through change the leadership is well respected and there is a high level of trust.

The General site is currently undergoing renovations to co-locate all levels of the ICU on one floor. This is well underway and was designed with input from patients and families. The Birchmount site is also wanting to move forward with co-locating its two units onto one floor to support staff, maximize resources, and provide a better space for patients and families.

Priority Process: Competency

The Critical Care staffing ratio is either 1:1 or 1:2 and all staffing decisions are made depending on the acuity and dependency of the patient using the multiple organ dysfunction (MOD) scores.

There is a very low turnover of staff and they are very engaged in the department regardless of the site they are working at. Many staff rotate between sites and feel included and embraced by teams regardless of site. There is a high level of recognition in the department, and they give daily congratulations to each other at their huddle boards.

There is a strong committed interdisciplinary team at each site with a dedicated interim clinical resource leader (CRL) working between the two sites to support education and best practice. All staff are current and up to date on their infusion pump training and although the learning management system is currently non-functional the CRL has up-to-date paper records. There is an obvious collegial atmosphere which has led to an open, honest, and respected area in which to work. The VIP chats are embraced and the conversations are respected by the teams.

Staff have access to education and new staff are offered formal ICU training off-site. New staff who were interviewed love the training and education and feel supported daily in their practice. There is a comprehensive unit and corporate orientation for all new staff to the units.

The team uses LEAN methodology and has daily huddles to review data on their scorecard. Staff frequently include patients and families in their daily huddles, demonstrating the commitment to inclusiveness in the units. Patients and families are encouraged to provide feedback and the teams are encouraged to continue to expand these roles in the unit as they continue on this new journey of patient and family engagement.

Priority Process: Episode of Care

The Critical Care staff are experienced and fully understand their roles and span of control within the organization. Both ICUs are a closed model with the most responsible physician being the intensivist. The teams are well integrated and follow evidence-based best practice in the provision of critical care.

The standards are aligned at both sites and cross-pollination of staff is encouraged and embraced.

Advance directives are discussed with the majority of patients. The program is encouraged to continue to work with patients and families to have those hard conversations when needed. All patients in ICU, regardless of level, receive full comprehensive assessments.

Due to the length of stay of some of the ventilated patients in ICU, families are included in many of the activites of daily living when appropriate. They are also included in patient teaching regarding suctioning and weaning. All patients are rounded daily with goals of care discussed.

Due to the limited number of chronic ventilator beds in the system, TSH is strongly encouraged to continue exploring taking smart risks and creating a new model to support these patients downstream from critical care, thus creating much-needed access to critical care beds. It is also suggested that the leadership team push some of the traditional boundaries with their chronic patient population to better meet the needs of patients and families.

All ROPs were met and staff vigilance with two patient identifiers and falls is congratulated.

Priority Process: Decision Support

All Critical Care staff enter data into the Critical Care Information System (CCIS) at the bedside. The CCIS goes to the organization and then to the Central East LHIN where it is reviewed and reported back to the sites through the medical leadership.

The intensivists have created an online CC note which is charted daily and is then printed in real time and placed in the chart. This is also used for handover. It is safely secured on the organization's database. The database provides real-time data that supports quality care within the unit and many of the metrics drive their dashboard. All charts and incidents are regularly audited by the clinical resource leader for accuracy.

Although the current charts are both online and on paper, they meet all standards. All charts reviewed demonstrated a high level of up-to-date charting.

The team is involved in quality and regularly at the huddle board notes changes that have been implemented in the current documentation system. The latest suggestion is to take a section of the 24-hour flow sheet that is currently underused and create a section to support patient- and family-focused care, to allow for more formal integration within the CC continuum.

Clear policies are followed in the ICU and families and patients who would like to review their charts are guided through the process and guaranteed access on the same day.

Priority Process: Impact on Outcomes

The Critical Care team aligns its metrics with the organization's strategic plan, as well as creating some unique critical care specific indicators and program goals that also align.

The team is fully committed to LEAN methodology and uses the huddle boards daily to review metrics, quality initiatives, patient satisfaction, and any issues that have arisen. Staff are clearly engaged. They have embraced quality and led many initiatives.

The team is commended on the supply and stock redesign. Even though it is only months in, the cost savings have been significant for the program at the General site. The team has decreased excessive waste and created a better space in the supply room which historically was disorganized and cluttered. The Birchmount site is anxiously waiting to roll out the same initiative.

The team is growing its patient and family involvement in care and is encouraged to continue this journey as it evolves across the organization. Due to limited research in the units, the indication regarding research and best practice was not evidenced.

Priority Process: Organ and Tissue Donation

The Trillium Gift of Life Network is a well-established program in Ontario that is fully embedded in the Critical Care program at TSH. There is a full-time Trillium donation coordinator who works between the two campuses and is fully integrated within the teams on site.

There are clear established policies and protocols and the coordinator is notified and takes the lead with all potential organ donations when the triggers are met. The coordinator also provides training and education to all staff, maintains and enters information into the registry, and works in partnership on quality reviews and audits with the teams regarding missed organ donation opportunities.

Standards Set: Diagnostic Imaging Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Competency

No specific comments for this area.

Priority Process: Diagnostic Services: Imaging

Diagnostic Imaging Services (DI) is a fully integrated program that crosses between both sites and is led by a well-established and experienced senior leadership team. DI provides a full comprehensive range of modalities with 24/7 access for the community for the majority of services. For services such as MR that are not 24/7, radiologists provide consultation to the site and bring in the team when it is required regardless of the time of day. At this time the existing Ontario funding model for MRI is not adequate for the needs of the community to address the wait list; however, between the two sites and a newer MR at the Birchmont site they are tackling it. Due to the wait list and at times high percentage of no shows the team is encouraged to continue to use their LEAN strategies and take smart risks to explore creative strategies to tackle this problem.

