ACCREDITATION
AGRÉMENT
CANADA
Qmentum

Accreditation Report

Rouge Valley Health System

Scarborough, ON

On-site survey dates: September 25, 2016 - September 30, 2016

Report issued: October 20, 2016

About the Accreditation Report

Rouge Valley Health System (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. As part of this ongoing process of quality improvement, an on-site survey was conducted in September 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

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

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

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

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

Accreditation Decision

Rouge Valley Health System's accreditation decision is:

Accredited (Report)

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

About the On-site Survey

- **On-site survey dates: September 25, 2016 to September 30, 2016**

- **Locations**

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

  1. Rouge Valley Health System - Ajax/Pickering Campus
  2. Rouge Valley Health System - Centenary 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. Organ and Tissue Donation Standards for Deceased Donors - Service Excellence Standards
  15. Perioperative Services and Invasive Procedures - Service Excellence Standards
  16. Point-of-Care Testing - Service Excellence Standards
  17. Rehabilitation Services - Service Excellence Standards
  18. Reprocessing and Sterilization of Reusable Medical Devices - Service Excellence Standards

19. Transfusion Services - Service Excellence Standards

- **Instruments**

  The organization administered:

  1. Governance Functioning Tool (2016)
  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)	56	0	0	56
 Accessibility (Give me timely and equitable services)	101	0	1	102
 Safety (Keep me safe)	688	6	8	702
 Worklife (Take care of those who take care of me)	139	4	1	144
 Client-centred Services (Partner with me and my family in our care)	415	18	3	436
 Continuity of Services (Coordinate my care across the continuum)	83	0	0	83
 Appropriateness (Do the right thing to achieve the best results)	1082	52	12	1146
 Efficiency (Make the best use of resources)	63	1	1	65
Total	**2627**	**81**	**26**	**2734**

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	49 (100.0%)	0 (0.0%)	0	96 (100.0%)	0 (0.0%)	0	145 (100.0%)	0 (0.0%)	0
Infection Prevention and Control Standards	41 (100.0%)	0 (0.0%)	0	31 (100.0%)	0 (0.0%)	0	72 (100.0%)	0 (0.0%)	0
Medication Management Standards	78 (100.0%)	0 (0.0%)	0	62 (100.0%)	0 (0.0%)	2	140 (100.0%)	0 (0.0%)	2
Ambulatory Care Services	37 (86.0%)	6 (14.0%)	3	61 (87.1%)	9 (12.9%)	8	98 (86.7%)	15 (13.3%)	11
Ambulatory Systemic Cancer Therapy Services	60 (90.9%)	6 (9.1%)	0	88 (97.8%)	2 (2.2%)	2	148 (94.9%)	8 (5.1%)	2
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	49 (98.0%)	1 (2.0%)	0	113 (98.3%)	2 (1.7%)	0	162 (98.2%)	3 (1.8%)	0

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Diagnostic Imaging Services	67 (100.0%)	0 (0.0%)	0	67 (100.0%)	0 (0.0%)	2	134 (100.0%)	0 (0.0%)	2
Emergency Department	70 (98.6%)	1 (1.4%)	0	105 (99.1%)	1 (0.9%)	1	175 (98.9%)	2 (1.1%)	1
Medicine Services	43 (95.6%)	2 (4.4%)	0	72 (93.5%)	5 (6.5%)	0	115 (94.3%)	7 (5.7%)	0
Mental Health Services	46 (92.0%)	4 (8.0%)	0	91 (98.9%)	1 (1.1%)	0	137 (96.5%)	5 (3.5%)	0
Obstetrics Services	68 (95.8%)	3 (4.2%)	2	86 (98.9%)	1 (1.1%)	1	154 (97.5%)	4 (2.5%)	3
Organ and Tissue Donation Standards for Deceased Donors	46 (90.2%)	5 (9.8%)	3	89 (92.7%)	7 (7.3%)	0	135 (91.8%)	12 (8.2%)	3
Perioperative Services and Invasive Procedures	105 (91.3%)	10 (8.7%)	0	105 (97.2%)	3 (2.8%)	1	210 (94.2%)	13 (5.8%)	1
Point-of-Care Testing **	38 (100.0%)	0 (0.0%)	0	48 (100.0%)	0 (0.0%)	0	86 (100.0%)	0 (0.0%)	0
Rehabilitation Services	39 (86.7%)	6 (13.3%)	0	75 (94.9%)	4 (5.1%)	1	114 (91.9%)	10 (8.1%)	1
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 **	75 (100.0%)	0 (0.0%)	0	69 (100.0%)	0 (0.0%)	0	144 (100.0%)	0 (0.0%)	0
Total	**1085 (96.1%)**	44 (3.9%)	8	1462 (97.7%)	35 (2.3%)	18	2547 (97.0%)	79 (3.0%)	26

* 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 (Rehabilitation Services)	Met	1 of 1	0 of 0
Client Identification (Transfusion Services)	Met	1 of 1	0 of 0
Information transfer at care transitions (Ambulatory Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information transfer at care transitions (Emergency Department)	Met	4 of 4	1 of 1
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
Information transfer at care transitions (Rehabilitation Services)	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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Medicine Services)	Met	5 of 5	0 of 0
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
Medication reconciliation at care transitions (Rehabilitation Services)	Met	5 of 5	0 of 0
Safe surgery checklist (Obstetrics Services)	Met	3 of 3	2 of 2
Safe surgery checklist (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
The “Do Not Use” list of abbreviations (Medication Management Standards)	Met	4 of 4	3 of 3
Patient Safety Goal Area: Medication Use			
Antimicrobial stewardship (Medication Management Standards)	Met	4 of 4	1 of 1
Concentrated electrolytes (Medication Management Standards)	Met	3 of 3	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
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
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
Infusion pump safety (Rehabilitation Services)	Met	4 of 4	2 of 2
Narcotics safety (Medication Management Standards)	Met	3 of 3	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Worklife/Workforce			
Client Flow (Leadership)	Met	7 of 7	1 of 1
Patient safety plan (Leadership)	Met	2 of 2	2 of 2
Patient safety: education and training (Leadership)	Met	1 of 1	0 of 0
Preventive maintenance program (Leadership)	Met	3 of 3	1 of 1
Workplace violence prevention (Leadership)	Met	5 of 5	3 of 3
Patient Safety Goal Area: Infection Control			
Hand-hygiene compliance (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Hand-hygiene education and training (Infection Prevention and Control Standards)	Met	1 of 1	0 of 0
Infection rates (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Patient Safety Goal Area: Risk Assessment			
Falls prevention (Ambulatory Care Services)	Unmet	0 of 3	0 of 2
Falls prevention (Ambulatory Systemic Cancer Therapy 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 (Critical Care)	Met	3 of 3	2 of 2
Falls prevention (Diagnostic Imaging Services)	Unmet	0 of 3	0 of 2
Falls prevention (Emergency Department)	Met	3 of 3	2 of 2
Falls prevention (Medicine Services)	Met	3 of 3	2 of 2
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
Falls prevention (Rehabilitation Services)	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
Pressure ulcer prevention (Rehabilitation 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			
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.

Rouge Valley Health System (RVHS) is congratulated on its ongoing commitment to the accreditation process and for truly embracing a culture of patient- and family-centred care, quality, and safety. This is particularly important to note as RVHS is preparing to cease as an entity effective November 1, 2016. This will lead to the Rouge Valley Centenary site and The Scarborough Hospital merging to form a new organization and the Rouge Valley Ajax and Pickering site joining Lakeridge Health. The organization is commended on remaining focused and committed to providing excellence in patient- and family-centred care despite being in this time of transition and uncertainty.

In alignment with its strategic directions of being innovators of a quality patient experience, champions of a connected health system for patients, and a workplace of choice, and its vision of “Together – the best at what we do,” RVHS clearly demonstrates the mission and lives the values set forth by the senior management team and the board in consultation with patients, families, staff, physicians, and volunteers. A sense of caring and extreme pride permeates the organization. There is also a commitment to excellence, innovation, and quality service delivery.

The board is highly engaged and committed to the strategic directions of the organization. This is a committed group of individuals who are well versed on the strengths and challenges facing the organization. They reach into the community as well as into the organization for consultation and validation of the organization’s direction. They are well informed and use their skills and abilities to ensure sound and effective governance.

The organization has begun to build its capacity to bring the voice of patients and families into its patient- and family-centred care approaches. During the on-site survey, a large and diverse group of patient advisers, community partners, and patients consistently offered praise for their experiences and for the opportunity to be engaged in a broad range of activities in the organization. The organization is supported in its ongoing efforts and phased approach to mature its patient- and family-centred care initiatives at the unit and program levels. RVHS is congratulated on the considerable strides made at the organizational level with the recent inclusion of two patient advisors as members of the senior management team and the Community Advisory Group’s links to the board.

RVHS has implemented a quality management approach throughout the organization, ensuring a high level of accountability. The foundation of this approach integrates patient- and family-centred care with quality and safety. There is a strong commitment to quality and safety. The organization has invested in LEAN training that has helped identify opportunities to optimize clinical operations, as was clearly evident by the calibre of the quality improvement initiatives.

A key strength of the quality culture at RVHS is its patient advisors, leadership, staff, physicians, learners, and volunteers. There are strong teams throughout the organization and a culture of working together. Staff recognize and seize opportunities for improvement and they are proud to share these achievements and successes. “Everyone’s Ideas Matter!" RVHS is reaping the benefits of engaging, educating, and empowering front-line staff to be active players in quality improvement at the unit level, recognizing this is key to moving the quality agenda forward.

For RVHS, the quality journey doesn’t just occur within the walls of the two hospital sites. By listening to the voice of the patient, family, and community, RVHS demonstrates its commitment to integration and continuity of care. This is shown, for example, in the continued expansion of the regional cardiovascular rehabilitation services to more community and hospital-based sites, the Healthy Outcomes pediatric program for Scarborough, new partnerships to support community-based mental health programs, and follow-up telephone calls to medicine and surgery patients who have been discharged from hospital.