The DI Department at the General site is unfortunately scattered throughout the campus on numerous floors; however approval has just been given from capital planning to be redesigned and co-located together on one floor directly underneath the ED. A high-level steering committee is overseeing the project. The schematic design is underway with full stakeholder engagement from all of the DI modality working groups, as well as input from clients and families. The teams were enthusiastic at the General site and anxiously awaiting their much-needed new space.

There is clear adherence to policies and protocols with regard to client and family responsibility for their safety that are audited and reported in each of the teams. All DI modality teams have adopted LEAN methodology and have weekly huddles. Team members enjoy the huddles and feel empowered to share and be more included in quality in the department. Quality benchmarks are tracked in the LHIN and reported to each site.

TSH has a well-established quality structure and each modality has a Quality Committee that reports to the DI Executive Committee. There is a DI Safety Committee that reviews issues and incidents in a timely fashion. The teams take safety seriously and follow best practice in all areas. Currently there are two groups of radiologists; however, they are in the process of being combined into one team. Many of the clinical areas traced such as ED and ICU had many positive comments regarding access to DI and felt that the services provided were exemplary.

The Required Organizational Practices in DI were all met, with a commitment to falls prevention and two person identifiers as part of their standard practice.

Standards Set: Emergency Department - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
2.6 Seclusion rooms and/or private and secure areas are available for clients.	!
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
12.3 Client privacy is respected during registration.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	
Priority Process: Organ and Tissue Donation	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Emergency Department (ED) team has collaborated with community and internal partners to address system issues to improve patient flow and avoid admission. Patient and family advisors who are representatives of the CPAC participate in and are engaged in planning for improvements in the ED. Improvements to flow, intake, and triage have resulted, along with the Hub, where a new flow for patients was implemented at the Birchmount campus. In addition, they have input into the discharge summary that is being developed by the team for patients.

Patients receive electronic educational materials. These are available in 11 languages and can be printed for them prior to discharge.

Triage processes and physical space continue to be tested for flow and patient privacy. Opportunities exist to continue to test improvements to this area at both sites. Privacy concerns were noted at both campuses. In addition, the secure area for mental health patients at the General campus is within the flow of acute ED patients and can cause disruption to the department. Exploring other options for patients who require seclusion is encouraged at this site.

While a number of innovative partnerships and initiatives have and continue to evolve, to improve discharge practices for patients there is an opportunity to continue to address ALC avoidance through the ED. Staff are committed and willing to continue to address this important need for the community.

Priority Process: Competency

The orientation program and ongoing professional training for ED staff is excellent, comprehensive, and top of mind for the leadership of the team. Developing staff to their fullest potential is important for all, including the physicians who have invested in development opportunities for themselves and the staff.

Annual skills training is monitored and staff are committed to following through. Training from the Crisis Prevention Institute is mandatory, as is advanced cardiovascular life support (ACLS), basic cardiac life support (BCLS), and pediatric advanced life support (PALS). In addition, staff follow a learning path for various modalities in the ED and move up to work in all areas. Staff are also able to complete the Emergency Nurses Association modules and are recognized on completion. Bursaries for ongoing continuing education are available for all staff in the amount of $1,500 per year for full-time employees and up to $750 per year for part-time staff. Building staff capacity and skills is a commitment of the leadership including physicians. Annual education retreats are also supported for the team by the physicians.

The ED physicians have invested in an Ultrasound Fellowship Program with the aim of improving length of stay and the patient experience. In addition, they have built in a quality assurance process to ensure images are always read by two physicians. Use of this technology requires specialized training which the physicians have.

Priority Process: Episode of Care

ED staff at both campuses are extremely proud of their accomplishments, which include improving flow and time to initial physician assessment, introducing the physician assistant role, implementing standardized processes for discharge and admissions, and using data and information to guide process changes and decisions. For instance, staff now start their shifts based on activity in the department and the times patients are most likely to present, instead of the traditional 12-hour shift times. All staff, physicians, team assistants, clerks, physician assistants, and allied health team members including pharmacists, social workers, and a geriatric emergency management registered nurse at both campuses collaborate and work cooperatively to ensure patients receive the best, most timely care possible.

As a result of a rapid improvement event, the Hub is now operational daily starting at 10:30 when most patients who only require "one touch" present to the ED. Patient advisors participated in this new process.

Translation and interpretation services are available at both sites. Many staff are able to support interpretation as well, due to their ethnic backgrounds.

There is an on-site ethicist for both campuses and two ED super users at each campus who are part of a clinical ethics consultation team. Staff understand who to contact for support and when. It is clear that capacity that has been built in the organization with ethics super-users as resources for their colleagues.

The ED physicians' commitment to develop themselves and their team (learning sessions, annual education retreats, professionalism through uniform standardization) was evident. The teamwork displayed by all the health professionals at both campuses was excellent.

Maintaining privacy continues to be a challenge at both sites and tests for compliance are in progress to improve this issue. Registration at the Birchmount campus uses an intercom speaker to bring patients into the department, and the patient's full name is called. Staff were not aware of the privacy and confidentiality concerns with this action. The organization is encouraged to provide mandatory training on privacy for staff, highlighting the need to use first or last names only when calling out patient names over an intercom.