RVHS is commended for its commitment to and support of its people. Staff, physicians, and volunteers are truly engaged in planning and delivering services. There is a connectedness between the leadership and the front-line staff. The commitment to staff education and training, the use of e-Learning, and the various professional practice meetings are evidence that the organization is committed to creating a sustainable and empowering work environment. Staff take pride in their work. Their contributions are valued and their ideas are acknowledged. RVHS also invests in its people through leadership development and by providing opportunities for advancement.

The community partners who are key stakeholders expressed their sincere appreciation to RVHS for its expertise, collaboration, and innovative spirit. They acknowledged that RVHS is intentional in connecting and engaging with the community and that the organization is viewed by many to be a champion on the ground. They commented that RVHS is willing and unafraid to work on the tough issues. Community partners were unanimous in their hope that the culture of RVHS would be infused into the new organizations after the transition, as RVHS has consistently demonstrated an open and respectful approach and is clearly doing something right!

As RVHS prepares to end a journey that started in 1998, this organization can take pride in the many accomplishments and contributions it has made to excellence in patient care. A deep culture of quality and safety has been instilled in the staff, physicians, and volunteers who work at RVHS. As a new journey begins, this spirit and culture, along with the many successes, will live on. Well done, Rouge Valley Health System.

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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: Risk Assessment	
Falls prevention To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated.	· Diagnostic Imaging Services 15.6 · Ambulatory Care Services 8.6

Detailed On-site Survey Results

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

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

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

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

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

See Appendix B for a list of priority processes.

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

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

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

Priority Process Results for System-wide Standards

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

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

Priority Process: Governance

Meeting the demands for excellence in governance practice.

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

Rouge Valley Health System (RVHS) is fortunate to have a committed, engaged, and knowledgeable board. The board is very committed to monitoring the organization's targets and accomplishments, and recognizing and celebrating its achievements and performance. The board actively challenges the organization to do the best it can. Board members are diligent in looking at the metrics and finding opportunities for efficiencies and quality improvement.

The board trusts the management and works to govern, question, and support the ideas and items management brings forward. All major decisions go through a comprehensive process that examines risk and all board decisions are carefully monitored. A risk and ethics framework is used to help make informed decisions.

The board is committed to the quality and safety of patient care. Every meeting of the Quality & Risk Committee commences with a patient story that is shared with the full board. Two members of the board are part of the Community Advisory Group which is composed of patients and families. This committee is actively engaged and consulted with regard to the functioning of the organization. Some examples include engagement in the review of the mission, vision, and values; development of the strategic plan; and playing a major role in the development of the end-of-life care initiative.

All board members receive a comprehensive orientation. Performance evaluation of the board members and the board chair occurs. After each meeting board members evaluate the effectiveness of the meeting and make improvements or changes accordingly to improve future meetings. They also have a process to review the performance of the CEO on an annual basis.

The board is very involved and always informed on critical issues. There is an atmosphere of openness within the board and the executive team. The board is in touch with the community and the population that RVHS serves. An excellent example of the board's commitment to consultation and engagement was the development of the new three-year strategic plan. Over a nine-month period, over 1300

stakeholders, including patients, families, community members, staff, physicians, volunteers, union leaders, health system partners, and local elected officials were invited to participate and be involved in the process.

The board uses a variety of mechanisms to stay in touch with the community, including public board meetings and the release of the annual report. The annual board retreat is very inclusive, with representation from unions, patients, families, and the community as well as several levels of leadership in the organization.

Priority Process: Planning and Service Design

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization has reaffirmed its mission, vision, and values. A rigorous process was undertaken to review and refresh the mission and vision. Extensive consultation and engagement with staff, patients, and families ensured that the mission and vision were meaningful and relevant.

The organization has been deliberate in ensuring the strategic plan is focused on the patient and family. It has undertaken an engagement strategy with internal and external stakeholders to ensure there is an awareness of the plan and the direction it is taking. It is evident the plan is used to guide planning and decision making at the leadership and board levels.

The quality improvement plan and the annual operational plans are aligned with the strategic plan. Each strategic objective has an assigned executive leader and there is a defined work plan to achieve each of the objectives. Regular reporting on the progress of the work plan occurs. There is an expectation that goals, objectives, and program plans for all clinical programs must be aligned with the organization's strategic plan.

The organization has clear policies and procedures to address the rights and responsibilities of patients and their families. The rights and responsibilities are posted and visible throughout the organization.

The organization is commended for its culture of using data and evidence, both qualitative and quantitative, to drive planning, decision making, and evaluation. It is also commended on its ongoing attention to risk management. This was recognized when the RVHS received the FM Global Award for excellence in highly protected risk achievement and its ongoing commitment to property loss prevention.

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)

RVHS has implemented sound processes to ensure fiscal accountability and responsibility. The organization uses a principle-based approach that includes integrating long-range planning with short-term operating and capital budget needs, while at the same time ensuring overall financial sustainability. Finance works collaboratively to help managers understand the financial reports. In turn, this collaboration helps finance staff develop an understanding and appreciation for the services being planned and delivered by the programs, and to support the managers in their understanding of financial responsibilities. There is an expectation that programs and services monitor and manage their budgets. There is a culture of financial accountability.

The organization has developed and implemented rigorous and transparent processes to allocate resources. Routine capital requests are reviewed by a multidisciplinary committee. The committee's recommendations are then reviewed by the senior management team, the Medical Advisory Committee, and the Finance and Audit Committee of the board before being approved by the board as a whole. The organization is mindful of the potential impact of resource allocations on other programs and services. This is a testament to the staff and leaders in this organization who believe in supporting each other.

A risk management lens is used when decisions are contemplated and when resources are allocated. It is evident there is a tremendous amount of trust in the processes. Overall, those involved in resource management can be proud of the discipline they have put in place to ensure resource allocation decisions can be successfully delivered and implemented.

Priority Process: Human Capital

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

A dynamic, energetic, and knowledgeable team leads and supports the human resources functions at RVHS. The team's goals align with the organization's strategic plan and focus on supporting the implementation of patient- and family-centred care and diversity into programs and communication strategies; developing a talent management strategy including recruitment, retention, performance development, and recognition; and enhancing a healthy workplace and a culture of workforce safety. Performance measures have been identified and are being regularly monitored and reviewed.

The team has implemented and evaluated several initiatives to support a safe work environment and a healthy workplace. This team has also incorporated patient- and family-centred care expectations into its recruitment strategy. The organization is commended for requiring staff, volunteers, and active physicians to complete the Communicate with Heart customer service program. For active physicians, completion of this program is tied to the reappointment process.

Since the last on-site survey, performance appraisal completion has improved, with 100 percent completion for leadership and 60 percent for unionized staff. The Human Resources team has also implemented a process to review managerial spans of control, which has resulted in some units receiving funding to support additional resources. The organization is encouraged to continue to forge ahead with ensuring completion of performance appraisals.

There is a very positive work culture throughout the organization, and healthy and collegial relationships with various labour unions. Strategies to engage and recognize staff are evident. Leadership rounds regularly occur where staff are being engaged in a dialogue and are asked about their ideas, suggestions, and what the organization can do to foster a culture of quality and safety as well as patient- and family-centred care.

The organization can be proud of the investment and commitment it has made in education, particularly in the area of leadership development with the Leading Edge program. There is no question that RVHS believes in its people and is investing in their career development and professional education as well as ongoing educational opportunities to support the quality and safety agenda. The Passport to Safety educational session is a creative and innovative approach to safety education. This is an example of how the organization ensures safety is always high on everyone's radar. The organization is looking forward to implementing a new learning management system in the near future.

RVHS is committed to providing and maintaining a healthy and safe workplace for staff, physicians, and volunteers, as is evident in the various programs and initiatives reviewed during the on-site survey.

Occupational health and safety along with key stakeholders (security, joint health and safety, mental health, risk management) successfully implemented a workplace violence and harassment program across the organization. Training, monitoring, and reporting procedures are in place to ensure ongoing success and sustainability of this program.

There are excellent recruitment processes for staff, physicians, and volunteers. The credentialing process for new physician recruits requires an impact analysis to be completed and signed off by the chief of staff. All newly hired staff and volunteers are required to attend an orientation session. There are also processes to conduct exit interviews, and learnings from these interviews support the commitment to quality improvement.

The Human Resources department is commended for its commitment to ensuring that processes and tools are in place to support the organization's leaders, physicians, staff, and volunteers in fulfilling the mission and vision of Rouge Valley Health System.

Priority Process: Integrated Quality Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization is congratulated for it efforts and the investments it has made to continue to mature and refine its integrated quality management journey. It is commended for integrating the quality improvement plan with the strategic goals and operational plans. It is also congratulated for providing resources to support quality improvement such as the Transformation Management Office where improvement support is provided to clinical and non-clinical programs.

The quality improvement plan encompasses an integrated approach that involves patient- and family-centred care, quality improvement, and safety. The philosophies of care include listening and building on the experiences of patients and families, empowering quality improvement teams to monitor outcomes and experiences at the unit and program levels, and coaching and capacity building for staff and patient and family advisors in the LEAN management system. The expected impacts are to partner with patients and families to design a better health experience, build safety into the patient experience, and continually look for solutions and improvements through the involvement of patients, families, staff, physicians, and volunteers.

There is evidence of ongoing performance indicator monitoring and reporting, policies and procedures for staff and patients to support a culture of quality and safety, implementation and monitoring of a safety learning and reporting system, sound processes for critical incident and adverse event reviews, and disclosure to patients and families. There is also evidence that quality improvement is happening at the program and the unit levels through unit councils and visibility boards. The organization has invested in quality improvement education and training for staff and physicians to ensure they have the necessary tools and knowledge to support quality improvement. The organization is encouraged to continue to publicly profile and celebrate their quality and safety improvement successes. “Everyone’s Ideas Matter" is an excellent example how staff can bring their ideas for improvement forward, implement them, and be recognized.