Priority Process: Decision Support

Patient charts in the ED are paper based. Lab results and diagnostics are available online. Order sets are used for common admitting diagnoses. The standard admitting order set includes venous thromboembolism prophylaxis.

There is opportunity to explore if the current Meditech software could be more user friendly with contextual launch to connecting GTA or electronic order sets. This is worthwhile for the organization to explore as this application is available elsewhere.

Portable ultrasounds in the ED are connected to the Meditech system.

Priority Process: Impact on Outcomes

Protocols and guidelines for all ROPs were evident. An excellent medication reconciliation process includes built-in accountability for the physician, pharmacist, and registered nurse. Teams welcome the voice of the patient in planning for and helping to develop these protocols.

Staff huddle each morning to review metrics from the day prior and develop action plans for the current day. In addition, they recognize each other and share ideas for improvements. Staff take accountability for following through on processes they bring to the table. An innovative initiative at the General site is to follow up on patients who left without being "surveyed" to see if they require support or follow up from the Community Resource Centre to help with self-management at home.

Ambulance offload times are some of the best in the area for the Birchmount campus, at 34 minutes. This is down from 90 minutes prior to changes that were made to flow and entry into the department.

Priority Process: Organ and Tissue Donation

Organ and tissue donation policies and processes are in place in partnership with Trillium Gift of Life Network.

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

Unmet Criteria	High Priority Criteria
Priority Process: Infection Prevention and Control	
12.2 The organization tracks health care-associated infections, analyzes the information to identify outbreaks and trends, and shares this information throughout the organization. NOTE: This ROP only applies to locations that have beds and provide nursing care.	ROP
12.2.1 The organization tracks health care-associated infections.	**MAJOR**
Surveyor comments on the priority process(es)	
Priority Process: Infection Prevention and Control	

At the General campus, the Infection Prevention and Control (IPAC) Department huddles once per week and meets weekly at the Birchmount campus. Policies are reviewed and revised annually using Provincial Infectious Diseases Advisory Committee (PIDAC) standards and evidence-based best practice. The IPAC Resource Service Group meets regularly and minutes go to laboratory, the Medical Advisory Committee, and occupational health and safety. An IPAC representative sits on the Quality Committee.

Two patient representatives sit on the IPAC Committee. One patient helped prepare education handouts for patients and families. There is no role description for the patient and the team is encouraged to clarify expectations for the patient role.

IPAC staff are engaged, motivated, and eager to improve and combat the risk of infection. They appear to be an energized group that works well together. They are currently working on projects such as the Every Day Improvement Program where staff are recognized for their IPAC successes, Bath in a Bag with the purpose of reducing antibiotic-resistant organisms, and publishing a journal article that discusses the management of methicillin-resistant Staphylococcus aureus (MRSA).

At orientation for new staff, volunteers and the construction workers involved in building the new hospital space are provided with education sessions on handwashing, non-smoking areas, and other IPAC protocols.

The organization is encouraged to review the memos and papers that are hung up around the organization, specifically in the clinical areas, and, for those that must be hung, laminate them or put them in plastic frames that can be wiped.

The influenza rate, including physicians, is approximately 50 percent. Travel carts are used to immunize staff on the spot. Designated areas are set up for staff to obtain the vaccine. Processes are in place to ensure safety for staff who do not receive the influenza injection during an outbreak.

The kitchen at the General campus is large and has designated areas for specific work flow. Staff wear appropriate apparel. The manager is hoping to obtain support to remove the outdated garburator and go green with compost. With the old drain pipes in the hospital, there is always a risk of blocking the pipes with the compost. The manager is encouraged to pursue this idea to understand the pros and cons of this project.

At the General campus, there is a small laundry room where designated staff launder only the patient lifts and slings. All other laundry is on a service contract. The door to this room was locked and there was an eye station in it. Laundry for the Birchmount site was located in the soiled MDRD area. The dryer setting is low heat and there have been no humidity issues.

Renovations are underway at this hospital site. An IPAC staff member is included in all aspects of this work and regularly visits the site and monitors progress.

The General campus had the first SARS patient in Canada and staff are well versed in isolation and IPC protocols. They see over 40 tuberculosis cases per year and because of this high volume, they feel they are well educated with required processes. Negative pressure rooms are located in the ED and on the critical care and medicine units. These rooms are checked regularly by Facilities. The organization has developed a template to assist staff with processes and protocols once a patient is suspected of a health-risk disease such as tuberculosis. The template highlights the steps staff need to take to meet isolation protocols.

Sharp containers are standardized and Environmental Services staff are trained on when to change the containers. There is a concise policy regarding needle sticks and staff safety.

Environmental Services staff are trained on personal protective equipment and isolation protocols. Products and supplies for cleaning carts are standardized.

Standards Set: Medication Management Standards - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Medication Management	

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)
Priority Process: Medication Management

TSH offers comprehensive medication management at both sites. The service is well organized, with skilled staff at both campuses.

The central pharmacy at the General campus has space limitations and is housed in an older building. They do have, however, automation with the use of a robot which increases productivity and faster processing of medication orders. There are a number of satellite pharmacies on the clinical areas. Some are located in areas that are not secured due to limitations of the aging building at the General campus. Cleanliness can be improved in some of the medication areas on the clinical floors. The pharmacy at the Birchmount site is more spacious in a newer building. There is a medication dispenser at the pharmacy to increase efficiency.

The standard operating procedures and clinical guidelines are standardized at both sites.