Significant effort has been made to engage patients, families, staff, volunteers, and physicians in quality and safety initiatives. RVHS has implemented several initiatives to support a philosophy of patient- and family-centred care under the four pillars of respect and dignity, information sharing, participation, and collaboration. The organization has several formal processes to include patients and families, including the strategic planning process, quality and safety issues at the organizational level, unit councils, and membership on the senior management team and organizational committees such as the Community Advisory Group. Patient advisors have been involved in interviewing for key leadership positions such as the manager of patient- and family-centred care. With the input of patients and families the organization

has developed a formalized patient experience program. Patient and family advisors have been recruited to three early adopter units which include emergency, critical care, and the neonatal intensive care unit. The organization is encouraged to continue to formalize and recruit patient and family advisors at the unit and program levels and to consider representation from diverse patient populations.

There are sound processes to report adverse events. Staff are aware of the steps that need to be taken when an adverse event occurs and there are processes to support everyone involved in these situations. Disclosure training and support is also provided.

The organization has continued to make progress with the Accreditation Canada Required Organizational Practices (ROPs). There is evidence across the organization where ROPs such as pressure ulcer prevention, venous thromboembolism prophylaxis, and medication reconciliation have been fully implemented. The organization is encouraged in its efforts to continue to move forward with full implementation of medication reconciliation and falls prevention in the ambulatory care outpatient setting. As well, it will be important for the team to continue to monitor the status of the ROPs to ensure sustainability.

The organization can be very proud of its quality and safety program and its many successes. The gains since the last on-site survey are outstanding. There is no doubt that patient- and family-centred care, quality improvement, and safety are embedded in the fabric of Rouge Valley Health System. This is truly an organization that can be an exemplar for other health care systems.

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)

RVHS has engaged the expertise and services of the Centre for Clinical Ethics to provide ethics support through education, case consultations, policy development, and research. The service provides on-site ethics coverage three days per week in addition to providing on-call for emergencies 24/7. Anyone can access the service. The ethics consultation service includes preventive ethics and retrospective case analysis. They use a principle-based decision-making framework called YODA (You, Observe, Deliberate, Act). The framework outlines clear steps for thinking through an ethical Issue. Metrics related to ethics trends and issues are regularly reported.

The Ethics Integration Committee meets on a regular basis to provide a forum for identifying and raising ethics issues and to support the work of the clinical ethicists. The committee has representatives from various disciplines. It reviews and develops guidelines and policies related to ethics, evaluates current policies and procedures related to ethics, promotes ethics education and internal capacity, and makes recommendations to senior management regarding ethical issues and processes. The committee has identified the need to add community members to the committee. In the spirit of patient- and family-centred care it is important they move forward with these appointments.

RVHS is commended on its strategies to sustain and integrate ethics throughout the organization. Examples include regular ethics grand rounds, journal clubs, unit-based rounds and in-services, attendance at medical rounds, and orienting new employees to the ethics framework and support available. When required, the ethicists have also been invited to the board, senior management team, and the Medical Advisory Committee. The team has been engaged in community outreach whereby ethics grand rounds are open to the public, a community member sits on the research ethics board, and the Centre for Clinical Ethics organizes an annual conference which is open to the public.

The purpose of the research ethics board is to ensure research protocols meet with current safety, scientific, ethical, and privacy standards as well as to ensure the research activities are aligned with the best interests of RVHS. Processes and procedures are in place to ensure the review process complies with all laws, policies, standards, and guidelines governing research. Since the last on-site survey, the organization has incorporated an appeal process when a research proposal has been denied.

RVHS is commended on its commitment to and investment in ethics support for the organization. Ethics is viewed as a normal standard of care and it is evident that ethics has been integrated into the entire fabric of the organization. The approach that RVHS has taken to create and sustain this culture is a model that other health care organizations may wish to adopt.

Priority Process: Communication

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Promoting the organization's services and its commitment to patient- and family-centred care is well addressed by the competent communications team. In a quest to optimize communication strategies, staff were recently surveyed on how they wish to access information about what is happening in the organization. In the future, the team will inform staff through regular emails. In response to the major restructuring that will occur in November, town hall meetings have been and will continue to be scheduled at both sites to answer questions and reassure staff as much as possible.

The message from the CEO to all managers and ultimately to staff on the need to remain focused on delivering safe and quality care to patients and families despite the impending restructuring, delivered via the Leadership Forum and other communication modes, is commendable. The team is commended for the Quality Forums and the Community Engagement Groups from which emerged the community's concern about palliative and end-of-life care. From these initiatives the organization has been able to hear and identify community concerns and how it can address them.

The information management systems team is commended for its focus on providing clinicians with the best tools available to facilitate and optimize care delivery. The implementation of the business intelligence model has proven successful. The implementation of the quality-based procedures is an example of how standardized protocols with a focus on outcomes, with supporting data highlighting the results, allows the clinical team to obtain the best results rather than average ones. Data required to make the best clinical decisions are available.

The team's focus on inter-operability of information systems is commended.

The team is commended for the proactive role taken by the organization in the significant privacy breach that occurred. The team went beyond simply implementing administrative measures internally. Full disclosure was done and the organization worked with the Information and Privacy Commissioner of Ontario. Internally the organization now provides extensive education to all staff and is proud to report that almost 95 percent of staff have participated in annual refresher sessions on the responsible use of information. The team is proud of the work it does with regard to audits on the major information systems to ensure the security of all patient information.

Priority Process: Physical Environment

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

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

The physical plant at the Rouge Valley Centenary site has aged significantly in the more than 45 years since it was built. There is a competent engineering and site maintenance team with strong leadership. The organization has committed to resourcing ongoing maintenance and renewal of key aspects of the infrastructure. New boilers, chillers, and various renewed back-up systems are evidence of this.

Patient and family feedback has been incorporated into food services and some physical renovations at the site.

Cleanliness is a priority and various quality and cleanliness audits are in place to ensure this is maintained.

Medical gases are handled safely and safeguards are in place to minimize risk.

Restricted areas and high-risk areas are clearly labelled and appropriate barriers are in place and maintained.

As with other structures from this era, sprinklers in the main building are lacking. While there is time before the deadline to have sprinklers installed, the cost will be significant. The organization is encouraged to plan for this in its resource allocation plan. Similarly, the presence of asbestos makes any such project or renovation risky and expensive. This is an ever-present risk if a leak or structural damage occurs.

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 organization has worked closely with its community partners to ensure all issues in an emergency situation are addressed and patient and staff safety is assured. The organization played an important role in providing psychological support to staff at the time of the fire at a neighbouring seniors' residence. The organization itself needed to institute a code grey when water flow to the institution was interrupted as a result of problems under municipal jurisdiction. The organization reached out to a neighbouring seniors' residence to offer support.

The team is commended for the excellent result of its last fire drill exercise carried out last November.

Ongoing monthly code exercises are carried out to ensure all staff are knowledgeable on the different codes. In addition, online learning modules are available to ensure maintenance of yearly competence.

To help on-call managers respond to emergency situations, the team developed an admin on-call/manager on-call emergency preparedness resource manual.

Board members are regularly updated on emergency preparedness.

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)

RVHS has an active and cohesive access and flow program at both sites. Both sites are challenged by a paucity of budgeted acute medicine beds. They do manage with one of the lowest provincial admission rates from the Emergency department (ED).

There is an active process to monitor certain access and flow metrics including readmission rates for chronic obstructive pulmonary disease and congestive heart failure.

Internal medicine specialists look after inpatients at the Centenary site while Ajax and Pickering has a hybrid general internal medicine and hospitalist model for inpatient care. The inpatient units are well supported by pharmacy, nurse practitioners, and other support services.

A surge plan is in place at both sites, managed and monitored by the access and flow manager and patient flow staff.

The Ajax and Pickering site benefits from a Critical Care Outreach Team that helps manage potential admissions to the intensive care unit. This site will at times get a large number of mental health admissions in its ED as there are no on-site mental health beds.

Rapid access general internal medicine clinics have led to a decrease in ED consultations, admissions, and length of stay.

Overall the Rouge Valley Health System has an active and positive patient access and flow program.

Priority Process: Medical Devices and Equipment

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Rouge Valley Centenary and Rouge Valley Ajax and Pickering both have medical devices reprocessing departments that are coordinated under excellent leadership and meet or exceed Central Service Association of Ontario standards. Hard copy and electronic support material at both sites provides safe, comprehensive support for processes in the departments. There are many visual cues and problem-solving algorithms at both sites.

Rouge Valley Centenary has implemented an electronic instrument tracking system that provides extensive detail to enhance patient safety.

At Ajax and Pickering, the change room for central processing department staff is used by men and women, with only a curtain between the change room and the staff break room. Adjacent space is available to create a separate male change room to enhance staff dignity and privacy.

Diagnostic imaging staff are reprocessing vaginal ultrasound probes in their department with a specialized hydrogen peroxide cleaning system. With three probes and one reprocessing machine, further redundancy of either the cleaning system or probes would prevent delays or cancellations in the event of the failure of the cleaning system.

Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Point-of-care Testing Services

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

Clinical Leadership

- Providing leadership and direction to teams providing services.

Competency

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

Episode of Care

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

Decision Support

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

Impact on Outcomes

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

Medication Management

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

Organ and Tissue Donation

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

Infection Prevention and Control

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

Diagnostic Services: Imaging

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

Diagnostic Services: Laboratory

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

Transfusion Services

- Transfusion Services

Standards Set: Ambulatory Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.3	Service-specific goals and objectives are developed, with input from clients and families.	
1.4	Services are reviewed and monitored for appropriateness, with input from clients and families.	
2.4	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		
3.1	Required credentials, training, and education are defined for all team members with input from clients and families.	!
3.10	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
3.11	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
4.5	The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified.	
Priority Process: Episode of Care		
8.6	To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated.	ROP
8.6.1	A documented and coordinated approach to falls prevention is implemented.	**MAJOR**
8.6.2	The approach identifies the populations at risk for falls.	**MAJOR**
8.6.3	The approach addresses the specific needs of the populations at risk for falls.	**MAJOR**

8.6.4	The effectiveness of the approach is evaluated regularly.	**MINOR**
8.6.5	Results from the evaluation are used to make improvements to the approach when needed.	**MINOR**
10.8	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support		
11.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
Priority Process: Impact on Outcomes		
13.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
13.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
13.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
13.5	Guidelines and protocols are regularly reviewed, with input from clients and families, to ensure they reflect current research and best practice information.	!
15.1	Information and feedback is collected about the quality of services to guide quality improvement initiatives, with input from clients and families, team members, and partners.	
15.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

The ambulatory care visit during this on-site survey included a review of the clinics and services within the ambulatory care unit at the Ajax and Pickering site. It did not include the Pre-Assessment Clinic.