Standards Set: Medicine Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
3.1 Required credentials, training, and education are defined for all team members with input from clients and families.	!
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Medicine Services are provided at the General and the Birchmount sites. The leadership team including the clinical directors, chief of medicine, and medical directors provide leadership across the program. Clinical managers provide unit leadership.

The team plans services using information from their utilization patterns and from community partners such as the Community Care Access Centre, the Ministry, and other hospitals in the Local Health Integration Network. Services and linkages with community partners have been aligned to ensure patients who can be discharged to the community are. The bed mapping process has resulted in a realignment of services to respond to the increase in ALC patients and the creation of a 30-bed transition care unit at the General site and a 16-bed unit at the Birchmount site. These units went live in May and focused on improving the patients' level of functioning while waiting for long-term care or the most appropriate community placement.

There are strong partnerships with the community. Staff from the Community Care Access Centres and long-term and primary care providers participate in daily bullet rounds with the interdisciplinary team to facilitate access to community services. There are strong partnerships with tertiary care centres for specialty services and repatriation agreements for some services.

Information brochures are available for patients describing services, suggestions, and contact information. Information is often available in several languages to meet the needs of the diverse populations. Interpreters are available to staff and patients.

There is a strong physician team across Medicine Services. The hospitalist model has been working well across the two campuses. Physician engagement as an integral part of the interdisciplinary team was evident across all services.

Patients and families are involved in planning and care decisions. Some but not all areas have patient and advisory committees. The team is encouraged to continue to implement these committees to formalize opportunities for input. Patients and families are also participating in the unit huddles and their suggestions are identified by a pink form.

Priority Process: Competency

The team members have the qualifications required to provide the general and specialized medical services, and credentials are verified. There is a comprehensive orientation program and staff are provided with opportunities to participate in ongoing education and training at the unit level.

The staff mix for the medical units is aligned with the types of patients being served. Staff work to full scope and work has been ongoing with the colleges to ensure appropriate training is completed. Access to services, such as an ethicist, is provided as required.

Staff indicated that training on infusion pumps was provided and ongoing annual certification is required. Clinical resource leaders provide education on many initiatives and best practice protocols. There are opportunities for staff to participate in formalized training programs to upgrade their skills and qualifications.

Many staff indicated that they received feedback on their performance through the VIP chats. Recognition of staff was also done at the daily huddles by peers and managers.

Patients and families are not currently providing input on staff roles and responsibilities and job design; however, this is evolving with the Patient and Family Advisory Council role.

Priority Process: Episode of Care

A comprehensive assessment is completed on patients at admission, with input from the patient and family members. Standardized assessment tools are used to identify patients at risk for falls, pressure ulcers, and venous thromboembolism. Team members are consulted depending on the patient's needs.

Daily bullet rounds on each medical unit are attended by the interdisciplinary team. The hospitalist, unit manager, pharmacist, social worker, patient flow coordinator, front-line nursing staff, physiotherapist,

occupational therapist, and Community Care Access Centre nurse, as well as other community partners, participate in the discussion and give updates on the patients' status. Actions or further tests are documented and team members responsible for follow up are identified. Community partner participation in the rounds facilitates access to services for the patient to return home or move to an appropriate service in the community. The potential discharge date is identified.

Standardized order sets identify when to initiate services for the patient.

Many initiatives have been implemented to facilitate access to appropriate services in the community for patients with complex needs. The partnership with Carefirst for access to six transitional care beds in the community provides integrated services with a goal to return home and divert from long-term care. Other services such as the Geriatric Assessment and Intervention Clinic (GAIN) provide interprofessional geriatric assessments focused on keeping frail seniors at home. The Virtual Ward program and the Assess and Restore program identify patients at high risk for readmission. These patients are followed by the social work navigators to monitor and support them to meet milestones to stay at home.

Patients indicated that they were given an information package on admission that included information on who to contact with questions about their care. The team is encouraged to explore ways to make patients and families aware of who their care provider is at each shift by using communication tools such as a white board in the patient's room.

Patients and families are engaged in decisions about care, and the teams actively involve them in discussion and planning around their care. Patients are asked to identify a goal they want to achieve on a daily basis.

Staff were observed to check two patient identifiers prior to providing treatment. When patients were unable to communicate staff verified identity either with a family member or another staff person.

There are well-established consult services for access to psychogeriatric psychiatrists and palliative care. There is spiritual and pastoral care support for patients and families, and interpreters are available to provide service to the very diverse population.

The teams have daily huddles on their units to review the quality improvement initiatives they are monitoring. These are attended by the interdisciplinary team and recently the quality leader. There are opportunities for staff to recognize each other for good work or for the manager to recognize staff. New ideas for improvement are discussed and added to the huddle boards. Patients and families are also encouraged to suggest ideas for improvement and provide feedback on initiatives. Staff suggestions are on white forms and those from patients and families on pink.

Transition plans are documented in the patient record. A recent initiative is a post-discharge clinic where patients at risk of readmission are given an appointment to visit their hospitalist for follow up. This has only been in place for a couple of months. It will be evaluated to determine if it is effective.

Priority Process: Decision Support

The team uses a combination of electronic and manual documentation. Physician notes are written and scanned into Meditech. The team is encouraged to move to full electronic documentation.

A standardized chart is in place, providing consistency and familiarity for staff who move across units and sites.

Information is shared across the system to facilitate continuity of care. The team participates in bullet rounds and information is shared regarding patients' statuses and treatment plans.

There is a process for patients to access their records. If a patient or family member has questions, the physician and team members review the chart with them.

There are processes to protect privacy. Staff and volunteers sign confidentiality agreements. Records are stored in a secure area.

The team has access to electronic evidence-based practice guidelines.

Priority Process: Impact on Outcomes

The team has adopted the Registered Nurses' Association of Ontario Best Practice Guideline on person- and family-centred care. The team has a patient experience lead and work is ongoing to provide patients and families with opportunities to provide input into care guidelines.

There are standardized care practices and standardized order sets to integrate best practices and reduce transcription and ordering errors.

The team has focused on many LEAN initiatives around access to care and patient flow. The use of standardized practices has enabled patients to move from the ED to appropriate beds at both sites.

The SAFE incident reporting system is used to report incidents that cause risk or harm. These are investigated and used to identify areas for improvement.

Standards Set: Mental Health Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The leadership team is very engaged in developing a community-focused mental health service. The team has been a leader in developing a patient- and family-centred approach.

The team uses information on the population to plan services. The population is culturally diverse and many lower socioeconomic areas are served. Services include general psychiatry, psychiatric intensive care, and geriatric psychiatry. Satellite sites provide outpatient services including individual and group therapy sessions, an innovative e-therapy hub which offers online evidence-based therapy, a depot and clozapine clinic, and online self-help apps.

There are designated psychogeriatric beds as well as intensive acute beds. The psychiatrists work as a team to meet the needs of the patients and ensure coverage seven days a week. The psychiatrist on call receives email updates on the weekend to ensure continuity of care and enable discharge plans to proceed.

The team has participated in rapid improvement initiatives to reduce length of stay. Several partners participate in the daily bullet rounds, including Hospital-to-Home program staff and the Community Care Access Centre.

The team is commended for its work in establishing a Patient and Family Advisory Council that is very actively involved in planning services and goals and objectives for the team. The Mental Health team has developed a toolkit for the council and representatives are embedded as an integral part of the team. The patient and family advisors indicated that they have input into policies, protocols, and quality initiatives; are voting members in the department's Stewardship Committee; and feel valued by the team.

There are strong partnerships with other programs such as cancer care and community partnerships with other programs in the area.

The team has moved to a new model of collaborative practice and is focused on recovery. The registered practical nurse role has been included in the intensive care unit and staff are working to full scope. The interprofessional team participates in daily rounds, with the psychiatrist, nurses, registered practical nurses, social workers, and pharmacist contributing to the care plan. The team has incorporated a "reading of the week" into the bullet rounds as an opportunity for the psychiatrist or team member to provide a brief synopsis of a relevant topic and educate the team on a current evidence-based practice.

Non-pharmacological approaches to care such as multi-sensory stimulation, gentle persuasion approach, and the Safewards model are used.

There are excellent relationships with other services, such as cancer care, to support the goal of providing a model of service in the locations where clients receive care and reducing stigma. A mental health nurse and psychiatrist provide consults to clients at the cancer clinic. Partnerships are also established with the long-term care centres and the geriatric psychiatrist visits for consults.

There are strong linkages with outpatient services. Staff members work across both areas to develop services to meet patient/client needs. Initiatives using a shared care model, where psychiatrists and mental health social workers are co-located in a family physician practice to provide education and consultation, has helped build capacity and competence for family physicians to manage clients who would be otherwise accessing services. A link has also been established with the forensic population and the team works with corrections officers and visits the jail.

Priority Process: Competency

There is a strong interdisciplinary team with a broad range of skills to manage the needs of the patient population. There was evidence that the team worked collaboratively and were focused on providing quality care.

There are opportunities for staff to participate in education and training. A comprehensive orientation is provided for new staff. Training is provided on crisis prevention intervention and non-pharmacological approaches such as gentle persuasive. There is regular training on equipment such as IV infusion pumps.

The team indicated that the VIP chat is used to provide feedback on their performance. Staff indicated that they appreciated the opportunity to receive feedback from their manager and that it provided an opportunity for them to identify areas where they would like to receive education or training.

The team uses a combination of electronic and paper documentation. Psychiatrist notes are written and scanned into Meditech. The psychiatrists are encouraged to move to electronic documentation.

Standardized tools and treatment protocols based on best practice are used.

Patient and family advisors participate in the team huddles and provide feedback on initiatives. Their input is used to make improvements and they are involved in selecting staff.

Priority Process: Episode of Care

The team have made several improvements to remove barriers for clients accessing service. Providing a mental health nurse and psychiatrist to the cancer clinic gives clients access while they receive treatment, and reduces stigma. Providing online cognitive-based behavioural therapy gives clients the opportunity to access therapy at home. This initiative has reduced the number of clients who drop out. The community-based ACT team works with corrections services and has made services available to clients who are in jail.

The acute care unit was designed to group patients with similar needs and provide safe care. There was space for activities and private space for interviews with patients and families. The space was clean and secure. There is a 24-hour visiting policy and family members can stay in the patient's room.

There is a centralized intake for outpatient services. The team has developed screening criteria to assess severity and prioritize clients. Clients may be diverted if there are other services they can use. Clients in crisis are prioritized and can access the mobile crisis team. The process changes have resulted in a 75 percent reduction in wait times for access to psychiatrist and therapist appointments.

Translation services are available for clients. Staff are often engaged to provide interpretation.

Standardized risk assessment tools are used to assess client risk for suicide, falls, and pressure ulcers. Plans to mitigate risks are developed as part of the care plan.