The clinics and services support either the medicine or surgery program. The clinics and care observed were plastics and general surgery, bronchoscopy, Medical Rapid Referral Clinics (MRRC), and medical day procedure. The implementation of the MRRC has helped improve access and flow issues in the ED, as patients can be triaged to this clinic for further follow up rather than waiting in the ED for specialist consults. As well, the unit facilitates follow-up care for patients who may have ended up going to the ED.

During the on-site survey, there was an unscheduled opportunity to briefly visit the Geriatric Assessment and Intervention Network (GAIN) clinic at the Centenary site. The GAIN team provides assessment, investigation, diagnosis, treatment, education, support, and care to older adults dealing with complex health concerns. The team is composed of nurse practitioners, a behavioural support nurse, pharmacists, occupational therapists, physical therapists, social workers, and a Community Care Access Centre coordinator. GAIN has successfully implemented the best possible medication history and has established performance indicators.

The team may want to consider developing its own unit-specific performance indicators to obtain information about its local program performance and to identify improvement opportunities.

Priority Process: Competency

The unit has access to interdisciplinary team members as required. Staff receive ongoing education to ensure they have the required knowledge when new technologies and treatments are introduced.

There is a commitment to ongoing learning. All new staff receive a comprehensive orientation.

The unit has access to a resource nurse.

Due to several management changes performance appraisals have not been completed. Once the management structure is confirmed the organization is encouraged to complete the performance appraisal process for staff.

Priority Process: Episode of Care

The team is commended on its responsiveness to the needs of the patients. They will do whatever they can to respond to urgent and short notice requests for their services. This was confirmed by the physicians and patients who appreciate the responsiveness by the staff when the services are required.

The patients interviewed in the unit also sang the praises of the staff and physicians. They indicated that they are treated with respect and dignity and that the staff really care for them. They are provided with the necessary verbal and written information and are well prepared when they are discharged. It is suggested the team evaluate the effectiveness of their transition processes to ensure they are effective and meeting the needs of the patients.

Patients do not receive information about their role in patient safety. It is suggested the unit consider providing a copy of the organization’s patient safety brochure to all patients who visit the ambulatory care unit.

A falls prevention strategy in the unit has yet to be implemented. Falls can occur anywhere and since the unit serves populations who are at risk for falls, it is important to implement the falls prevention strategy.

The team is encouraged to consider how it can mature its processes to provide opportunities for input from patients and families.

Priority Process: Decision Support

The team ensures that a comprehensive record of the patient's visit is maintained.

Staff are very conscientious about maintaining patient privacy and confidentiality. There are processes to ensure patient information is coordinated with other providers outside of the organization.

Priority Process: Impact on Outcomes

The staff take great pride in offering care based on a philosophy of patient and family centredness, as well as quality and safety.

The unit monitors several indicators that are posted on the quality board. The team may wish to consider conducting regular patient satisfaction surveys to receive real-time feedback on how they are doing and where there may be opportunities for improvement.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.3	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.	
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		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
16.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
Priority Process: Impact on Outcomes		
18.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
18.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
18.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
18.5	Guidelines and protocols are regularly reviewed, with input from clients and families, to ensure they reflect current research and best practice information.	!
18.6	There is a policy on ethical research practices that outlines when to seek approval, developed with input from clients and families.	!
Priority Process: Medication Management		
The organization has met all criteria for this priority process.		
Surveyor comments on the priority process(es)		

Priority Process: Clinical Leadership

The Cancer Care program is a Level 3 affiliate Systemic Treatment Centre as defined by Cancer Care Ontario. It provides chemotherapy for patients diagnosed with breast, colon, lung, pancreatic, rectal, and stomach cancer, as well as lymphoma and multiple myeloma, and provides procedures such as therapeutic phlebotomies, blood transfusions, paracentesis, thoracentesis, and bone marrow biopsies. The program has implemented diagnostic assessment units for prostate, radiation, thoracic, and thyroid head and neck as well as a palliative outpatient clinic.

The team goals of access to care, service excellence, team engagement, and fiscal responsibility are aligned with the organization's strategic directions.

The team has a complement of dedicated medical oncologists, pharmacists, nurse practitioners, a clinical practice leader, nurses, volunteers, and clerical support as well as access to supportive care services from social work, spiritual care, physical and occupational therapy, and dietetics.

This team exemplifies its commitment to excellence in patient care for the patients and families, and this was confirmed in discussions with patients and families. They had glowing compliments about the staff and physicians and the program as a whole. They felt supported and felt their needs and concerns are addressed in a timely manner.

The team is encouraged to continue to engage patients and families in various aspects of service delivery and design.

Priority Process: Competency

This team works well together and embraces a philosophy of patient- and family-centred care.

All staff receive a comprehensive orientation.

All of the full-time oncology nurses have de Souza certification.

Continuing education is offered when new protocols or treatments are introduced.

All staff have received infusion pump training.

Nursing is now provided in a primary nurse model where the nurse works regularly with the same oncologist. Feedback from patients about this change has been very positive.

Priority Process: Episode of Care

The team ensures patients have timely access to care as directed by Cancer Care Ontario targets. Access is available 24/7 if required.

Patients and their families are actively involved in their care. Patients are welcome to bring family members and friends to appointments.

The team is sensitive to the needs of diverse cultures and have ready access to translation services.

Sound processes to obtain informed consents are in place.

Staff are well informed on how to address ethical issues and are also aware of the resources available to them.

Medication reconciliation is fully implemented. The pharmacy services that support this process are appreciated.

The team has developed and implemented an SBAR (situation, background, assessment, recommendation) communication tool to effectively communicate patient information during transitions of care. They also conduct six-week post-operative adjuvant follow-up calls, and contact patients who have been prescribed oral chemotherapy one to two days later to ensure they have filled the prescription.

The team also offers the Survive 'N Thrive program to support patients who are close to completing their chemotherapy or radiation treatment. This program helps them move forward with their lives after treatment and focuses on addressing the physical, psychosocial, and practical concerns that patients may experience once their cancer treatment is complete.

Priority Process: Decision Support

Comprehensive and accurate patient files are kept. The team has the opportunity to engage in tumour rounds with the tertiary cancer care. There are processes to bring forward cases when required for further consultation.

The team follows evidence-based clinical practice guidelines and chemo protocols as outlined by Cancer Care Ontario. They have the opportunity to engage in continuing education events such as those hosted by Cancer Care Ontario or the Central East Regional Cancer Program.

Priority Process: Impact on Outcomes

The team is well aware of and demonstrated consistent use of two patient identifiers and independent double checks before starting chemotherapy administration.

A falls prevention strategy has been implemented, and there is ongoing assessment to ensure current information related to the risk of falling is available to staff.

The staff have contributed to and been recognized for "Everyone’s Ideas Matter."

There is evidence of a culture of quality improvement, safety, and patient- and family-centred care throughout the unit. Patient satisfaction surveys have been ongoing for the past eight years and the results have contributed to process improvements in the unit. Quality improvement initiatives are posted in public areas.

The team has been involved in several initiatives including developing a fridge magnet for patients that highlights do's and don’ts for side effect management, developing an oral chemotherapy call-back program, ensuring compliance with standards for chart documentation, introducing a fever card should the patient need to visit the ED, and implementing oncology rehabilitation for metastatic disease.

This team can take pride in keeping safe, quality patient care at the forefront, and is commended for supporting this culture through the program.

Priority Process: Medication Management

Sound processes are in place for the safe handling, preparation, and administration of chemotherapy. Guidelines are adhered to and staff working in the pharmacy are very knowledgeable about their roles and responsibilities.

Spill kits are available and staff understand how to manage spills should they occur.

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
Both sites are equipped with an Ontario Laboratory Accreditation-certified laboratory and blood bank.

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.	!
3.12	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
Priority Process: Episode of Care		
8.2	The assessment process is designed with input from clients and families.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
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 intensive care and coronary care units provide level 2 and 3 care which includes acute dialysis, balloon pump, ventilator, and code STEMI care. Staff report being supported to access specific training for each modality and ongoing education in intensive care nursing.

The leadership team for critical care services reports that a Rapid Response team was provided through a Local Health Integration Network grant for the Ajax and Pickering site only. Staff and leaders at that site believe the data support the value of this initiative and would be welcomed at the Centenary site.

The team describes a collaborative process for resource allocation and decision making that includes patient and family input. As well, team members describe processes to consider new practices which include data analysis and resource prioritization.

Palliative and end-of-life care is described by the team as a priority, with the recruitment of an intensivist with a specialty in palliative care who functions as the director of palliative care at RVHS.

Priority Process: Competency

Records show staff have completed infusion pump training and this is monitored on an ongoing basis. Staff indicate that support is available for ongoing education.

A falls program is in place, evidenced by policy and procedure, signage, and patients in special socks.

Documentation and communication tools used in the units were demonstrated by staff who were part of their development. They are consistent and comprehensive.

Priority Process: Episode of Care

Staff of the critical care units are aware of the ethics framework structured under the acronym YODA.

The risk for falls and skin impairment are assessed every 12 hours on a structured documentation form.

Medication reconciliation is done on admission, transition to another unit, and discharge, with a dedicated full-time equivalent of pharmacist time for each of the units.

Discharge care is coordinated with community agencies.

Safer Healthcare Now bundles are in place and are monitored by the Critical Care team.

Staff and leaders at both sites report that sometimes patients with chronic ventilator care needs will be in the critical care unit for many months due to a lack of chronic care ventilator-assisted beds in the province. Staff feel that critical care beds would be relieved if a small chronic care ventilator-assist unit was created in the hospitals.

Another factor reported by physician leadership at Ajax and Pickering as a barrier to discharging patients from the critical care unit is access to dialysis at a critical care level.

Priority Process: Decision Support

The critical care unit at the Centenary site uses a paper documentation system, while Ajax and Pickering uses an electronic documentation system, with plans to standardize electronic documentation.

Priority Process: Impact on Outcomes

The Critical Care team described several incidents where disclosure of unintended events was carried out.

Priority Process: Organ and Tissue Donation

Policies to define neurological death and other aspects of organ donation are in place.

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		
15.6	The team implements and evaluates a falls prevention strategy to minimize client injury from falls.	ROP
15.6.1	The team implements a falls prevention strategy.	**MAJOR**
15.6.2	The strategy identifies the populations at risk for falls.	**MAJOR**
15.6.3	The strategy addresses the specific needs of the populations at risk for falls.	**MAJOR**
15.6.4	The team establishes measures to evaluate the falls prevention strategy on an ongoing basis.	**MINOR**
15.6.5	The team uses the evaluation information to make improvements to its falls prevention strategy.	**MINOR**

Surveyor comments on the priority process(es)

Priority Process: Competency

Private space is available for counselling and changing in the Diagnostic Imaging (DI) departments.

Spiritual space is available at both sites in the form of multi-faith spiritual rooms.

Priority Process: Diagnostic Services: Imaging

There are excellent operational processes at the DI department at the Ajax and Pickering site. Inappropriate utilization is monitored on a regular basis to optimize the appropriate use of diagnostic services. Staff receive appropriate training and ongoing professional education to support current and new diagnostic regimes.

Performance and outcome indicators are monitored. The department embraces a culture of patient- and family-centred care, coupled with a commitment to quality and safety. As identified in the last on-site survey, there continues to be a need to ensure a falls risk assessment occurs with each outpatient who presents to the DI department, and to consider adopting the same falls risk armband as the inpatient units.

There is a comprehensive quality assurance program at both sites, led by the radiologists' peer review process. Appropriate access is available for urgent investigations required by the ED and inpatients as well as community physicians.

Referral sources are surveyed to obtain information to be used for ongoing improvement of access and quality improvement. Wait times in CT and MRI can be a challenge but are monitored on an ongoing basis.

The mammography department at the Centenary site functions well with the patient navigator. It is physically separated from the main DI department but is able to provide quality service. Registration is shared with the lab as well as with some waiting areas. This is not ideal at times due to the nature of the exam.

Overall the diagnostic imaging programs at both sites provide quality service with a dedicated team.

Standards Set: Emergency Department - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
4.15	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
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		
16.5	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 Centenary site ED is challenged by physical space limitations, as volumes now far exceed the original design. The ED team has designed many multipurpose areas that are used to meet or bypass these space challenges. While it is not clear whether direct patient, community, or partner input is solicited for the co-design of certain solutions, the ED has the unique I-PILLAR program which solicits real-time feedback from patients and families. This is incorporated into the ongoing process improvements in the department.

The Ideas program is a unique concept to enhance staff participation in positive change.

The program has a daily DART which is clearly displayed and visible to team members and patients, for a transparent sharing of results, whether good or bad.

The Ajax and Pickering site has high volumes as well. The department is somewhat better laid out with more spacious care areas, but this is offset by a lower number of budgeted inpatient beds which contributes to overcrowding in the department.

Leadership at both sites is strong and active, maintaining excellent team morale and ongoing quality improvement.

Priority Process: Competency

At both sites the ED team is a close knit and co-operative team. The team works collaboratively to support each other during the sometimes difficult situations that often arise in a busy ED.

The team is sensitive to the diverse needs of the community. The physician and nursing leadership at both sites is congratulated for maintaining and promoting a positive culture and working environment at both sites.

Infusion pump training is ongoing and documented appropriately.

Feedback from patient and family representatives is used for various aspects of care, but there was no evidence of this in role design and/or role satisfaction. This may be the next step in the journey the organization has embarked on in enhancing the involvement of patients and families in quality improvement measures.

Priority Process: Episode of Care

The Centenary site ED has outgrown itself, with volumes currently more than three times the original volume for which it was designed. The space issues lead to possible privacy concerns as patients are seen and held in close quarters. Infection prevention and control practices can be hindered for the same reason.

The team does an adequate job of ensuring privacy is afforded to patients and appropriate infection prevention and control practices are in place despite these limitations.

There is a definite team atmosphere among all ED team members, with significant collaboration and co-operation evident.

There is a good electronic medical record system (Pulsecheck) that is used for tracking, triage, and access to lab and diagnostic imaging results. Physicians do not use the Pulsecheck system. It is suggested that the organization encourage physicians to use this system to enhance the flow of information for ED team members and patients. Of note, while this may be due to a lack of hardware devices, this did not appear to be an issue at the time of the on-site survey.

Medication reconciliation is in place, with a best possible medication history for admitted patients. The presence of two ED pharmacists enhances this process. There is a gap in that medications are often not acquired at triage and then subsequently also not obtained or recorded by the primary care nurse and/or the ED physician. This leads to an incomplete record for patients who are discharged and can put them at risk of medication interactions when they are prescribed outpatient medications.

A comprehensive SBAR (situation, background, assessment, recommendation) system is in place for transfer of information between nurses when patients are transferred.

Falls prevention strategies and suicide assessment checklists are in place. There is also a process to reassess patients who are waiting in the waiting room.

Overall this is a comprehensive department challenged by volume and space but functioning well with a strong team.

The Ajax and Pickering ED is well laid out, with spacious patient care areas. As with the Centenary site, this site has competent and committed leadership. It is an alternate funding site for physicians, so it has more hours of physician coverage. The use of the Pulsecheck tracking system is similar at both sites, but Ajax and Pickering is attempting to launch physician electronic documentation which is a step forward.

As with the Centenary site the Ajax and Pickering site has good best possible medication history, falls precautions, suicide assessment, and two patient identifiers in place and practiced.

Ajax and Pickering works collaboratively with Ontario Power Generation on an ongoing basis to practice and review Code 77/Code Orange in the event of exposure to nuclear waste from the nearby nuclear power plant.

Both sites have a daily DART in place and continually monitor quality and flow measures to optimize patient flow and maintain quality improvement.

Inpatient mental health beds are available only at the Centenary site. There are outpatient services at both sites. This will lead to an increased propensity for certified and non-certified mental health patients to remain in the Ajax and Pickering ED for long periods before being transferred to an inpatient unit. This is not optimal for quality mental health care, but is not uncommon across EDs in Ontario. A short-stay mental health unit concept may be considered for this site.

The internal medicine call schedule at Ajax and PIckering has 24-hour shifts, which leads to decreased productivity by the on-call internist in the latter parts of the day and internal medicine patients and consults being held in the department. A more optimal schedule with distributed workload may help resolve this issue.

The security presence at the Ajax and Pickering ED can be an issue at times as security is stationed some distance away from the ED.

Priority Process: Decision Support

Information about patients' rights to access their health records and their rights to privacy is easily visible to patients and ED team members at both sites.

Feedback from patients and families is used on an ongoing basis for various improvement measures at both sites. The I-PILLAR at both sites enhances this process.

Priority Process: Impact on Outcomes

The Idea program is great for team building and helps promote change from a grassroots level.

The I-PILLAR program in the ED involves patients and families in ongoing suggestions for improvement.

Priority Process: Organ and Tissue Donation

Organ and tissue donation in conjunction with Trillium Gift of Life is an integral part of the ED and end-of-life process. Staff are trained in the policies and procedures and access the Trillium Gift of Life coordinator as required. This is evident at both sites.

The organization has improved its identification and conversion rates over the last two years.

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

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

The organization has met all criteria for this priority process.

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

At strong infection prevention and control team at RVHS supports the patient care team. There are dedicated infection control practitioners at each site.

The team indicates that education and surveillance has raised and maintained hand-hygiene compliance above 90 percent both prior to and after patient care. Dedicated equipment and furniture have been obtained for isolation rooms. Staff report that daily Chlorhexidine bathing for medical and intensive care unit patients has been implemented. Housekeeping staff indicate that ultraviolet light disinfection is used following room and equipment cleaning.

The infection prevention and control team implemented the use of bright green indicator flags to indicate equipment that has been disinfected. Staff report that a disposable human waste system at the point of care that includes bedpans, urinals, and emesis basins and liners has been implemented. These efforts have resulted in an 86 percent decrease in hospital-acquired antibiotic resistant organisms (MRSA and VRE) across the board. This is shared on various communication boards through the hospital.

The infection prevention and control team reports that the team's visible sign of approval must be in place on or near in-house construction projects before they begin. Support staff report being educated in infection prevention and control aspects of construction, and that dedicated shifts handle clean or dirty items respectively. There is also a separate shift to handle bio-waste.

Hand-hygiene monthly audit results are posted prominently at the nursing station on each unit. Infection prevention and control reports that over 600 hand-hygiene auditors have been trained at both sites. A Hands Up program is evident on the units and on the intranet and includes an annual film festival where staff submit videos on the topic of the year.

Toronto Public Health is an active partner in auditing hand hygiene and assisting with administering the influenza vaccine. However, the vaccine rate continues to be around 40 percent despite determined efforts, mainly due to philosophical objections to the vaccine.

The infection prevention and control team discussed an annual retreat where goals and objectives were formulated and accomplishments celebrated.

The infectious diseases physician responsible for both sites and the assigned pharmacist stated that antibiotic stewardship has been in place at Ajax and Pickering for about four years and at Centenary for about three years. A second infectious diseases physician is actively involved at the Ajax and Pickering site. At each site, pharmacists dedicated to antibiotic stewardship report that all patients receiving antibiotic therapy and anyone for whom laboratory data indicates a need are reviewed. The ongoing review of antibiotic use identifies units using more than usual and action is taken. There is a restricted list of formulary antibiotics, and a program to convert from intravenous to oral antibiotics. A sepsis management order set was formulated by the two site teams. The infectious disease physician described physician champions for antibiotic stewardship.