A transition plan is developed when the patient is at the end of care. The discharge social worker identifies services the patient can access in the community and arranges for in-home care when appropriate. Strategies to mitigate readmission are developed with input from patients and their families. Follow-up appointments are set and medications may be provided to those who may be at risk of not filling the prescription.

Priority Process: Decision Support

The team uses a combination of electronic and paper documentation. Psychiatrist notes are written and scanned into Meditech. Psychiatrists are encouraged to move to electronic documentation.

There are standardized tools and processes for charting. Information is shared across the system for continuity of care.

Records are kept in a secure area to protect privacy. There is a process for clients to access their chart. If clients have questions about their chart the psychiatrist and team members review it with them.

Staff and volunteers sign a confidentiality agreement. There is a process for patients to access their records.

The team has access to clinical best practice guidelines electronically and sources of information to inform their practice. E-learning modules are available to staff for training.

Priority Process: Impact on Outcomes

The team adopts evidence-based practice guidelines.

The Patient and Family Advisory Council is involved in reviewing and selecting practice guidelines.

The team is committed to quality and safety and has made a number of improvements, such as the adoption of best practice guidelines for suicide risk assessment from the RNAO.

The team's commitment to quality was evident in the many initiatives it is leading, such as improving access to service for clients in cancer care and forensic care. The development and implementation of the internet-based cognitive behavioural therapy modules provides clients who are unable to participate in individual or group sessions with the option to participate at home. This initiative is part of a research study with Queen's University to compare the in-person and online dropout rates. The online dropout rate is significantly less.

The team is involved in research on the safe initiation of the drug clozapine for outpatients. The pharmacist has established protocols around point-of-care testing that will enable clients to have blood tests monitored without having to have venipuncture.

The organization encourages the team to report incidents and incidents are tracked and used to identify quality improvement initiatives. These are identified and reviewed at daily huddles. Patients and family advisors are involved in the huddles and their input is sought.

Standards Set: Obstetrics Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Nursing leadership is shared between the two sites. There is a medical site chief at each campus.

An effort has been made to standardize protocols, guidelines, and charting at both campuses to facilitate sharing of resources and personnel. Some nursing managers have been on an interim basis as they prepare to merge with Rouge Valley Health System.

A pediatric program is offered. In addition, a public health employee who is a lactation consultant provides breastfeeding support to new mothers.

Priority Process: Competency

There is a robust training program for staff and ongoing staff feedback through the VIP chats.

Staff feel they work in a safe and collegial environment where they are respected, and that they are able to bring new ideas for consideration at the huddle boards.

Priority Process: Episode of Care

Comprehensive level 2 and primary obstetric services are offered at both sites.

There are excellent high quality services and a high degree of satisfaction among patients/families interviewed. Staff are also happy and comfortable with the work environment.

Great support is offered to patients to increase breastfeeding initiation and maintenance. All patients discharged from the hospital can download an innovative breastfeeding app; this is a great education tool that encourages mothers to succeed with breastfeeding once they are discharged.

A great service for newly discharged babies is provided at both campuses in the outpatient clinics. At the General campus all infants are seen by the pediatrician on call within 48 hours of discharge to monitor bilirubin levels and feeding (especially breastfeeding). At the Birchmount campus, babies are seen at the hospital if an appointment with a community family doctor or pediatrician cannot be secured. This service is provided 7 days/week, 365 days/year. This no doubt would significantly reduce the number of hospital readmissions within the first week of life for hyperbilirubinemia and feeding problems.

Priority Process: Decision Support

The organization is transitioning some services (such as pediatrics) to electronic medical records, while others are still in paper form. Documentation in the obstetrics medical records is complete and accurate. Patients can access their medical files if they so wish.

Priority Process: Impact on Outcomes

High quality level 2 and primary obstetrics services are offered at the organization with a high degree of patient satisfaction.

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

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
14.3 A safe surgery checklist is used to confirm that safety steps are completed for a surgical procedure performed in the operating room. 14.3.2 The checklist is used for every surgical procedure.	ROP **MAJOR**
17.6 Aseptic technique is used at all times during the procedure.	!
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	
Priority Process: Medication Management	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Medical senior leadership of surgical services at both sites is unified and stable.

Nursing leadership at both sites is unified, but due to the transition and uncertainty about the upcoming merger with Rouge Valley Health System, nursing leadership has been on an interim basis. This situation has the potential to negatively influence moving forward with new initiatives and advancing surgical care services.

Priority Process: Competency

A wide range of surgical services are provided. Services have been integrated and consolidated as much as possible at the two sites. The unified leadership has facilitated harmonization of guidelines, protocols, and processes at both sites.

Priority Process: Episode of Care

Overall TSH offers high quality surgical services at both campuses. Opportunities for improvement have been identified regarding compliance with the safe surgery checklist and implementation of strict aseptic techniques during all procedures in the operating room.

Priority Process: Decision Support

At both sites patient medical records are complete. They are made available easily to patients who wish to review their records.

Priority Process: Impact on Outcomes

Surgical procedures and clinical care pathways have been introduced at both campuses at The Scarborough Hospital. These guidelines are updated according to new scientific evidence. Processes have been harmonized at both campuses.

Priority Process: Medication Management

In collaboration with pharmacy there is a robust medication reconciliation system in place at surgical services at both campuses of TSH.

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

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

The organization has met all criteria for this priority process.

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

A number of devices (e.g., blood gas machines, blood sugar) are available to clinicians in the wards. The central lab maintains and tests these devices for accuracy according to guidelines and standards.

Standards Set: Transfusion Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Transfusion Services	

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)
Priority Process: Transfusion Services

In partnership with Canadian Blood Services, comprehensive blood transfusion services are offered to patients at both the General and Birchmount sites.

Instrument Results

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

Governance Functioning Tool (2011 - 2015)

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: December 1, 2015 to December 31, 2015**
- **Number of responses: 15**

Governance Functioning Tool Results

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1 We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations.	0	0	100	93
2 Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	0	0	100	96
3 We have sub-committees that have clearly-defined roles and responsibilities.	0	0	100	97
4 Our roles and responsibilities are clearly identified and distinguished from those delegated to the CEO and/or senior management. We do not become overly involved in management issues.	7	0	93	94

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
5 We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decisionmaking.	0	0	100	93
6 Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	95
7 Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	97
8 Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	0	0	100	97
9 Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	0	0	100	94
10 Our governance processes make sure that everyone participates in decision-making.	0	0	100	95
11 Individual members are actively involved in policy-making and strategic planning.	0	0	100	90
12 The composition of our governing body contributes to high governance and leadership performance.	0	0	100	93
13 Our governing body’s dynamics enable group dialogue and discussion. Individual members ask for and listen to one another’s ideas and input.	0	0	100	96
14 Our ongoing education and professional development is encouraged.	0	0	100	90
15 Working relationships among individual members and committees are positive.	0	0	100	97
16 We have a process to set bylaws and corporate policies.	0	7	93	96
17 Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	98
18 We formally evaluate our own performance on a regular basis.	0	0	100	83
19 We benchmark our performance against other similar organizations and/or national standards.	7	0	93	71

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
20 Contributions of individual members are reviewed regularly.	0	7	93	66
21 As a team, we regularly review how we function together and how our governance processes could be improved.	0	0	100	79
22 There is a process for improving individual effectiveness when non-performance is an issue.	0	13	87	62
23 We regularly identify areas for improvement and engage in our own quality improvement activities.	0	0	100	79
24 As a governing body, we annually release a formal statement of our achievements that is shared with the organization's staff as well as external partners and the community.	0	7	93	81
25 As individual members, we receive adequate feedback about our contribution to the governing body.	0	7	93	69
26 Our chair has clear roles and responsibilities and runs the governing body effectively.	0	0	100	96
27 We receive ongoing education on how to interpret information on quality and patient safety performance.	0	0	100	90
28 As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	96
29 As a governing body, we hear stories about clients that experienced harm during care.	0	7	93	88
30 The performance measures we track as a governing body give us a good understanding of organizational performance.	0	0	100	95
31 We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	0	0	100	91
32 We have explicit criteria to recruit and select new members.	0	0	100	87
33 Our renewal cycle is appropriately managed to ensure continuity on the governing body.	0	0	100	94

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
34 The composition of our governing body allows us to meet stakeholder and community needs.	0	0	100	93
35 Clear written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	95
36 We review our own structure, including size and subcommittee structure.	0	0	100	91
37 We have a process to elect or appoint our chair.	0	0	100	93

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

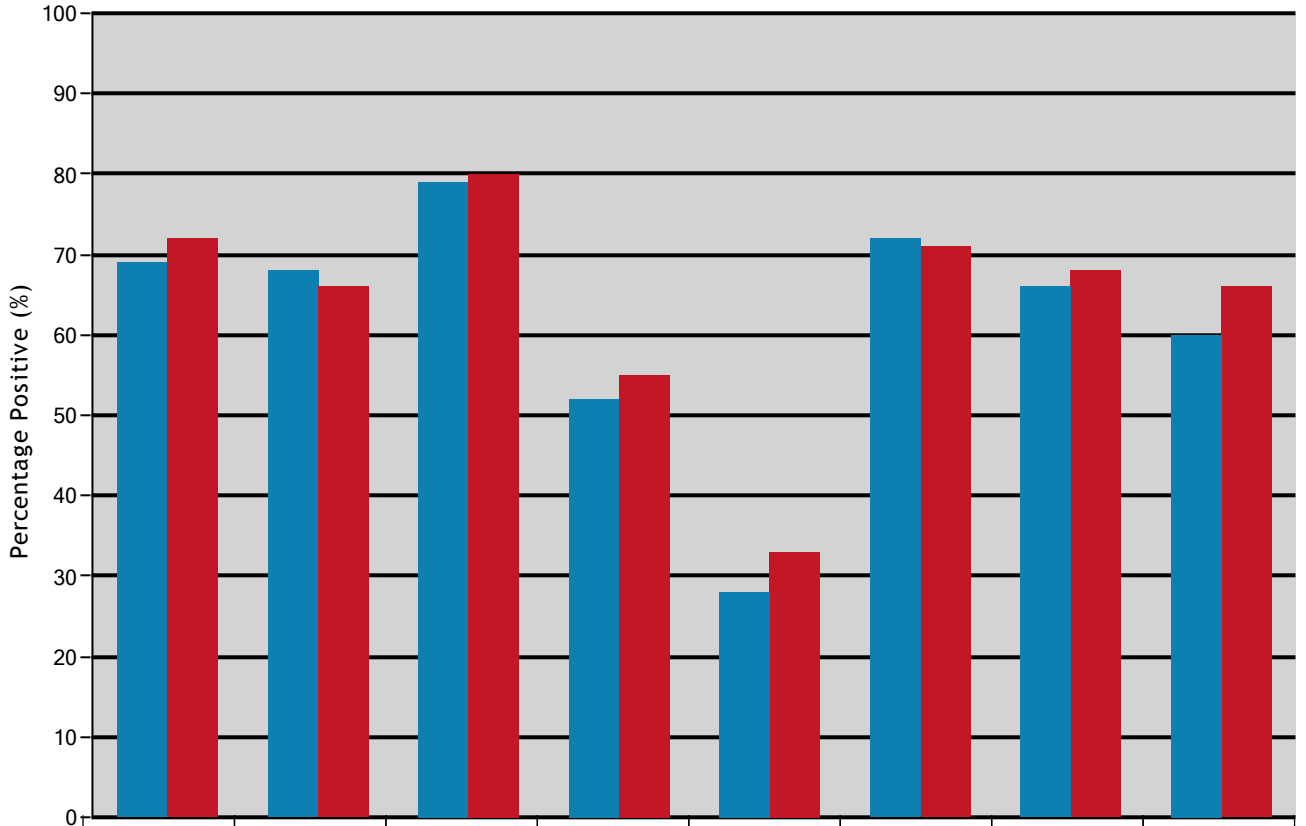
Canadian Patient Safety Culture Survey Tool