A unit on the eighth floor of the Centenary site is equipped with negative pressure air systems as part of the pandemic plan described by the infection prevention and control team. It is also used for overflow and emergency bed spacing (such as when a local nursing home experienced a fire).

RVHS contracts out laundering of hospital linen. Clean linen is returned in plastic-wrapped carts delivered to the units. During the on-site survey it was noticed at both sites that clean linen was taken through the hallways without the plastic wrap, which was not part of the process described by infection prevention and control staff. As well, food carts with used patient meal trays had plastic covering that only reached part way down the cart, which was again not part of the process described by infection prevention and control staff.

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

The pharmacy works well with all programs in a comprehensive and complete medication management program. The organization has an expansive formulary, with evidence-based processes and guidelines to introduce new medications. There is an active Pharmacy and Therapeutics Committee and regular reports are given to the Medical Advisory Committee.

The organization manages high-alert medications adequately. Medication preparation, IV solution preparation, and chemotherapy drugs are handled safely. At the Centenary site the mixing and preparation area in pharmacy requires renovation, and planning for this is underway.

There is a robust antimicrobial stewardship program at both sites, with infectious disease specialists and pharmacists working collaboratively.

Medication reconciliation begins in both EDs and progresses to a best possible medication history on inpatient floors.

Unfractionated and low molecular weight heparin products are adequately audited and controlled, and narcotic and opioid products are audited on an ongoing basis. Exceptional policies are in place where needed.

All units have access to Do Not Use Abbreviations and Inclusive Abbreviations.

In reviewing medication reconciliation and best possible medication history data form each unit, there are some months with low activity but overall there is a positive trend.

Medication management at RVHS is a priority and there are robust processes to ensure ongoing monitoring in high-risk areas. The organization does an excellent job in pharmacy and therapeutics initiatives.

Standards Set: Medicine Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.3	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.	
2.5	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
5.2	Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from clients and families where appropriate.	
Priority Process: Competency		
3.12	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
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		
13.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
13.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
13.5	Guidelines and protocols are regularly reviewed, with input from clients and families, to ensure they reflect current research and best practice information.	!
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

Clinical leadership is competent and progressive in advancing the Medicine program at both sites. The Ajax and Pickering site has a hybrid hospitalist and general internal medicine model for inpatient care which works well for the on-site presence of the most responsible physician.

Input from patients and families is sought through the Community Advisory Group and patient representatives on the senior management team. Patient and family surveys as well as follow-up calls after discharge aid in ongoing quality improvement efforts.

At the Ajax and Pickering site the Ideas program is planning to involve patients and family members to suggest ideas for improvement. There is minimal patient and family involvement on deeper issues such as role definition or space co-design. Enhancing patient and family feedback in every aspect of operations is a journey, and RVHS may get there in time.

All medical floors have an appropriate mix of skill level and experience within the team.

Priority Process: Competency

There are processes to ensure team members maintain their credentials. Team members are supported for new continuing medical education opportunities and can be subsidized in certain cases. Team members who deal with cardiac/telemetry patients have added training. A robust NP program is in place to support the medicine program at both sites, and this is well appreciated by patients and team members.

Staff members are aware of the complaints process as well as how to report incidents that involve patient care and/or workplace violence.

Infusion pump training is completed in a timely manner on all units, with an adequate process to evaluate competence.

Nursing and physician orientation occurs with each new hire. Nursing orientation can involve a buddy system in the early stages of employment. The physician groups in medicine will put in place a physician mentor to help a new physician become oriented to the organization

The team seems to function well and in a cooperative and collaborative manner.

Priority Process: Episode of Care

The Medicine programs at both sites are comprehensive programs with multi-specialty support. Both sites have competent and collaborative physician and nursing leadership and innovative team members who ensure optimal patient- and family-centred care.

There are not nearly enough budgeted beds at the Ajax and Pickering site to meet the demands of a very busy ED. Of note, across both sites the admission rate from the ED is one of the lowest in the province, which is one of the reasons patient flow is good throughout the organization on most days. Both sites have an adequate surge process that can be initiated on busier days.

The hospitalist program at the Ajax and Pickering site and the support of pharmacists and nurse practitioners in the Medicine program enhances the quality of care. The Critical Care support team at Ajax and Pickering is a welcome addition to assist general medicine floors in managing patients who may need advanced care.

Falls prevention, medication reconciliation, best possible medication history, venous thromboembolism prophylaxis, and pressure ulcer prevention are key aspects of routine care. Two-step patient identification is present on all units. Interviews with patients and team members as well as chart reviews confirmed these initiatives.

Daily huddles/bullet rounds are an effective way to manage day-to-day issues on each floor. They are attended by nursing as well as pharmacy, physician (in some cases), and other support services.

Patient- and family-centred care has become a more integral part of the program with the involvement of patients and families in the Ideas program, as well as patient surveys and discharge phone calls.

Incident reports and medication errors are managed well through the IRIS incident reporting system and there is a good process to manage patient complaints.

Priority Process: Decision Support

All team members are aware of privacy laws and use precautions in their work. Patient charts are appropriately organized with appropriate record keeping. An electronic records system provides access to current and past medical records with relative ease.

The new Medworx pilot will be a welcome addition for documentation and patient flow solutions. The organization is commended for investing in innovative software solutions.

Priority Process: Impact on Outcomes

The Medicine department takes part in the corporate-wide quality improvement program and also has its own set of quality metrics which are regularly reviewed. There is an incident management and reporting system. When required, quality of care reviews take place in a multidisciplinary forum. Recommendations from the quality of care reviews are shared with team members, the senior management team, and the Medical Advisory Committee. When required the recommendations can also be shared with patients and/or family members.

Patient and family members are involved in various aspects of quality improvement and the Medicine program is committed to this initiative. Robust patient and family involvement is a journey that RVHS has launched and is committed to, but this has not yet permeated all aspects of care and process design, including aspects such as policy, job descriptions, and role descriptions.

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		
13.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
13.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
13.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
13.5	Guidelines and protocols are regularly reviewed, with input from clients and families, to ensure they reflect current research and best practice information.	!
13.6	There is a policy on ethical research practices that outlines when to seek approval, developed with input from clients and families.	!
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

The team is commended for the comprehensive services developed and implemented over the years and provided to patients and families who require mental health care. Working in close proximity with services in the community, they ensure continuous seamless care is provided to children and adults. Patients and families as well as professionals are well aware of these community services, seeking them out and referring to them as required.

In response to an evident need, the team secured funding to put a crisis team in place at the Centenary ED for 24 hours/day and at Ajax and Pickering for 16 hours/day. The team is particularly proud of this accomplishment. The Shoniker clinic treating youth is deemed the gold standard in care and families seek services here for their children.

At the Ajax and Pickering site, patient input has been taken into account regarding renovations for the crisis clinic. A patient family advisor is being added to the team and they are looking forward to the advisor's input about ensuring the services provided address the unique needs of this population.

Priority Process: Competency

Services are provided to patients and families by a highly competent team with expertise and many years of experience in their defined areas, whether it be crisis in the ED, the intensive care beds, the inpatient unit, day hospitals, or the youth and adult clinics.

Managers and clinical practice leaders at both sites ensure that the professionals have the education and training required to meet patient service needs. There are strong and expert multidisciplinary team members in all areas of care along the continuum, such as the highly skilled crisis workers in the EDs at both sites and the unique experience needed by nurses who work in the medicine psychiatric unit at Centenary. Patients admitted with both a medical condition and a mental health diagnosis are well served by this competent team.

Medical coverage is more challenging at the Ajax and Pickering site, and the team is encouraged to pursue its efforts to secure additional resources for this site despite the upcoming reorganization.

Priority Process: Episode of Care

The team provides the full complement of services needed by its clientele, who range from young children and youth to the geriatric population.

Services are readily available in the ED, staffed by well-trained crisis workers, all the way through to well-coordinated services in the community. The particular needs of youth are assured by the inpatient services, day hospital, and clinics at the Centenary site. Families are provided with the necessary support and have easy access to the professionals involved in the care of their children. The team is especially proud of the work done by all members to ensure young adults receive services in as short a time as possible. Communication between services is a high priority for the team, to ensure everyone knows about patients who are waiting to access a particular service and to reduce delays. As a result transfers to day hospital for youth can be arranged seamlessly and quickly, which is beneficial to patients.

The team is commended for the consistent outpatient care provided by the staff in the Clozaril clinic, successful in preventing hospitalization for a number of clinics with positive impact on their level of functioning in the community.

The inpatient units at the Centenary site are implementing medication reconciliation, supported by the work of the clinical practice leader and the pharmacist. All staff are on board.

The team is commended for the comprehensive work done with all partners involved in complex cases. A coordinated complex care plan is developed with input from all professionals and services involved in the care of patients presenting with complex issues. This coordinated approach is viewed as a way to ensure continuity of care no matter where in the continuum the patient seeks services.

Community resources are numerous and come into play all along the continuum of care. Excellent collaboration and collegiality among professionals ensures patients receive the care they require.

The team is commended for its initiative in elaborating the draft of the AWOL protocol in response to a very complex ethical issue faced by staff on the child and adolescent unit. Working closely with the ethicist and all professionals involved in the case, the protocol is in the process of receiving final approval.

The team is also proud of its excellent work on "Mood Walks," done in collaboration with Parks Canada and partnering with local colleges. The group received recognition from the office of Sophie Grégoire Trudeau.

The team is working in partnership with the University of Toronto around resilience in youth.

Kudos to the team!

Priority Process: Decision Support

An accurate and up-to-date record is kept for all patients, in compliance with service requirements.

Working in a collaborative and coordinated manner, relevant patient information is documented in a timely fashion by professionals providing care and is available to all members of the team.

Priority Process: Impact on Outcomes

All staff working in mental health receive Crisis Prevention Institute training to ensure safe interventions for patients and staff.

Falls and suicide prevention assessments are completed and monitored.

Patient complaints are addressed in a timely fashion and changes have been made in response. The team is pleased that a patient and family advisor has been added to the team.

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		
15.2	Policies on the use of electronic communications and technologies are developed and followed, with input from clients and families.	
Priority Process: Impact on Outcomes		
16.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
16.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
16.5	Guidelines and protocols are regularly reviewed, with input from clients and families, to ensure they reflect current research and best practice information.	!
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

Medical leadership determines the direction and the services to be provided to the population served based on current evidence, case reviews, and mortality and morbidity rounds. The medical leadership team subsequently works with clinical operations to ensure staffing is adequate and the required skill mix is in place to address the needs.

Medical leadership is sensitive to the growing communities it serves and recognizes that an insufficient number of general practitioners in the area is resulting in many families not having access to a family doctor and having to turn to walk-in clinics for care.

In response to patient and family comments regarding inadequate signage, the team is commended for introducing door skins as a wayfinding measure at the Ajax and Pickering site.

Priority Process: Competency

The organization ensures all staff have the necessary skills and expertise to deliver safe and quality care, and education and training is provided as required. Online education is available to facilitate access.

The team is commended for the expertise and leadership provided by the clinical practice leaders in ensuring certification and support to the professionals.The unit manager and the clinical practice leader ensure all staff meet the requirements of annual IV infusion pump training and certification for all professionals who must provide IV pump intervention.

PALS (pediatric advanced life support) and BCLS (basic cardiac life support) are required for all staff working in the area.

Staff working in the neonatal intensive care unit are encouraged to pursue certification in neonatal care through George Brown College.

Through the Idea board, staff are encouraged to bring forth concerns and ideas on how to address everyday frustrations that can often be addressed by simple interventions or new ways of doing things.

Priority Process: Episode of Care

During the on-site survey, the neonatal intensive care unit and post-partum unit were visited. In addition, pediatric surgical services were carried out and provided the opportunity to observe service being delivered in a timely fashion by competent staff.

The excellent and innovative initiatives that have been put in place by staff are impressive. The team is commended for initiating newborn screening for critical congenital heart disease. This will be rolled out to the entire province in the future. As part of the commitment to ensuring the birthing experience is a positive one, a patient family advisor has recently joined the neonatal intensive care team, and has suggested that parents be present for the report when patients are transitioned between the tertiary care facility and the service.

Attention is paid to C-section and induction rates so as to remain within or below the national rates, and comparable to sites with similar patient populations.

To ensure patient safety at all times, falls assessments are done on all adult patients as well as the pediatric population via the Humpty Dumpty scale.

Communication boards are present in all patient rooms and families are encouraged to use them to make comments and additions. Ensuring that patients understand the information communicated is stressed.

There is patient follow up within 24 to 48 hours of discharge, to ensure discharge plans and instructions given at the time of discharge were well understood. Post-natal newborn follow up or follow up for a child post-discharge by a family doctor is encouraged; however, due to the shortage of family doctors in the community, access is not always possible. Some families obtain follow up through walk-in clinics which is not ideal. The team is well aware of this reality and will bring pediatric patients back to the unit for follow-up visits within a few days post-discharge, to ensure safety.

Priority Process: Decision Support

The organization has made a strong investment in clinical applications for the neonatal intensive care unit, to assist with clinical documentation and order management.

Patient information in other areas of the program is entered in a timely fashion and is readily available to the team.

Priority Process: Impact on Outcomes

The team is committed to the quality improvement and performance initiatives it has identified. As a result of less than optimal results for the CritiCall indicator, staff reflected on the reasons and implemented a simple reminder bell to ensure data were entered four times daily, as required, and within the expected time frame. Since this measure was put in place, this performance indicator now meets the target. The team is proud that it will be presenting the results at an upcoming conference.

Hand-hygiene auditors have recently been trained to audit practice at four moments where hand hygiene should occur. Peer auditing has proven to be motivational for all to comply with hand-hygiene requirements.

Results of the quality performance initiatives are easily accessible to patients and families so they can discuss them with staff if they wish.

Standards Set: Organ and Tissue Donation Standards for Deceased Donors - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.4	Policies for both organ and tissue donation are developed with input from clients and families.	
1.5	A policy on donation after cardio-circulatory death (DCD) is developed with input from clients and families.	
3.10	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
7.4	Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from clients and families where appropriate.	
Priority Process: Competency		
5.16	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
15.5	Records are retained for a minimum of 30 years after the donation. CSA Reference: Z900.1-03, 7.3.3.	!
16.2	Policies on the use of electronic communications and technologies are developed and followed, with input from clients and families.	
Priority Process: Impact on Outcomes		
17.3	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
17.4	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
17.5	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!

17.6	Guidelines and protocols are regularly reviewed, with input from clients and families, to ensure they reflect current research and best practice information.	!
18.3	Verification processes are used to mitigate high-risk activities, with input from clients and families.	!

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

Organ and tissue donation at the Ajax and Pickering site was reviewed.

There is excellent leadership from the hospital and Trillium Gift of Life Network to ensure families are asked about organ donation and to achieve an optimal donor conversion rate. The teams in the ED and the intensive care unit as well as other parts of the organization have been trained and are continually retrained and reminded about the benefits of organ donation.

Input from families is used for ongoing improvement.

The organization is commended for its ongoing work in organ donation and its collaboration with the Trillium Gift of Life Network.

Priority Process: Competency

The organ donation program is supervised and led by competent and collaborative leaders who show passion for their work and outcomes. The organization ensures ongoing training and mentorship is provided for team members.

The organization monitors and manages credentials of the recovery teams and its own team members with diligence.

Priority Process: Episode of Care

A complete history and physical is documented on all donors with appropriate laboratory investigation.

Priority Process: Decision Support

Chart reviews show adequate and up-to-date record keeping. Appropriate information is shared with the provincial registries and the families of donors and recipients.

Records are retained and maintained at the organization, as per the Canada Health Act, for a minimum of 10 years.

Priority Process: Impact on Outcomes

The program has standard operating procedures for various processes and procedures.

There is significant input from families on quality improvement and new ideas. The organization is on a fulsome journey to client- and family-centred care but has not yet reached the point of involving families in advanced policy development.

Quality metrics and targets are set and reviewed on an ongoing basis, with input from the organization and the provincial partner (Trillium Gift of Life).

The organization is commended for its commitment to this program.

Priority Process: Organ and Tissue Donation

This program is a well-managed and impressive program. There is a significant commitment from program leaders and team members in equal measure. Critical care, surgical, and emergency teams play a pivotal role with a significant contribution from nursing, ethics, and the Trillium Gift of Life Network.

This is a very client- and family-centred program and significant accommodations are made for individual and family preferences in often difficult times. There have been many examples of nurses, physicians, organ donation coordinators, and other team members stepping up and coming to the hospital to contribute to optimal outcomes.

All team members are congratulated for their commitment to this program.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.1	Services are co-designed with clients and families, partners, and the community.	!
8.2	Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from clients and families where appropriate.	
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		
10.17	A process to investigate and respond to claims that clients' rights have been violated is developed and implemented with input from clients and families.	!
Priority Process: Decision Support		
21.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
Priority Process: Impact on Outcomes		
23.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
23.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
23.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
23.5	Guidelines and protocols are regularly reviewed, with input from clients and families, to ensure they reflect current research and best practice information.	!
23.6	There is a policy on ethical research practices that outlines when to seek approval, developed with input from clients and families.	!

24.1	A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families.	!
24.2	Strategies are developed and implemented to address identified safety risks, with input from clients and families.	!
25.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Priority Process: Medication Management

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Service planning is described by staff at both sites as a collaborative effort among the service team. Staff outlined a defined process to obtain approvals and resources for new programs and services.

At the Centenary site, there is a lack of privacy for patients to share details when final checks are made by the day surgery staff before walking patients to the operating room.

Service planning at RVHS is described by the perioperative team as using feedback and input from patients, but there is no clear or continuous role for patients and families in this process.

While RVHS is on a clear patient- and family-centred journey, these groups have not been involved in a concrete sense in work and job design, roles and responsibilities, or assignments.

Patient advisors are present or planned for a number of committees.

Priority Process: Competency

Education and credentialing are well documented at both sites.

Leaders report that patient input and feedback are welcome; however, there is no process for their input into required credentials, training, and education for all team members.

Leaders and staff at Rouge Valley Ajax and Pickering report a growing scarcity of surgical assistants despite implementing the registered nurse first assistant role. Augmenting the registered nurse first assistant complement could help with that shortage.

Malignant hyperthermia carts were seen at both sites in the perioperative suites, and the response to emergencies in that area is clearly described by staff and outlined in policies and procedures.

Priority Process: Episode of Care

Pre-operative education and assessment as well as pre- and post-operative rehabilitation for joint replacement occur at both sites. Operating room standards as far as discharge criteria were clearly evident on both sites.

A unique communication tool is used between the operating room, the post-anaesthetic care unit, and the inpatient surgical unit, where information is accumulated on the same form and used at each point of transfer of accountability.

The perioperative suites at both sites use an electronic record which is accessible through the various parts of the area.

A process to investigate and respond to claims that patients' rights have been violated is in place at the Centenary site; however, leaders report that the development and implementation of such processes is not always done with structured input from patients and families.

There is an electronic patient tracking system where all departments and family members waiting for a patient to move through the perioperative suite can see where the patient is on the journey. To protect privacy, waiting room screens display only a unique number which is given to the family member.

Surgical safety checklists are used at both sites; however, these are usually led by nursing or anaesthesia.

Priority Process: Decision Support

Patients have informal input into the process to monitor and evaluate record-keeping practices, but there is no defined role for them in this area.

Priority Process: Impact on Outcomes

RVHS demonstrates a robust evidence-informed approach to establishing clinical guidelines and practices, such as the Choosing Wisely Canada standards for least necessary pre-operative testing.

Goals and objectives are defined by the team members, who described successful outcomes of quality improvement initiatives such as the development of a shoulder clinic at the Ajax and Pickering site, and progress toward a sports medicine specialty service at the Centenary site.

There is a comprehensive clinic where diagnostics and interventions can be expedited for thyroid and prostate consults at the Centenary site. Joint replacement at Centenary is approached through a collaborative surgical clinic where orthopedic surgeons see patients for speedy surgical decisions.

RVHS has made great progress in patient- and family-centred care by including patients and families on several committees (senior management team, Community Advisory Groups) and on three clinical unit

committees. However, there is no evidence of a formal process to include patients and families in selecting evidence-informed guidelines; deciding among conflicting evidence-informed guidelines; reviewing protocols and procedures to reduce unnecessary variation in service delivery; developing a proactive and predictive approach to identify safety risks and implement strategies to address safety risks; or evaluating quality improvement initiatives for feasibility, relevance, and usefulness. Formalizing their input is one way to advance the community-based philosophy of RVHS at both sites.

Priority Process: Medication Management

The organization provides comprehensive and safe medication management in the perioperative areas at both sites.

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

Point-of-care testing is available at both sites, including i-STAT testing for critical areas to enhance emergency care.

Standards Set: Rehabilitation Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.3	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.	
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.	
2.5	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
Priority Process: Competency		
3.1	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		
11.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
Priority Process: Impact on Outcomes		
13.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
13.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
13.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
13.5	Guidelines and protocols are regularly reviewed, with input from clients and families, to ensure they reflect current research and best practice information.	!
13.6	There is a policy on ethical research practices that outlines when to seek approval, developed with input from clients and families.	!
Surveyor comments on the priority process(es)		

Priority Process: Clinical Leadership

Recently, the team implemented significant changes in bed mapping as a result of an extensive evaluation of the existing service delivery model, where acute care and active rehabilitation co-existed on the same units. The resulting exercise involved cohorting all restorative rehabilitation patients on the same units at both the Centenary and the Ajax and Pickering sites, and placing all acute stroke patients on the same unit at the Centenary site. This required an adjustment to staffing levels in some areas and the movement of staff to the units of their choice, following the patient populations they were caring for.

The organization is commended for following through on the recommendations from this exercise, which demonstrated that the expected results of the original delivery model were not achieved

Priority Process: Competency

Care at both sites is delivered by a complement of qualified professionals committed to providing safe and quality care to patients and families.

The presence of the discipline leaders responsible for ensuring all staff have the necessary education and training to care for the patients admitted on the units. The movement of staff as a result of changes in bed mapping has led to increased needs to support the staff in caring for new patient populations on the units.

Priority Process: Episode of Care

At the Centenary site, as a result of the bed-mapping exercise, acute stroke care patients and stroke rehabilitation patients are now on two separate units. Restorative care and complex continuing care are provided at both sites.

The team is commended for its excellent work on the falls prevention policy and tools implemented throughout the organization, the senior-friendly approach, and delirium. Order sets have been developed to manage delirium. Staff are trained in gentle persuasive approach with the goal of reducing the use of restraints.

The initiative called Move to Improve arose from family feedback. Posters and education material related to falls has gone through the Community Advisory Group.

On some units, implementing the 4P approach over the past two years has had positive results in patient outcomes, with decreases in the number of falls and pressure ulcers and a quieter environment.

Priority Process: Decision Support

Working collaboratively with patients and families, patient information is collected and documented in a timely fashion, providing all health care professionals with the information required to provide care.

Under the leadership of one of the unit managers who designed and pilot tested the communication boards, all units are now equipped with electronic communication boards that are used in daily bullet rounds.

Priority Process: Impact on Outcomes

Monitoring quality improvement initiatives, such as the number of falls and hand-hygiene audits, is done on all units in the rehabilitation service.

Measures implemented to decrease falls include purchasing lower beds, with bed alarms that sound when a patient is attempting to get out of bed. Results are posted and made available to patients and families.

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
Transfusion services are available at both 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 (2016)

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

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

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

- **Data collection period: January 25, 2016 to March 15, 2016**
- **Number of responses: 18**

Governance Functioning Tool Results

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1. We regularly review and ensure compliance with applicable laws, legislation, and regulations.	6	0	94	N/A
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	0	0	100	N/A
3. Subcommittees need better defined roles and responsibilities.	78	6	17	N/A
4. As a governing body, we do not become directly involved in management issues.	11	6	83	N/A
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	N/A

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
6. Our meetings are held frequently enough to make sure we are able to make timely decisions.	6	0	94	N/A
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	0	100	N/A
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	0	0	100	N/A
9. Our governance processes need to better ensure that everyone participates in decision making.	72	11	17	N/A
10. The composition of our governing body contributes to strong governance and leadership performance.	6	6	88	N/A
11. Individual members ask for and listen to one another's ideas and input.	12	0	88	N/A
12. Our ongoing education and professional development is encouraged.	6	0	94	N/A
13. Working relationships among individual members are positive.	12	0	88	N/A
14. We have a process to set bylaws and corporate policies.	0	0	100	N/A
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	N/A
16. We benchmark our performance against other similar organizations and/or national standards.	0	0	100	N/A
17. Contributions of individual members are reviewed regularly.	0	0	100	N/A
18. As a team, we regularly review how we function together and how our governance processes could be improved.	6	6	89	N/A
19. There is a process for improving individual effectiveness when non-performance is an issue.	12	6	82	N/A
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	6	6	89	N/A

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
21. As individual members, we need better feedback about our contribution to the governing body.	72	11	17	N/A
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	6	0	94	N/A
23. As a governing body, we oversee the development of the organization's strategic plan.	0	6	94	N/A
24. As a governing body, we hear stories about clients who experienced harm during care.	0	0	100	N/A
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	6	0	94	N/A
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	11	0	89	N/A
27. We lack explicit criteria to recruit and select new members.	83	0	17	N/A
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	6	0	94	N/A
29. The composition of our governing body allows us to meet stakeholder and community needs.	6	0	94	N/A
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	N/A
31. We review our own structure, including size and subcommittee structure.	6	0	94	N/A
32. We have a process to elect or appoint our chair.	0	6	94	N/A

Overall, what is your assessment of the governing body's impact over the past 12 months, in terms of driving improvements to:	% Poor / Fair	% Good	% Very Good / Excellent	%Agree * Canadian Average
	Organization	Organization	Organization	
33. Patient safety	17	11	72	N/A
34. Quality of care	17	11	72	N/A

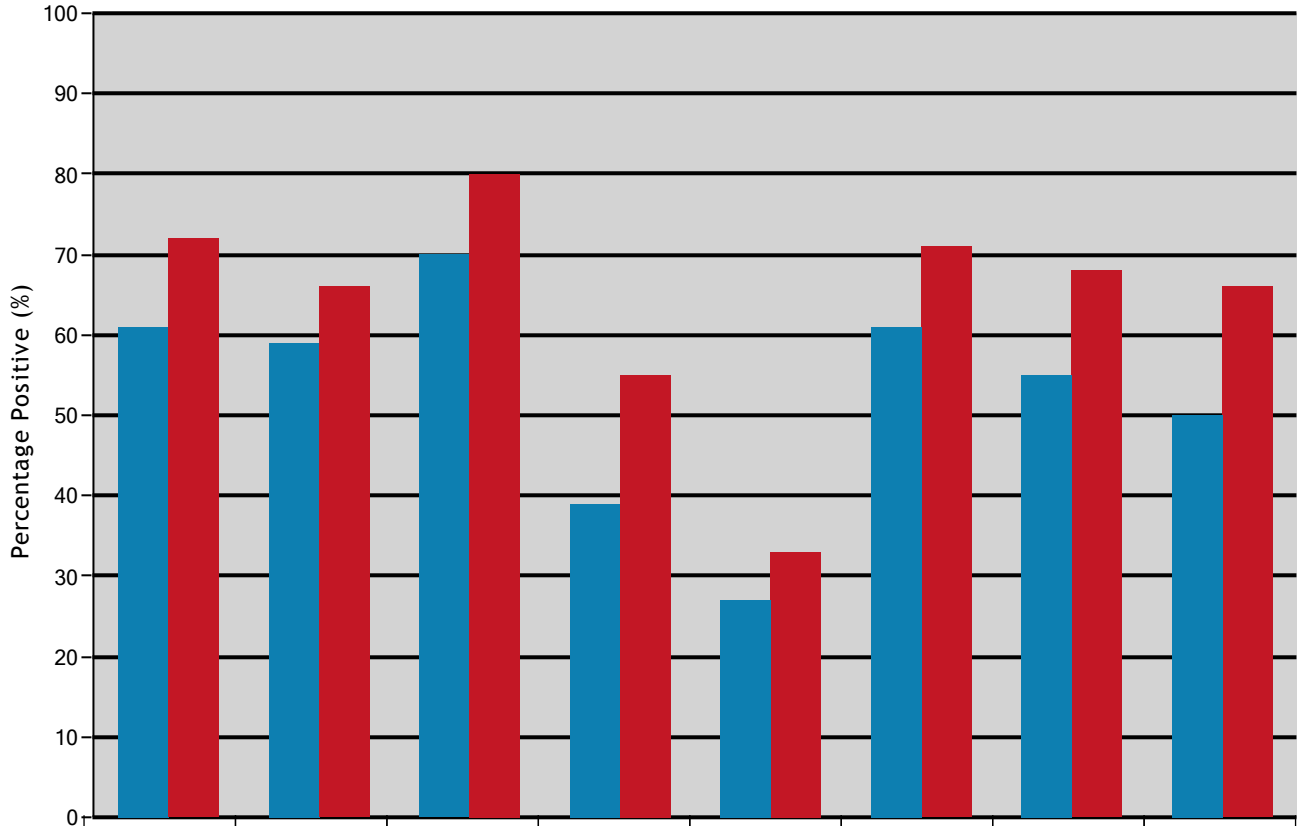
Canadian Patient Safety Culture Survey Tool

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: June 1, 2015 to June 26, 2015**
- **Minimum responses rate (based on the number of eligible employees): 323**
- **Number of responses: 679**

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
	61%	59%	70%	39%	27%	61%	55%	50%
	72%	66%	80%	55%	33%	71%	68%	66%

Legend

Rouge Valley Health System

* 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

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