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

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

- **Data collection period: September 1, 2015 to September 30, 2015**
- **Minimum responses rate (based on the number of eligible employees): 325**
- **Number of responses: 644**

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



	Organizational (senior) leadership support for safety	Supervisory leadership for safety	Unit learning culture	Enabling Open Communication I: judgment-free environment	Enabling Open Communication II: job repercussions of error	Incident follow up	Stand-alone items	Overall Perceptions of Client Safety
	69%	68%	79%	52%	28%	72%	66%	60%
	72%	66%	80%	55%	33%	71%	68%	66%

Legend

The Scarborough Hospital

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2016 and agreed with the instrument items.

Worklife Pulse

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

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

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

Client Experience Tool

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

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

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

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

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

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

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

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

Organization's Commentary

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

The Scarborough Hospital (TSH) was honoured that Accreditation Canada's report praised our work in "Leading the way with Patients as Partners." We were encouraged that the Survey Team highlighted how well the adoption of Person- and Family-Centred Care at TSH aligns with Accreditation Canada's Client- and Family-Centred Care approach, and recognized our overall commitment to quality improvement, safety, and innovation.

The report captures many other successes within our organization, including the exceptional teamwork and passion of our staff, physicians, and volunteers, as well as how we have made diversity, equity, and inclusion a fundamental part of how we operate at TSH.

At the same time, the Survey Team recognized how we are responding to many of the challenges facing our organization, such as our ongoing commitment to delivering the very best patient care as we merge with Rouge Valley Health System's Centenary site, and our space limitations that impact patient flow and ALC patients.

TSH will be addressing the opportunities for improvement identified in the report, including monitoring our space issues, developing leading Information Technology strategies, and standardization in all aspects of our patient care.

TSH's Accreditation Sustainability Team, in collaboration with physicians and the hospital's Executive Team, will work to ensure ongoing compliance with Accreditation Canada's Standards and ROPs so that our newly-merged organization can continue to provide the highest quality health care for our global community.

Appendix A - Qmentum

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

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

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

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

Action Planning

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

Evidence Review and Ongoing Improvement

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

Appendix B - Priority Processes

Priority processes associated with system-wide standards

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

Priority processes associated with population-specific standards

Priority Process	Description
Chronic Disease Management	Integrating and coordinating services across the continuum of care for populations with chronic conditions

Priority Process	Description
Population Health and Wellness	Promoting and protecting the health of the populations and communities served through leadership, partnership, and innovation.

Priority processes associated with service excellence standards

Priority Process	Description
Blood Services	Handling blood and blood components safely, including donor selection, blood collection, and transfusions
Clinical Leadership	Providing leadership and direction to teams providing services.
Competency	Developing a skilled, knowledgeable, interdisciplinary team that can manage and deliver effective programs and services.
Decision Support	Maintaining efficient, secure information systems to support effective service delivery.
Diagnostic Services: Imaging	Ensuring the availability of diagnostic imaging services to assist medical professionals in diagnosing and monitoring health conditions
Diagnostic Services: Laboratory	Ensuring the availability of laboratory services to assist medical professionals in diagnosing and monitoring health conditions
Episode of Care	Partnering with clients and families to provide client-centred services throughout the health care encounter.
Impact on Outcomes	Using evidence and quality improvement measures to evaluate and improve safety and quality of services.
Infection Prevention and Control	Implementing measures to prevent and reduce the acquisition and transmission of infection among staff, service providers, clients, and families
Living Organ Donation	Living organ donation services provided by supporting potential living donors in making informed decisions, to donor suitability testing, and carrying out living organ donation procedures.
Medication Management	Using interdisciplinary teams to manage the provision of medication to clients

Priority Process	Description
Organ and Tissue Donation	Providing organ and/or tissue donation services, from identifying and managing potential donors to recovery.
Organ and Tissue Transplant	Providing organ and/or tissue transplant service from initial assessment to follow-up.
Point-of-care Testing Services	Using non-laboratory tests delivered at the point of care to determine the presence of health problems
Primary Care Clinical Encounter	Providing primary care in the clinical setting, including making primary care services accessible, completing the encounter, and coordinating services
Public Health	Maintaining and improving the health of the population by supporting and implementing policies and practices to prevent disease, and to assess, protect, and promote health.
Surgical Procedures	Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge