ACCREDITATION AGRÉMENT CANADA
Qmentum

Accreditation Report

Scarborough Health Network

Scarborough, ON

On-site survey dates: November 13, 2022 - November 18, 2022

Report issued: December 19, 2022

About the Accreditation Report

Scarborough Health Network (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. As part of this ongoing process of quality improvement, an on-site survey was conducted in November 2022. 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 will be treated in confidence by Accreditation Canada in accordance with the terms and conditions as agreed between your organization and Accreditation Canada for the Assessment Program.

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

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

A Message from Accreditation Canada

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

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

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

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

We look forward to our continued partnership.

Sincerely,

Leslee Thompson
Chief Executive Officer

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Executive Summary

Scarborough Health Network (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

Scarborough Health Network's accreditation decision is:

Accredited with Exemplary Standing

The organization has attained the highest level of performance, achieving excellence in meeting the requirements of the accreditation program.

About the On-site Survey

- **On-site survey dates: November 13, 2022 to November 18, 2022**

- **Locations**

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

  1. Scarborough Health Network: Birchmount hospital
  2. Scarborough Health Network: Centenary hospital
  3. Scarborough Health Network: General hospital

- **Standards**

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

  System-Wide Standards

  1. Governance
  2. Infection Prevention and Control Standards
  3. Leadership

  Service Excellence Standards

  4. Ambulatory Care Services - Service Excellence Standards
  5. Biomedical Laboratory Services - Service Excellence Standards
  6. Critical Care Services - Service Excellence Standards
  7. Diagnostic Imaging Services - Service Excellence Standards
  8. Emergency Department - Service Excellence Standards
  9. Inpatient Services - Service Excellence Standards
  10. Medication Management (For Surveys in 2021) - Service Excellence Standards
  11. Mental Health Services - Service Excellence Standards
  12. Obstetrics Services - Service Excellence Standards
  13. Perioperative Services and Invasive Procedures - Service Excellence Standards
  14. Point-of-Care Testing - Service Excellence Standards
  15. Rehabilitation Services - Service Excellence Standards
  16. Reprocessing of Reusable Medical Devices - Service Excellence Standards
  17. Transfusion Services - Service Excellence Standards

- **Instruments**

  The organization administered:

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

Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
 Population Focus (Work with my community to anticipate and meet our needs)	50	0	0	50
 Accessibility (Give me timely and equitable services)	92	0	0	92
 Safety (Keep me safe)	644	2	6	652
 Worklife (Take care of those who take care of me)	132	1	0	133
 Client-centred Services (Partner with me and my family in our care)	370	2	0	372
 Continuity (Coordinate my care across the continuum)	73	0	0	73
 Appropriateness (Do the right thing to achieve the best results)	1024	4	4	1032
 Efficiency (Make the best use of resources)	59	0	1	60
Total	**2444**	**9**	**11**	**2464**

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	35 (97.2%)	1 (2.8%)	0	85 (98.8%)	1 (1.2%)	0
Leadership	50 (100.0%)	0 (0.0%)	0	95 (99.0%)	1 (1.0%)	0	145 (99.3%)	1 (0.7%)	0
Infection Prevention and Control Standards	39 (97.5%)	1 (2.5%)	0	29 (100.0%)	0 (0.0%)	2	68 (98.6%)	1 (1.4%)	2
Medication Management (For Surveys in 2021)	100 (100.0%)	0 (0.0%)	0	50 (100.0%)	0 (0.0%)	0	150 (100.0%)	0 (0.0%)	0
Ambulatory Care Services	45 (100.0%)	0 (0.0%)	2	77 (100.0%)	0 (0.0%)	1	122 (100.0%)	0 (0.0%)	3
Biomedical Laboratory Services **	72 (100.0%)	0 (0.0%)	0	105 (100.0%)	0 (0.0%)	0	177 (100.0%)	0 (0.0%)	0
Critical Care Services	60 (100.0%)	0 (0.0%)	0	103 (98.1%)	2 (1.9%)	0	163 (98.8%)	2 (1.2%)	0
Diagnostic Imaging Services	68 (100.0%)	0 (0.0%)	0	69 (100.0%)	0 (0.0%)	0	137 (100.0%)	0 (0.0%)	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
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Emergency Department	72 (100.0%)	0 (0.0%)	0	104 (97.2%)	3 (2.8%)	0	176 (98.3%)	3 (1.7%)	0
Inpatient Services	60 (100.0%)	0 (0.0%)	0	85 (100.0%)	0 (0.0%)	0	145 (100.0%)	0 (0.0%)	0
Mental Health Services	50 (100.0%)	0 (0.0%)	0	92 (100.0%)	0 (0.0%)	0	142 (100.0%)	0 (0.0%)	0
Obstetrics Services	71 (100.0%)	0 (0.0%)	2	88 (100.0%)	0 (0.0%)	0	159 (100.0%)	0 (0.0%)	2
Perioperative Services and Invasive Procedures	115 (100.0%)	0 (0.0%)	0	109 (100.0%)	0 (0.0%)	0	224 (100.0%)	0 (0.0%)	0
Point-of-Care Testing **	38 (100.0%)	0 (0.0%)	0	46 (100.0%)	0 (0.0%)	2	84 (100.0%)	0 (0.0%)	2
Rehabilitation Services	45 (100.0%)	0 (0.0%)	0	80 (100.0%)	0 (0.0%)	0	125 (100.0%)	0 (0.0%)	0
Reprocessing of Reusable Medical Devices	85 (98.8%)	1 (1.2%)	2	40 (100.0%)	0 (0.0%)	0	125 (99.2%)	1 (0.8%)	2
Transfusion Services **	76 (100.0%)	0 (0.0%)	0	69 (100.0%)	0 (0.0%)	0	145 (100.0%)	0 (0.0%)	0
Total	**1096 (99.8%)**	2 (0.2%)	6	1276 (99.5%)	7 (0.5%)	5	2372 (99.6%)	9 (0.4%)	11

* Does not includes ROP (Required Organizational Practices)
** Some criteria within the standard sets were pre-rated based on your organization's accreditation through the Quality Management Program – Laboratory Services (QMP-LS) program managed by Accreditation Canada Diagnostics

Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

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

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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information transfer at care transitions (Perioperative Services and Invasive Procedures)	Met	4 of 4	1 of 1
Information transfer at care transitions (Rehabilitation Services)	Met	4 of 4	1 of 1
Medication reconciliation as a strategic priority (Leadership)	Met	3 of 3	2 of 2
Medication reconciliation at care transitions (Ambulatory Care Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Critical Care Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Emergency Department)	Met	1 of 1	0 of 0
Medication reconciliation at care transitions (Inpatient Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Mental Health Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures)	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 (Rehabilitation Services)	Met	4 of 4	0 of 0
Safe Surgery Checklist (Obstetrics Services)	Met	3 of 3	2 of 2
Safe Surgery Checklist (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
The “Do Not Use” list of abbreviations (Medication Management (For Surveys in 2021))	Met	4 of 4	3 of 3
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management (For Surveys in 2021))	Met	4 of 4	1 of 1
Concentrated Electrolytes (Medication Management (For Surveys in 2021))	Met	3 of 3	0 of 0
Heparin Safety (Medication Management (For Surveys in 2021))	Met	4 of 4	0 of 0
High-Alert Medications (Medication Management (For Surveys in 2021))	Met	5 of 5	3 of 3
Infusion Pumps Training (Ambulatory Care Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Critical Care Services)	Met	4 of 4	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Infusion Pumps Training (Emergency Department)	Met	4 of 4	2 of 2
Infusion Pumps Training (Inpatient Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Mental Health Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Obstetrics Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Perioperative Services and Invasive Procedures)	Met	4 of 4	2 of 2
Infusion Pumps Training (Rehabilitation Services)	Met	4 of 4	2 of 2
Narcotics Safety (Medication Management (For Surveys in 2021))	Met	3 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Client Flow (Leadership)	Met	7 of 7	1 of 1
Patient safety plan (Leadership)	Met	2 of 2	2 of 2
Patient safety: education and training (Leadership)	Met	1 of 1	0 of 0
Preventive Maintenance Program (Leadership)	Met	3 of 3	1 of 1
Workplace Violence Prevention (Leadership)	Met	5 of 5	3 of 3

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
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 Strategy (Critical Care Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Inpatient Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Mental Health Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Obstetrics Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Perioperative Services and Invasive Procedures)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Rehabilitation Services)	Met	2 of 2	1 of 1
Pressure Ulcer Prevention (Critical Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Inpatient Services)	Met	3 of 3	2 of 2

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

Summary of Surveyor Team Observations

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

--- VIRTUAL---

To follow

--- ON-SITE ---

The Scarborough Health Network (SHN) team is commended on its commitment to quality improvement and patient safety through its active participation in the accreditation program. The on-site accreditation survey has demonstrated that SHN is extremely valued by its patients, families, and volunteers, and by its broad array of health service providers and partners. At SHN leaders, staff and physician are committed, engaged, and caring and provide exceptional care and services to its communities. With the introduction of Ontario Health Teams, SHN has engaged in high levels of integration and cooperation.

SHN serves one of Canada's most diverse and multicultural communities in Canada and provides care to a catchment area of over 850,000 people across Scarborough and beyond. It is Ontario's third largest community health network with three hospitals and several community-based satellite sites which include the Birchmount, the Centenary and the General sites.

In June of 2018 a strategic plan was launched. At that time, the vision, mission, and values were reviewed and refreshed, and input into the strategic plan and the hospital rebranding process were provided by staff, leaders, physicians, patients, families, and the community. The Board is familiar with its role and responsibilities as a governing body and is aware that oversight for patient safety, risk management and quality improvement are fundamental roles of governance. The Board takes ownership for board accountability, strategic planning, and fiscal oversight. The current Strategic Plan guides the organization with its mission - improving lives through exceptional care, its vision - Canada's leading community teaching health network-transforming your health experience, and its values - in all our interactions, we will be Compassionate-Inclusive-Courageous-Innovative.

The leadership team is committed to providing leadership support across all three sites. The pandemic's heavy impact on SHN resulted in the management of some of the highest volumes of COVID-19 patient cases in Ontario. Throughout the pandemic SHN continued to deliver exceptional care for patients and families and made every effort to keep a safe workplace environment for SHN teams.

SHN has a solid recruitment process and is considered an attractive employer. Employee satisfaction is carefully monitored, and the VIP chats promote fruitful exchanges between staff and leaders in an atmosphere that promotes collaboration and learning. A wellness program supports the quality of work life and promotes healthy environments for physician, staff, and leaders. SHN has created a robust human

resource plan that outlines seven guiding principles and employee satisfaction surveys are inspired by them. The organization is engaging members of the Patient Family Advisory Council (PFAC), and staff in survey results action planning.

SHN has made deliberate decisions to put a focus on quality and safety across the organization. From a patient safety perspective SHN has rigorous and appropriate safety reporting policies in place and appropriate follow-up mechanisms of near misses and occurrences. Trends are identified and influence quality improvement projects. The SHN C.A.R.E.S. quality boards are visible throughout the network and are revised daily and weekly with front line staff, physicians, and leaders. Bright ideas are highlighted, quality indicators and metrics are revised to track progress towards outcomes/goals, and leading practices are implemented to close the gap between currant and desired performances.

Patients and families spoke highly about the care they receive and SHN makes continued efforts to include their voice in a variety of ways. Patient satisfaction surveys are regularly reviewed, and patients can complete surveys with the assistance of QR codes that are posted in clinical areas and in hard copy formats. Patients can also access the SHN website and provide feedback on their care.

SHN has a well-developed patient and family advisory program that includes both corporate and department level Patient Family Advisory Councils (PFAC). The organization is encouraged to continue to recruit Patient Family Advisors (PFA) that are reflective of the diversity of Scarborough's community and to develop additional program level PFAs.

SHN has much to be proud of. The commitment, teamwork and dedication of the entire staff and community will serve as a valuable support as it continues its journey towards becoming one connected network.

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)

--- VIRTUAL---

The virtual survey interview with the Board of Directors (Board) included the Board Chair, and chairs of all key Board subcommittees – Governance; Quality; Finance, Audit, Infrastructure and Tech; and Joint Professional Staff Oversite. Ex-officio staff members, including the president, chief of staff and VPs also attended the discussion however all responses were through the voting directors.

There was clearly a strong appreciation for the role of the board in strategic oversite, with necessary governance direction provided across all key areas. The 2017 merger was noted, with the Board commended for the way this occurred. These types of key, very visible, structural changes in healthcare require strong leadership, vision and resilience, all characteristics exhibited.

With the merged organization came an opportunity to re-brand, by revisiting values, vision and mission. The Board ensured a very strong process that engaged all key partners, internally and externally to the organization resulting in a strategic plan and direction that was well understood and supported.

The overall structure and operational integrity of the Board were sound, including a clear process to identify the skills necessary when recruiting. Onboarding practices were solid, with Board members feeling well supported. As with all boards, ensuring that evaluation processes remain dynamic – individual member, chair, and full Board reviews, is important. There appeared to be a good appreciation of the tools available, with members encouraged to participate in the ongoing Ontario Hospital Association survey on governance needs and expectations. The Board addressed its accountability with president/CEO evaluation/oversite and recognized that with the chief of staff role in transition they would be required to focus on their accountabilities with chief of staff recruitment and oversite in the coming months.

Community partners engaged in the survey process were impressed with the transparency of the organization, the tone of which is set through the Board. All were impressed with how visible Board

members were, and appreciated the leadership provided to the Ontario Health Team (OHT). On this note, the Board was commended for the approach it took in engaging with and supporting the OHT. Despite being the largest partner, SHN was at the table as an equal thereby facilitating the development of the trust necessary to ensure strong relationships between and across the partners.

An area the Board is encouraged to consider moving forward is the inclusion of a patient partner/advisor as an ex officio member of the Board as well as the Medical Advisory Committee.

--- ON-SITE ---

Assessed Oct 2021 Virtual

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)

--- VIRTUAL---

Following a forced merger of three hospitals (Birchmount, Centennial and Scarborough General) in 2016 a newly branded hospital was renamed the Scarborough Hospital Network (SHN) and in June of 2018 a strategic plan was launched. At that time, the vision, mission, and values were also created. Input into the strategic plan and the hospital rebranding processes was provided by staff, leaders, doctors, patients, families, and community partners.

SHN is an 831-bed organisation and is the third largest community hospital in Ontario. It provides on an annual basis care and services to more than 41,000 inpatients and more than 600,000 outpatient clinic visits, including approximately 186 emergency department visits and more than 5900 births. In addition, SHN is one of 34 Ontario Health Teams and is committed to putting patients and families in the center of care.

SHN is in the process of exploring options to replace their aging facilities. The hospital received a 2.5 million dollars grant to support hospital redevelopment proposals. Three options were recommended including the renovation of one of two sites or the redevelopment of a brand-new site. All proposals were ranked according to cost effectiveness and to their speed of completion and as a result, the renovation of the Birchmount site was identified. This redevelopment project will provide state of the art patient care that is accessible and efficient. Emphasis will also be placed on mental health and addiction needs in Scarborough – particularly for youth – as well as the orthopedic (bone) surgery and cancer care needs. The organization is commended for the work that has been completed in engaging PFAC (patient family advisory council) on matters pertaining to planning new programs.

SHN has experienced significant changes over the past several months. The organization is partnering with Central Eastern Ontario in implementing the Epic clinical information system which is planned to go live on December third of this year. SHN has also become a COVID-19 pandemic assessment center as well as a designated inpatient unit for COVID-19 and continues to relentlessly offer ongoing clinical and leadership support to long term care homes and other external communities. This speaks to the hospital's values of inclusive and compassion that are embraced. SHN created a first VaxFacts clinic to assist with vaccine administration. Results indicate that an increase of 80 percent of double doses occurred since the creation of the clinic.

SHN has used the ADKOR (awareness, desire, knowledge, ability, reinforcement) business change

management model to prepare staff for change however since the onset of the COVID-19 pandemic the approaches have been more day-to-day fixes and in crisis mode. Once the organization regains some stability it is recommended to have a common and formal approach for change management.

COVID-19 has pushed SHN to offer care into a virtual landscape thus helping patients to receive treatments in their home. The organization is encouraged to monitor the impact of these initiatives on coast effectiveness, patient safety, quality, and patient experience.

--- ON-SITE ---

Assessed Oct 2021 Virtual

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)

--- VIRTUAL---

SHN has well defined processes to develop and monitor operating and capital budgets. The development of the operating budget begins at the department level with the previous two years' budget allocation as the starting point. Managers are required to complete monthly variance reports and financial analysts assist them upon request. A comprehensive report on activity levels and performance metrics including personal protective equipment (PPE), sick leaves, overtime, orientation hours, ER visits, and other relevant information related to service volume are closely monitored. The data are benchmarked against similar facilities and the organization has mechanisms in place to identify areas of risk and pressure.

Annual operating and capital budgets are reviewed by a multi-disciplinary committee, and then they are rolled up to the operating committee, the senior leadership committee and the final approval is by the Board of Directors.

In terms of planning services and allocating resources effectively, SHN conducts regular marker share exercises to help guide decisions. For example, considering the onset of COVID-19 pandemic, a decision was made to continue the development of the integrated stroke unit however, the decision to renovate the ICU was postponed.

Examples of cost saving strategies include: to decrease patients' length of stay by 25 percent, to continue to provide care and services on a virtual basis, to continue to perform pulmonary function testing at one site instead of two, and to reduce unnecessary testing.

Since the onset of the COVID-19 pandemic, SHN has generously supported COVID-19 assessment centers and long-term care homes with PPE supplies and support from infection prevention and control practitioners, community vaccines services and school programs. SHN is commended for its continuous desire to reach out and to offer support internally and externally

--- ON-SITE ---

Assessed Oct 2021 Virtual

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)

--- VIRTUAL---

The Human Resource (HR) department has developed a wellness program to support the quality of work life and to promote healthy work environments for staff, physicians, and leaders who provide the care. SHN received the runner up wellness award in 2018. Good job!

A wellness coordinator and social workers are instrumental in ensuring that the program meets staffs' physical, psychological and social needs. Since the onset of the COVID-19 pandemic and considering the restrictions associated with close personal contacts, some wellness programs were temporarily interrupted and others, such as having access to in person wellness resources, were increased.

SHN has developed seven guiding principles that are outlined in the HR plan, which are:
- Value driven
- Patient centered
- Co-ownership with collaboration
- Inclusive
- Engagement
- Innovative
- Sustained

Employee surveys are developed based on these guiding principles and results are analysed and benchmarked against similar organizations. SHN is encouraged to articulate the survey results and to engage members of PFAC and the staff in action planning.

The corporate workplace violence prevention policy is regularly updated and revised. Training to understand the policy and to carry it out appropriately includes crisis prevention intervention learning modules and courses on how to be gentle and persuasive especially when working with patients with cognitive impairments and with mental health challenges.

Staff recruitment is an ongoing concern for the leaders at SHN. There are robust processes in place for the recruitment and selection of staff and emphasis is placed on recruiting staff whose talents reflect the organization’s values. Members from the PFAC are invited to assist with hiring specific groups of professionals. Between January 2021 and September 2021, 2800 new employees were hired of which 1300 were nurses.

Retention strategies include VIP chats with staff, spiritual care team support for staff by registered psychotherapists, timely access to EFAP (employee and family assistance program), exclusive exchanges with the organization's CEO, the implementation of a LEADS (leading, engaging, achieving results, developing, system transformation) capability framework, the health and equity certification program and numerous accesses to onboarding and learning opportunities.

In person or online exit interviews are conducted when a staff member leaves the organization and leaders can easily access information on such data as turnover rates, voluntary and involuntary exits, that are posted on the SHN's integrated metrics system.

SHN is commended for its human resource team who are on the edge and who continuously seek learning and development opportunities and ways to offer ongoing support to employees, volunteers, patients and families.

Depending on our findings during the onsite survey and from what we have assessed thus far this organization may consider applying to become a leading practice organization for their HR model of excellence.

--- ON-SITE ---

Virtually assessed in October 2021.

Comments from onsite survey November 2022.

SHN has been successful in recruiting and retaining qualified staff members, physicians, and leaders. A robust wellness program is offered to and appreciated by physicians as well as staff members. Although the fall accreditation survey conducted in 2021 addressed most of the criteria associated to human resources, a few areas required completion during the on-site survey namely, human resource records are well maintained and appropriately stored. SHN is encouraged to continue its efforts in transferring hard copies of employee charts to an electronic format.

In addition, initiatives such as B.U.I.L.D (Black United for Inclusion and Leadership Development), Pride, and other communities of inclusion, are opportunities that were created to hear the voices (including wishes and concerns) of employees from diverse backgrounds and to offer to them a platform to be heard meaningfully and supportively. These are additional examples of ways that the value of being inclusive is embedded at SHN.

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)

--- VIRTUAL---

A very dynamic team engaged in the virtual survey process to share SHN's vision and commitment to quality, safety and risk mitigation.

As the leadership priority process with the highest number of required organizational practices, significant time was spent reviewing the patient safety plan, incident management system, disclosure and reporting structures and medication reconciliation. SHN was felt to meet and exceed all tests for compliance however acknowledged the need to continue focusing on closing the loop with incident reporting. Specifically, the organization was making a significant effort to reinforce a transparent safety culture, including the reporting of all incidents through the RL6 tracking system. Key to sustaining staff commitment is circling back to all who complete the initial reports to update on process/next steps as necessary. By doing this, people recognize the importance of engaging in the process.

SHN's SAFETY pillars, notably Speak up, Act, Focus/Follow, Everyone Empowered, Teamwork/Open Communication, and You, were reviewed with the team being very high on the impact they were having on the culture of safety, both for team members and patients and caregivers. In saying this, time was spent discussing the results of the patient safety culture tool, which were skewed towards respondents feeling great efforts needed to be made in strengthening the culture. While every organization can continually improve, a number of mitigating factors needed to be considered, most acutely the impact of the pandemic on overall perceptions of safety combined with the ever-increasing pressures faced by staff. Results however cannot be discounted and were viewed as honest in the context of the realities faced, with the current efforts expected to pay dividends.

The reporting structures for quality and safety were reviewed, including reviewing with the Board of Directors the type and frequency of reports. All were noted with approval and SHN is to be commended for their investments in the quality dyad created with medical and administrative leadership. Separating risk and quality was also noted, with the processes in place for quality of care reviews, including involving patient partner/advisors specifically flagged. The weekly safety incident reporting processes were discussed and are clearly ensuring that the organization stays on top of concerns raised.

One of the key challenges for many quality programs is the identification of priorities and ensuring the priorities selected can be appropriately resourced and supported by the organization. The team is commended for the process undertaken through a senior executive leadership retreat, and for landing on

a number of important priorities aligned with the Strategic Plan. SHN's capacity for analytics is impressive, with very strong reporting support to track and report progress of various initiatives.

Education, training and supports were impressive. The iLearn module and required change management learnings for all leaders were noted. The role of professional practice leaders in training and supporting initiatives was discussed and played a key role in the high reliability culture in place. There were considerable, ongoing efforts in place to strengthen overall capacity across the organization when addressing quality, safety and risk mitigation which, when combined with a very strong, results oriented team and a commitment to aligning program goals and objectives directly to SHN's Strategic Plan has positioned the organization well to continue to advance this important program.

--- ON-SITE ---

Virtually assessed in October 2021.

Comments from on-site survey November 2022.

Scarborough Health Network (SHN) is commended for its overall focus on integrated quality and patient safety programs.

The quality Improvement Team is comprised of dedicated and committed clinicians, leaders, and physicians who are passionate about creating an environment that is safe and in compliance with quality standards of excellence.

Quality and patient safety plans are aligned with SHN's Strategic Plan. Several quality and safety initiatives have been put in place throughout the organization and are displayed on departmental quality boards. The boards serve as an opportunity for staff and leaders to huddle on a daily or weekly basis and to review quality and safety initiatives and how they apply to each department. Discussions on falls, wait times, pressure injury reduction, length of stay, patient satisfaction and patient complaints, are a few examples of topics discussed. Consideration is encouraged to invite patients to participate in the huddle exercise to provide their comments about quality and safety initiatives.

One area that was highlighted as a challenge was in relation to disclosing incidents and accidents. Although the process to report occurrences is clear, staff members may hesitate to disclose them, and the leadership team understands their hesitation and is reinforcing a culture of transparency and safety.

Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems.

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
1.10 Support is provided to build the capacity of the governing body, leaders, and teams to use the ethics framework.	
Surveyor comments on the priority process(es)	

--- VIRTUAL---

From the board room to the boiler room to the bedside – this was how the priority process was introduced to the surveyor, and it was a wonderful encapsulation of the organizations approach and commitment to ethics.

The survey team was very impressed with the Scarborough Health Network's commitment to and focus on ethics, including the many and varied supports necessary for a strong program. With the two founding partner organizations having strong, foundational ethics programs, there was a very good understanding of its importance in addressing the many complex and varied issues in play.

With the merger and rebranding, the opportunity was taken to redefine the corporate focus on ethics, landing on the GREAT framework, standing for Gather, Refine, Evaluate and Act with Transparency. The process followed in developing the framework was reviewed and noted with approval. It was also noted that the pandemic has somewhat limited more formal roll-out of the framework, which is contemplated shortly. The availability of an ethicist 24/7 was a very strong underpinning for the program and ensured that the service was always available. Given the nature of some ethical dilemmas, this ready availability is key. While still really in its infancy, the benefits of the GREAT framework are already clear. As the pandemic unfolded, the framework was applied to a number of very challenging situations, notably the use of N95 Respirators, PPE distribution, the ramping down/ramping up of services, mass vaccination, and the compassionate visitor policy. In all cases, the framework helped guide SHN to the best possible decisions in situations that were, at times very emotionally charged.

The framework and supports have also been very helpful in guiding and supporting staff through ongoing challenges including Medical Assistance in Dying and complex discharge rounds. Supporting conscientious objectors with MAiD has also benefitted from the framework and team, with all engaged being very appreciative of the passion, commitment, respect and reflection brought to all discussions.

One of the true benefits of a culture built on a sound understanding of the importance of ethics is that it helps identify and address unconscious bias. Investments as noted here, as well as resources including a

diversity consultant, allow SHN to continually review and refresh its approaches to ethics to ensure all perspectives and views, across multiple stakeholders and cultures, are identified.

The strong commitment to research ethics was noted with approval, with all processes reviewed being stellar. Research and education are clear priorities of the organization and both the internal supports, as well as external ones were viewed as positive. Notably, the Ethics Education Network through the University of Toronto and internal groups such as the Ethics Advisory Council ensured that this important area of focus remained a priority. As with governance, reviewing the engagement of patient partners/advisors formally into the structure could be of benefit. In addition, further developing online supports would be beneficial.

Lastly, SHN's commitment to health equity is commended. While not specifically included through this priority process, ensuring the equitable, culturally sensitive availability and delivery of services is key to a successful organization. As such, a specific shout out to efforts in this area is provided.

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)

--- VIRTUAL---

A dynamic team participated in the virtual communications survey, representing all key communication areas of the organization. The 2018-23 Corporate Communications Plan was reviewed and was noted for its comprehensiveness. The three pillars of: We are all connected; First. Best. Only; and, Celebrating Scarborough, were well defined with very clear strategies associated with all.

All audiences, internal and external to the organization had been identified, with SHN being commended for the approach taken in defining unique communication needs and channels for all. The team reviewed the various communication tools utilized by SHN reinforcing that there was flexibility based on audience and message.

The team, as were all teams, was commended for the manner in which they responded to the pandemic, notably with the introduction of new tools necessary to facilitate operations. A Virtual Care Task Force had been established and, like many organizations, SHN was reviewing how it would maintain appropriate virtual tools moving forward. The Virtual Town Halls, connecting with 16,000 households were a tremendous way to engage the broader community in activities of importance and to provide a venue where people could get information important to them.

Given the major issues being addressed by the organization – merger, pandemic, accreditation, Epic installation, the team was commended for its ongoing commitment and focus. The migration from Meditech to Epic is a massive initiative and the team was commended for the structure and attention to detail placed on this. An overview of the process involved in the migration, including across the seven partner organizations involved, was provided. Privacy was addressed, with conversations ongoing to ensure that the right approaches are taken through standard work. A Cybersecurity Working Group and Regional Policy Task Force have been instrumental in advancing the implementation. With cut over date by the end of the calendar year, the team was commended.

Policies on release of information and chart completion were discussed. The introduction of MyChart with Epic was going to significantly advance the relationship with patients and caregivers in relation to access to information, and the group was very much on top of the issues that needed to be addressed.

One of the real strengths of SHN is its access to data, not only through communications analytics, but through a broader commitment to enterprise analytics. This allows the organization to very effectively review issues through an evidence-based lens, ensuring that the decisions made are sound and

supported.

The strong communications focus of the organization has been a key enabler in establishing and growing the culture of excellence that clearly exists. With the key strategic areas of focus noted here, SHN is well positioned to come out of the pandemic stronger and more integrated. The partnerships and relationships that have further developed through the pandemic and through efforts such as the OHT implementation and leading Canada's first hospital led COVID-19 vaccine clinic will certainly facilitate this moving forward.

--- ON-SITE ---

Assessed Oct 2021 Virtual

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)

--- VIRTUAL---

To be reviewed onsite April 2022

--- ON-SITE ---

Although SHN's buildings are older they are well maintained and welcoming for patients, visitors and staff. The organization is preparing for the redevelopment of the Birchmount site, and some units and departments are being renovated to better accommodate increased volumes of patients and equipment. In terms of patient safety, the organization is encouraged to conduct an environmental review of patient bathrooms as some are not wheelchair accessible and are not all equipped with call bells in case of an emergency. Environmental services may wish to include falls prevention as a quality improvement and risk management project.

In addition, when planning for the ICU renovations, SHN is encouraged to rethink the location of the Pyxis medication cabinet to ensure that it is placed in a closed area that is only accessible to health care providers who administer medications.

In terms of facility management, SHN meets CSA standards and is environmentally conscious with a focus on sustainability and moving forward. There are back-ups for all essential lifesaving systems with redundant hydro systems, boilers, and generators in the event of a power failure. There is a complete preventative maintenance program that is software based. Fire exits are free from clutter and treatment and patients' rooms are equipped with appropriate alarm systems and call bells. Audits are regularly performed.

A signage project is underway to optimize way finding throughout the hospitals. Moving forward, signage will be in English with graphic images that represent departments and services. Input from patients is being sought throughout the signage project.

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)

--- VIRTUAL---

Emergency preparedness (EP) is a noted strength of the organization. SHN has developed an impressive Disaster Management Plan that is comprehensive and inclusive. Standing committees that support the EP are interdisciplinary with representation and engagement from the PFAC.

The Emergency Preparedness team is determined to keep the people in the organization safe and secure and well prepared to manage emergency situations. SHN has a well-defined contingency plan for all types of emergencies that is supported by the Toronto police and by paramedics. SHN follows standardized colour codes and terminology for all codes. There is a process in place to prioritize code development; code OB (care of the pregnant patient) and triple AAA (ruptured abdominal aortic aneurysm) will soon be added to the EP plan. SHN teams practice codes during the year with regular scheduled drills. All codes are consistently debriefed. Opportunities for improvement are acted on. The teams are looking forward to continuing to conduct 'in person mocks' especially on weekends and on evenings and nights.

Excellent outbreak management structures and processes are developed and implemented. Teams rapidly respond to emergencies; in 2018 the organization was challenged with a real code red that turned into a code green in a matter of minutes. Effective communication strategies are established to inform and to keep families updated during emergency situations. Agreements are established with off-site centres to receive patients should there be a need to decant the facility. For example, Rosalie Hall has played an important role in accommodating women and children who require a place to stay during an evacuation.

Ongoing education and information on EP are available in a variety of ways including the Monthly Safety Matters newsletter, the annual patient safety week, and all new hires and physicians receive training on codes during their orientation and are required to complete EP e-training modules.

SHN has been a leader in the management of the COVID-19 pandemic. Assessment and vaccination centers and pop-up clinics for COVID-19 were created throughout the communities and the organization is a dedicated center for patients admitted with COVID-19. SHN is in full partnership with IPAC and reaches out to the community partners including long term care homes and schools and has developed virtual platforms to communicate and to educate internally and externally. EP teams effectively participate on the Joint Health and Safety committee and receive regular updates on staffs concerns so that continuous support to ensure their safety can be offered.

In preparation for this accreditation survey and considering the discussions that took place with all teams

it was evident that SHN's all hazard disaster and emergency plan and responses are well established for the management of COVID-19. At this time there may be an opportunity for the organization to review its all-hazard approach to emergency planning to ensure that it is up to date and appropriate for all sorts of emergencies.

SHN's EP teams have demonstrated outstanding compassion, courage, innovation, and inclusion throughout these unpredictable and challenging times. In addition, the trust and praise that were expressed by members of the PFAC and the numerous documents that were provided and reviewed allowed us to appreciate the extraordinary efforts and the tenacity that were invested by the organization to manage the pandemic.

Congratulations to all!

--- ON-SITE ---

Emergency Preparedness was done Virtually.

Priority Process: People-Centred Care

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

Unmet Criteria	High Priority Criteria
Standards Set: Governance	
2.3 The governing body includes clients as members, where possible.	

Surveyor comments on the priority process(es)

--- VIRTUAL---

SHN is an organization that takes great pride in being patient centered and has a culture of caring and commitment to the delivery of high quality of care and services. The Patient and Family Advisory Council (PFAC) members that were met during the survey stated that they were always treated with compassion and with respect. They also emphasized the importance that SHN places on involving them in planning opportunities. For example, a patient who experienced falls in the nephrology clinic was delighted to know that his request to have more wheelchairs available for patients with mobility issues was approved.

In addition, Scarborough is a large multicultural community with approximately 60 percent of patients experiencing linguistic barriers. In order to support them in accessing care, interpreter services are offered 24/7 to patients and families who don’t speak English. There is an opportunity for leaders to continue to ensure that the programs and services provided at SHN meet the diverse needs of patients and families especially with respect to language and culture.

A significant amount of health promotion material is consistently offered to clients through various mechanisms including pamphlets and posters and there are a significant number of initiatives that support people centered care. Patient advisors spoke highly of the leaders' abilities to listen to their needs; one member described her positive interactions with the nurse leader in the ED. The organization is encouraged to continue to promote patient engagement at the unit level/bedside.

In terms of learning opportunities, one PFAC member appreciated a conference on patient experience that was offered to her in Texas, another opportunity to attend a program on Indigenous culture safety, and to undergo the Lean Green Belt training course.

In terms of patient safety, quality and experience, clients expressed their appreciation regarding the positive impact COVID-19 has had on their ability to stay connected with SHN via virtual platforms. Examples that were shared include access to online courses from home, being able to participate in meetings and discussions despite being away from home. One PFAC member stated that in cardiac rehab

there is now a feeling that professionals stay in contact with him.

Once the exercise to refresh the Patient Bill of Rights and Responsibilities is completed the organisation is encouraged to ensure that it is consistently visible throughout SHN.

Finally, when PFAC members were asked to provide examples on how the hospital can improve, comments made were around the importance of having PFAC representation on the full board, receiving additional information on the topic of organ donations and on MAID, having more discussions around mandatory vaccinations for COVID-19, and on ways to support poverty, mental health challenges and inequity in the community.

--- ON-SITE ---

Onsite Survey Observations November 2022

The organization's values of being compassionate, inclusive, courageous, and innovative are consistently demonstrated by SHN staff. A culture of Patient and Family Centred Care (PFCC) is enabled by dedicated leaders and supported by PFCC champions.

PFCC at SHN is built on six components: Clinical Best Practices, Education, Information Sharing, Patient Experience, Patient and Community Engagement, and Organizational Commitment.

All new employees, volunteers and patient advisors receive a comprehensive orientation that includes education on PFCC principles and practices. Staff are provided the opportunity to take the organization's Health Equity Certificate Program, designed to empower those delivering care to take a full-spectrum view of health, and to help develop strategies to reduce health disparities. Patient advisors are engaged to help deliver a portion of the program's content.

Patient and Family Advisors (PFAs) play an important role at SHN, and represent a variety of backgrounds, cultures, and age groups that reasonably reflect the population of Scarborough. The corporate Patient and Family Advisory Council (PFAC) oversees the well-being of the three program PFACs: Nephrology, Adult Mental Health, and Youth Mental Health. The organization is encouraged to work to develop additional program PFACs.

After pausing PFA recruitment during the pandemic, SHN is now actively recruiting PFAs, with a focus on recruiting advisors that reflect Scarborough's diverse community. Currently, there are 36 active Patient and Family Advisors. Providing supports to cover dependent care, travel costs and/or technological support will help to ensure that all advisors can meaningfully contribute, especially those from underrepresented communities. The organization is encouraged to provide secure SHN email addresses to those advisors asked to engage patients and families through digital means.

PFAs are involved in many committees, including the Quality –of Care Committee, the MAiD Committee, the Stroke Committee, and the Board of Directors Nominating Committee. PFAs are also engaged in

working groups, on hiring panels for senior leaders and physicians, and in the review of patient resource materials. Documents that have been codesigned or reviewed by PFAs receive a recognizable PFAC stamp of approval. The organization's goal is to have all initiatives, decisions, and products receive the PFAC stamp of approval.

Onboarding for Patient and Family Advisors (PFAs) includes a formal interview, an online application, completion of e-learning modules, participation in corporate volunteer orientation, and a PFA specific orientation. PFAs are regularly engaged to provide input and feedback on their roles and responsibilities, role design, and role satisfaction, and are provided the opportunity to participate in capacity building activities, including having access to Beryl Institute resources.

Patient compliments and complaints are managed by the patient relations department, and patient and family feedback is solicited through various means, including staff conversations, via the website, through fillable physical comment cards, and through the active presence of Patient Relations Facilitators. Key performance targets are being met, with 96 percent of concerns and compliments being acknowledged in two business days, and 98 percent of files being resolved in 60 business days. Fulsome tracking and analysis enable leaders to trend and track compliments and complaints at the unit level. Unit specific patient experience surveys have been developed in several areas, including the women's and children's unit and the NICU. These surveys are easily accessed on smart devices using QR codes and enable the gathering of real-time feedback. SHN is currently working with a vendor to develop a digitally enabled user-friendly patient satisfaction survey. The organization is encouraged to continue to work with staff and leaders on first point-of-contact service recovery, in connection with their effort to build a just culture.

SHN is to be commended for their community engagement efforts, especially as they relate to COVID-19 vaccination. SHN's VaxFacts clinic provides free one-to-one consultations to community members and people across the country looking to gather accurate information about vaccines in a judgement-free setting.

At the direct care level, patients and families are engaged as active members of the collaborative care teams and are provided with the information necessary to support the self-management of their conditions. This is enabled by regular communication with patients and families through varying means, including MyChart, the new online patient record portal. SHN is encouraged to promote the use of MyChart, as patients and families who utilize it note it increased their ability to be actively engaged in their care.

The organization regularly partners with patients and family in many areas of quality improvement and patient safety, and quality improvements are often developed as a result of patient and family feedback. Patients and families are invited to quality huddles in several units, and to contribute to the codesign of services and spaces. Patients and families were highly involved in the design of the new Integrated Stroke Unit, and in the redesign of the GAIN clinic intake process. The Nephrology PFAC has been highly engaged in the co-development of innovative new spaces and services, including initiatives that will allow patients to be true partners in their care by empowering them to self-manage their conditions at home.

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)

--- VIRTUAL---

to be reviewed onsite April 2022

--- ON-SITE ---

The Scarborough Health Network (SHN) is committed to improving system flow. The approach is grounded on the Institute for Healthcare Improvement (IHI) principles. A steering committee is accountable for flow across the system. Quality improvement methodologies are drawn upon to improve processes. Such initiatives include improving the reliability of the Estimated Date of Discharge (EDD), standardizing repatriations, and surge management processes.

Surgical smoothing exercises to address variability and improve efficiencies have resulted in many surgeries shifting to day procedures, most notable of which are joint surgeries for hip and knee replacements. This has resulted in greater inpatient capacity and shorter surgical waitlists.

Bullet rounds occur across units and include physicians and multidisciplinary teams to understand discharge planning better. Processes and work standards have been created to support multi-site capacity across SHN in response to a high level of Alternate Level of Care (ALC) patients on the wards. Community partnerships have resulted in transitional care units as part of the ALC strategy.

SHN has shifted in many instances to be a seven-day-per-week operation, supporting continuous discharge planning, with home and community care partners on site on weekends. This has been a demonstration of collaborative accountability.

Bed huddles occur twice daily, where units across all three sites report on their capacity and staffing situations. This is an excellent initiative. However, it could be improved by moving towards a Microsoft Teams format with the visual support of the report outs. At present, the calls are chaotic and slightly unorganized. Work should be undertaken to streamline the process and minimize the distraction and disruption of those reporting out.

Work continues in the Emergency Department to improve patient flow, including the introduction of the horizontal waiting room at the Centenary site, where a patient who has not yet been triaged but requires a bed is left in the care of a personal support worker. The Fit 2 Sit program has advanced at Birchmount and is beginning at Centenary and the General. The No Wait ED initiative, where ED physicians will

provide rapid evaluation of patients in triage rooms, will be revolutionary once infrastructure changes can support its implementation.

Priority Process: Medical Devices and Equipment

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

Unmet Criteria	High Priority Criteria
Standards Set: Reprocessing of Reusable Medical Devices	
3.2 The MDR department is designed to prevent cross-contamination of medical devices, isolate incompatible activities, and clearly separate work areas.	!
Surveyor comments on the priority process(es)	

--- VIRTUAL---

to be reviewed onsite April 2022

--- ON-SITE ---

The on-site survey for the Medical Devices and Equipment priority process included the Medical Device Reprocessing Department (MDRD) and Endoscopy. Reprocessing takes place at all three sites of Scarborough Health Network (SHN). Other than Endoscopy, all medical device reprocessing is centralized to the MDRD. Of note, the staff of the MDRD were the recipients of Accreditation Canada's Leading Practice Award for their work utilizing Medline, which has cut down on the need for sterile storage, and time for assembly of carts.

SHN has a very good process for the prioritization, selection and purchase of medical devices and equipment. The process is managed through a roll-up of local and corporate prioritization and engages a wide variety of stakeholders from across the organization. A prioritization tool is utilized to support the appropriate allocation and distribution of resources. The SHN Foundation has also been a great supporter of the organization’s capital needs.

There are two streams related to preventive maintenance: biomedical engineering and through contracted services. There is a comprehensive preventive \maintenance program that is tracked and monitored. Training is provided to all clinical staff on the safe operation of new equipment such as IV pumps; the training is completed annually.

MDRD provides an excellent service based on best practices and standard work. Touring the reprocessing and repackaging area was most impressive, as the flow from dirty to being ready to reutilize was reviewed. There is an electronic instrument management system facilitating annual reviews of reprocessing and sterilization activities. The teams have done a very good job of undertaking focused on quality improvement initiatives and tracking key performance indicators and capturing electronic

workload statistics and service volumes / trends to identify areas for broader system improvements.

The sense of teamwork was very visible from directors to managers to front line staff. They knew their roles and collectively focused on providing safe and reliable equipment to support the delivery of health care to SHN. What was most refreshing was the utilization of front-line staff and their experience in creating MDRD solutions to unique local challenges. The development of the team charter was noted with approval. The organization has been very active in recruiting and training new staff and is encouraged to continue with this good work. Health human resource planning aligned with clinical activity forecasting is encouraged.

Opportunity

The physical layout for the reprocessing of endoscopy probes does not allow for physical separation between dirty and clean probes at the General site. It is recommended that this area be reviewed from and infection prevention and control perspective, to ensure that cross-contamination does not occur. Ideally, the space should be remedied to provide physical separation between the dirty and the clean, facilitated by a pass-through window. At the other two SHN sites, there is physical separation of dirty and clean during reprocessing of endoscopy probes.

Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Point-of-care Testing Services

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

Clinical Leadership

- Providing leadership and direction to teams providing services.

Competency

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

Episode of Care

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

Decision Support

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

Impact on Outcomes

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

Medication Management

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

Organ and Tissue Donation

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

Infection Prevention and Control

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

Diagnostic Services: Imaging

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

Diagnostic Services: Laboratory

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

Transfusion Services

- Transfusion Services

Standards Set: Ambulatory Care Services - Direct Service Provision

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

--- VIRTUAL---

--- ON-SITE ---

Nine ambulatory clinics were visited and assessed across all three sites.

All clinics offer similar care delivery models, utilizing consistent policies, procedures and processes, employee education, administrative oversight, and some shared staffing from both physicians and allied health providers.

There is strong leadership within the ambulatory clinics, including directors, managers, clinical practice leaders, and physician leaders. The engagement of the leadership is commendable with a shared and consistent commitment to quality and patient safety.

Patient and Family Advisors (PFA) are utilized throughout the clinical areas, assisting with development and review of patient education material, quality projects and working with the organization on future design of ambulatory services.

The ambulatory clinics have been very successful in creating opportunities within their areas to reduce admissions to hospital, decrease inpatient length of stay, and avoid emergency rooms visit.

Priority Process: Competency

--- VIRTUAL---

--- ON-SITE ---

All of the interdisciplinary teams surveyed were highly motivated and engaged in their work, in quality and patient safety, and in supporting their community.

There are well structured orientation programs, supported by the clinical practice leaders (CPL), and ongoing professional development opportunities are supported and promoted throughout the ambulatory areas.

Competencies are updated using the iTeam platform and tracked by CPLs and managers. Staff spoke of feeling well supported in their practice and have training and education when new equipment is introduced, or when new care processes are developed.

There is a commitment to staff safety and wellness, with education provided on violence prevent and de-escalation. SHN has a commitment to staff wellness, and this is evident in the resilience of the teams through the pandemic.

Performance appraisals have been replaced by VIP chats (valuing individual performance). VIP chats appear to be up to date.

Priority Process: Episode of Care

--- VIRTUAL---

--- ON-SITE ---

The ambulatory clinics have a strong commitment to patient and family centered care and take pride in providing quality care to the community they serve. The response to the COVID-19 pandemic demonstrated the teams' adaptability in developing new ways to do assessments and deliver care, pivoting to virtual appointments in some areas.

The coordination of vaccination for geriatric patients being seen in the GAIN (Geriatric Assessment and Intervention Network) clinic is an example of how the team identified a barrier to a vulnerable population receiving vaccination and developed a plan to coordinate care in a way that removed that barrier. The rapid establishment of a COVID-19 clinic for IV monoclonal antibody treatment as well as the establishment of the long COVID clinic within the two GIM (general internal medicine) clinics are

examples of the ambulatory team's ability to quickly respond to the changing needs of the community.

The clinics work closely with the Emergency Department and other referral sources to facilitate timely access to care, often avoiding emergency room visits and inpatient stays. The work the orthopedic clinics have done in both their outpatient arthroplasty program and access to the fracture clinic and surgical waitlist for urgent care has reduced hospital admissions.

There are waitlist management processes in place and the ability of the clinics to maintain services throughout the pandemic has served the community well with respect to access to care. Practices such as central intake within the oncology clinics has provided opportunities to improve efficiency and exceed the expected wait time targets.

Patients are all screened for falls risk and a purple wrist band is used to identify patients at risk. Patient identification, using two patient identifiers for all treatments was evident throughout the clinics.

The teams are aware of the G.R.E.A.T. (Gather, Refine, Evaluate, Act with Transparency) ethics framework, and the Oncology Clinic recently accessed their Ethics Team for a review of a patient care issue.

Patient and family centered care was evident throughout the ambulatory clinics. Some clinics offer self-referral options such as the GAIN clinic and the Inflammatory Bowel Disease clinic. Patients spoke of feeling very well cared for and well informed. The patients who are accessing MyChart felt well informed and able to contribute better to their care. There is opportunity to promote this further and expand access to MyChart in different languages, given the diverse population of the community served.

The Pharmacy areas in both Oncology clinics (Centenary and General) are challenged with respect to physical infrastructure. The consolidation and redevelopment of the Oncology Clinics is a priority for the organization, and this will be required to meet all the environmental, and infection control standards. The eyewash and shower in the Oncology Pharmacy at the General overlaps with a supply cart. Although the cart is mobile and can be moved if these stations are in use, there is potential for water leakage over the supply cart.

There were mixed practices with respect to hand hygiene in some of the clinics, even with hand hygiene audits at 100 percent compliance. A reinforcement of the four moments of hand hygiene is recommended.

The ambulatory clinics have access to and actively engage and utilize PFAs. The Oncology clinics specifically would benefit by expanding their patient and family engagement through a dedicated PFA assigned to the Oncology service.

Priority Process: Decision Support

--- VIRTUAL---

--- ON-SITE ---

With the introduction of Epic, patient information is accurate, up to date, and standardized so a consistent approach to patient information is utilized across all areas.

Patients have access to their health information through MyChart. Although this feature isn't well used by patients at this time, there is tremendous opportunity in promoting this to patients and families in the future.

Priority Process: Impact on Outcomes

--- VIRTUAL---

--- ON-SITE ---

All teams have huddle boards within their clinics that are used to display key performance indicators and discuss successes and opportunities for quality improvement.

The teams utilize online patient safety reporting system to report safety incidents and near misses.

The safety reports are reviewed, process improvements identified, and the team receives feedback on the improvement plan. Trends in safety incidents are tracked and monitored with recommendations shared across sites.

Standards Set: Biomedical Laboratory Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Episode of Care

--- VIRTUAL---

--- ON-SITE ---

Universal Fall precautions are in place. This is an OLA rating.

Priority Process: Diagnostic Services: Laboratory

Diagnostic Services: Laboratory Biomedical Laboratory Services

--- VIRTUAL---

--- ON-SITE ---

The Laboratory (Lab) is currently accredited by Accreditation Canada (previously IQMH) and therefore, a limited number of criteria were evaluated during the on-site survey. All three of the SHN labs underwent the Lab Accreditation in May 2022 and achieved great success, with no major unmet criterion.

The labs at all three sites were assessed during the on-site hospital survey. All sites have core labs with microbiology samples sent to the Shared Hospital Lab. The Labs are clean and orderly and have adequate space (although more would be appreciated). The Lab at the General site is fully automated, while only chemistry is automated at the Birchmount site. Manual processes are in place at the Centenary site. The staff are dedicated, knowledgeable and committed to providing excellent service.

The Shared Hospital Lab is one of the largest microbiology labs in Ontario. It is a partnership between SHN, Sunnybrook, Michael Garron and North York General hospitals. It is highly regarded for its role in response to COVID-19. It was the first lab to start COVID testing in Ontario and was able to quickly ramp up capacity and capability to perform approximately 5,000 tests per day. It is one of five labs in Ontario to

do whole genome sequencing for COVID-19. SHN's chief of laboratory medicine is credited as the driving force in the creation of the Shared Hospital Lab. This is commendable.

The staff and physicians are committed to quality and sustaining a strong quality management system. Staff and physicians are actively engaged in regular reviews and process improvement efforts focused on learnings and opportunities. The team collects utilization data and service volumes and uses the information to inform service planning. The department collects and reviews many metrics. The quality indicators are posted within the lab and corridors.

In the core lab, a strength is their commitment to working collaboratively with their clinical stakeholders to improve turnaround times. Turnaround times are closely monitored in real time with color coding at their workstation in the lab.

The laboratory staff have access to education and training support including a wealth of online information regarding standard operating procedures (SOPs). Staff appear knowledgeable and engaged in their work.

Standards Set: Critical Care Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
2.7 The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
10.1 Oral communication is facilitated or alternate means of communication are used when the client is unable to communicate orally due to ventilator use, physical condition, or other reasons.	
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

--- VIRTUAL---

--- ON-SITE ---

There is solid and respected clinical leadership across the ICU sites at Scarborough Health Network. Medical leadership is engaged and involved in day-to-day operational decisions. There is a true partnership with administrative leaders. The director and managers are new but keenly involved. They are true change makers driving quality improvement and changing culture.

There is work to do regarding universal patient partnership from all team members. However, a strong foundation for patient and family participation and collaboration has been established.

The units have engaged a PFA for all ICUs at SHN. The organization should broaden its patient and family partners to reflect the community served and the lived experiences at each of the three ICU locations.

A recent revamp of space at the Birchmount ICU was conducted with little input from patients or nursing staff, the prominent team members working within the area. This was a missed opportunity to create a user-friendly space. As new sites are re-developed, the organization are encouraged to ensure that patients, families and all team members are intimately involved in redesign and space planning.

There has been a lot of turnover in staff, with several new and inexperienced registered nurses joining the units. Mentorship programs are being developed to address the challenges that this poses. Given the current shortage of registered nurses, consideration of a team-based approach to care that achieves skill task alignment could be explored on the units.

Priority Process: Competency

--- VIRTUAL---

--- ON-SITE ---

The staff mentioned that they feel skills days on the unit amongst staff would help to build and maintain skills while building the team simultaneously. SHN is encouraged to initiate regular skills days to ensure that team members are well-equipped to meet patients' needs.

Priority Process: Episode of Care

--- VIRTUAL---

--- ON-SITE ---

Across all locations, patients are provided high-quality, safe care in intensive care units. Everyday leadership from the medical and administrative director over the sites drives consistency.

There is concerted work to ensure the Transfer of Accountability (TOA). This has resulted in standardized tools to support verbal transfers, and documentation within Epic is standardized and consistent. An SBAR (situation-background-assessment-recommendation) format is used to facilitate a transfer at care transitions. This ideally occurs face-to-face but can also occur by telephone—the RN documents the TOA at the sending and receiving unit within Epic. At a minimum, the TOA must include patient identification, code status, infection control isolation status, allergies, safety concerns and care plan.

Team-based rounds occur daily at the bedside and include patients and their families. These look slightly different at the three sites but include multi-disciplinary and bedside components, allowing for family participation where possible.

A significant focus on the team this fall is on reducing hospital-acquired pressure injuries in the ICU. A quality improvement initiative is underway to address a recent increase in pressure injuries. This has coincided with the inexperienced nursing staff. A focus includes improved education and specialized nursing opportunities. Patients and nursing staff suggested tests for improvement.

A patient's family member raised concern that the tools to facilitate communication for patients that cannot express themselves are inadequate. The patient's family member created their own binder with laminated pictures, letters and diagrams that would improve communication. There is an opportunity to work from that creation to build an enhanced communication tool. This would be an excellent opportunity for patient and family engagement in process improvement.

Dedicated, responsive and respected leaders make a difference across SHN ICUs, and patients and their families benefit.

Priority Process: Decision Support

--- VIRTUAL---

--- ON-SITE ---

Epic has been a game changer for the organization regarding accurate, up-to-date and complete record-keeping. Staff who were skeptical of its roll-out report confidence in the system and admitted that it had improved the care they provide in many ways.

While the patient has access to the patient portal, SHN could promote the record more widely.

Priority Process: Impact on Outcomes

--- VIRTUAL---

--- ON-SITE ---

There was note made that because the Epic instance is across numerous hospitals and organizations, implementing standard screening tools and order sets can be quite arduous. I is recommended that SHN endeavour to make the right thing to do the easy thing to do when it comes to standardizing patient management.

Priority Process: Organ and Tissue Donation

--- VIRTUAL---

--- ON-SITE ---

The teams in the ICU are well aware of which patients to identify as potential organ donors and how to

contact the organ donation program. There are high rates of those identified. However, there is a low rate of those consenting to be an organ donor. The staff felt this was partly due to specific cultural communities in Scarborough not being comfortable with organ donation.

There is an opportunity for broader community engagement through coalitions with community partners. There is a physician lead for organ donation, and their role in the engagement strategy is essential. It is recommended that patient and family partners be engaged in such an initiative.

Standards Set: Diagnostic Imaging Services - Direct Service Provision

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

The organization has met all criteria for this priority process.

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

--- VIRTUAL---

--- ON-SITE ---

The DI (diagnostic imaging) program at SHN offers a multitude of diagnostic examinations which include radiography, CT, ultrasound, MRI, mammography, nuclear medicine, invasive and non-invasive procedures, bone density and C-arm. Positive comments were expressed in relation to the availability of equipment and thorough processes are in place for cleaning equipment. All DI probes are cleaned in the Medical Device and Reprocessing Department. Good job!

DI is staffed with twenty-five radiologists, one hundred and fifty technologists and sonographers and fifty clerical staff. The department is open 24-7, the hours of operation vary from site to site, and approximately 350,000 exams are performed yearly. Access to care, wait times and no shows are rigorously monitored and although patients can access their personal file through MyChart they did not seem to be aware of this online opportunity. In addition, patients will be able to book their mammography online which will facilitate their lives!

With the exception of the General site, the DI departments are strategically located close to the Emergency Department and to Ambulatory Care, and the physical layout facilitates easy movement of patients. Wayfinding towards medical imaging is facilitated by floor dots and all restricted areas are clearly marked. Washrooms are not wheelchair accessible at all sites and some washrooms do not have a call bell in case of an emergency. This is a patient safety issue that SHN is encouraged to investigate.

Waiting rooms are large and all patients who are at risk for falls are appropriately identified and managed. The patient's date of birth and name are used to verify their identity. Mock codes are conducted to ensure readiness to respond to an emergency and the organization plans to conduct mock codes on a regular basis. Quality boards are strategically located in DI and staff engage in discussions on quality, safety and patient experience once a week. In addition, snacks and chats are managed by the clinical practice leads and their goal is to review policies and procedures in a relaxed atmosphere that is conductive to exchanges.

In terms of patient satisfaction, QR patient satisfaction codes are visible throughout the department however when speaking with patients, they did not seem to be aware of this opportunity. The department is encouraged to invite patients to express their satisfaction regarding the care and the services they receive. This issue can be brought to the Quality Committee for discussion.

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		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
8.8	Clients waiting in the emergency department are monitored for possible deterioration of condition and are reassessed as appropriate.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		
Priority Process: Organ and Tissue Donation		
11.5	Training and education on organ and tissue donation and the role of the organization and the emergency department is provided to the team.	
11.6	Training and education on how to support and provide information to families of potential organ and tissue donors is provided to the team, with input from clients and families.	
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

--- VIRTUAL---

--- ON-SITE ---

Emergency departments (ED) across the country are stretched to meet the demands of patients, and those at SHN are no different.

SHN's medical and administrative leadership is stellar. It is beneficial that all ED physicians work across all three sites to drive consistency where possible. However, moving towards a consistent culture across all

sites will take time and focused leadership.

SHN has prioritized human resource pressures by recruiting, training and mentoring staff. Like other EDs, the nursing staff is relatively junior and inexperienced, presenting challenges and opportunities.

There could be further expansion of team-based models of care to include more Personal Support Workers within the Emergency Departments.

There are opportunities underway to partner with EMS to develop community paramedicine, which could enable safe discharge and prevent ED visits. Partnerships with EMS exist to expedite ambulance offloads.

Priority Process: Competency

--- VIRTUAL---

--- ON-SITE ---

Opportunities for ongoing training exist at SHN, and staff are supported to pursue RNAO (Registered Nurses Association of Ontario fellowships. There are courses available that enhance both clinical skills and leadership skills. A simulation program is also being developed for staff and physicians to work together on scenarios. There is tuition assistance available for programs of the staff member's choosing.

All new RN hires to the ED require a crisis intervention course offered by SHN. Physicians are also offered the course, and there is good uptake from the physician group.

There is a partnership with Humber College to create an emergency training program for RNs at SHN. This has resulted in many new hires to the site over the past six months.

A simulation program led by emergency department physicians has been established that involves the entire multidisciplinary team. This occurs at the General and Centenary locations. Six modules occur on 18 different dates. RNs and other staff are reimbursed for time spent in simulation.

Physician assistants have become essential members of the emergency department teams but are still a relatively new profession for the organization. The PAs interviewed felt that they were appreciated within their departments but felt unseen in the larger organization. SHN may wish to profile its employee roles more broadly so that the unique work and skillsets of its workforce are understood by others working within the organization.

Priority Process: Episode of Care

--- VIRTUAL---

--- ON-SITE ---

Patients presenting for emergency care at any of the Scarborough Health Network's emergency departments receive safe, high-quality care. Care is standardized, and the implementation of Epic has further improved this.

Per the organization's policy, suicide risk assessments are performed on any patient with a mental health concern. This is not a universal screen, and there is the opportunity that some at-risk patients may be missed due to this approach. SHN may wish to revise its policy so that universal screening can occur.

The suicide risk assessment is built into the triage note. Regular audits reveal that RNs consistently do this screen at the time of triage.

At the General site, there is an internal waiting room where patients wait after being initially assessed while ongoing investigations or treatments are pending. There is a poor line of sight into that waiting room. The nursing staff does reassess patients, but the poor lines of sight present a risk. The organization may consider placing a camera in the room or look into other ways to ensure that staff can continually monitor the space.

Pharmacists work in the Emergency Departments during the day, seven days per week. To obtain the Best Possible Medical History, they prioritize reconciliation of home medications amongst admitted patients, addressing those with polypharmacy first by working with families, using ConnectingOntario to inform medications and then calling the patient's community pharmacy. Consulted patients are prioritized after admitted patients.

Documentation on transitions of accountability is made in Epic. It is consistent and requires documentation from the sending and receiving parties. The transfer is supported by a standardized SBAR format that captures the pertinent information. The organization has emphasized and prioritized transfers of accountability to its staff.

The Emergency Department staff knew there was support to call when an ethical issue arises but were unfamiliar with the G.R.E.A.T. ethical Framework.

Overall, the Emergency Departments are supported by superb clinical leadership, and this is reflected in the quality of care provided to patients.

Priority Process: Decision Support

--- VIRTUAL---

--- ON-SITE ---

There has been a very extensive and supported rollout of the Epic health record at SHN within the past six months. This has gone well, and staff report feeling supported throughout the process. The implementation of Epic has revolutionized the patient data systems at SHN and resulted in a robust hospital record for patients. Patients have access to MyChart, an Epic feature that gives them access to their medical record.

Priority Process: Impact on Outcomes

--- VIRTUAL---

--- ON-SITE ---

SHN has demonstrated the benefit of an amalgamated system of hospitals in this regard; initiatives can be trialled at one location, refined, and then spread more broadly, where applicable. Learnings from one site can be used to inform improvements at another. This has been true of numerous initiatives. The cultures at all three sites remain distinct, so what has worked at one location may not be as easily implemented at another. Nonetheless, the organization is taking available opportunities to spread success across sites.

Priority Process: Organ and Tissue Donation

--- VIRTUAL---

--- ON-SITE ---

There is an opportunity to better educate staff working in all Emergency Departments across all three sites on their role in organ and tissue donation. The Emergency Department is an important location where the identification of organ donation can occur. There is an opportunity to engage the community better, and staff at SHN can play a role in that.

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

Unmet Criteria	High Priority Criteria
Priority Process: Infection Prevention and Control	
6.1 Clients, families, and visitors are provided with information about routine practices and additional precautions as appropriate, and in a format that is easy to understand.	!
Surveyor comments on the priority process(es)	
Priority Process: Infection Prevention and Control	

--- VIRTUAL---

--- ON-SITE ---

A very impressive group of people are focused on the provision of IPAC services at the Scarborough Health Network (SHN). Leadership, teamwork, collaboration, and passion are all evident here. Infection prevention and control are ably led and supported by capable individuals who are exceptionally well versed in IPAC issues and processes. They are a model of teamwork and functionality. There is a commitment to education, training, knowledge transfer, communication, and partnerships.

SHN is to be commended for the leadership and expertise that they have provided both within and outside of the hospital during the COVID-19 pandemic. In addition to establishing test and vaccination sites, they have successfully implemented the first IPAC hub servicing congregate settings in Scarborough during the pandemic. The team is passionate about their work and ability to collaborate during trying times to ensure practices and policies are followed, monitored and communicated. The organization has invested in resources to support effective infection prevention and control practices, especially as they relate to COVID-19. Staff discussed the education that the teams are provided with and their confidence in the hospital's approach to COVID-19. Of note, the Toronto Zoo named Blanding's turtles after four individuals in recognition of their time and commitment to the Scarborough community during the COVID-19 pandemic.

At the current time, all patients that are admitted to SHN undergo COVID-19 testing. There is a very detailed cohorting algorithm that is in place to assist with cohorting decisions, depending on whether the patient is an active positive case under review, confirmed, or has a history of the virus. Staff at all three sites commented on how helpful the algorithm was, and if for any reason they were unsure of their cohorting decision, IPAC was available for assistance.

Since the last on-site survey, a new EMR Epic, has been implemented at SNH. The IPAC team can be

commended for their work in successfully implementing SHN's user-friendly and in-depth IPAC Epic functionality.

SHN has well-developed infection prevention and control policies and procedures which are developed with input from the Provincial Infectious Diseases Advisory Committee (PIDAC) and Public Health Ontario. EPIC serves as the information hub for epidemiological review of the patient population in conjunction with microbiological reports received from diagnostic laboratories. There is evidence of effective surveillance processes to identify, communicate, track and analyze infections including surgical site infections, nosocomial infections and multi resistant organisms.

In review the Laboratory, Endoscopy, and MDRD were in full compliance with IPAC standards. The leadership in the various sites are well aware of the implication of letting something fall through the system and are very focused and committed to ensure safe and detailed practices to ensure sterility, careful separation of clean and dirty, and ensuring staff compliance with the standards.

All three SHN hospitals have aging infrastructures which are a challenge to maintain from an IPAC perspective. In many of the inpatient units, there were three to four bedded rooms. Overall, the physical environment is well maintained, and housekeeping practices provide a very clean and inviting atmosphere. There are multi-skilled workers at the Centenary site that are tasked with environmental cleaning, portering, and the passing out of dietary trays. At the other two sites these are separate functions done by separate workers. Observational audits are done at all three sites to ensure compliance with best practices.

There is a multidisciplinary, SHN wide IPAC Committee that meets quarterly and is co-chaired by the two IPAC medical directors. Membership consists of internal representatives from all aspects of SHN services, in addition to external partners, such as Toronto Public Health and the Shared Hospital Laboratory. Quality metrics, surveillance data and current environmental issues are shared. IPCs also meet as needed, sometimes weekly.

At the Birchmount site, visitors to the inpatient units are required to sign in upon arrival. This provides the staff the opportunity to provide in-the-moment reminders to the visitors about the need for hand hygiene and proper PPE, especially if they were visiting someone in isolation. It is recommended that this practice be standardized across all the sites to ensure that visitors are using the necessary/proper PPE while visiting. In was noted during the tracers that there where patients under isolation without PPE. Lots of work has gone into the design, format, size of the font, and color scheme of the isolation precaution signage. Patients were asked for their feedback on the isolation signs. However, the signs did not do what they were intended to do on a consistent basis which is to make visitors/families stop before going into the room, and do what was required as to hand washing, donning and doffing of PPE based on the type of isolation.

Standards Set: Inpatient Services - Direct Service Provision

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

--- VIRTUAL---

--- ON-SITE ---

Centenary Site:

Paediatrics 7th floor and their outpatient clinics:

This unit is physically well laid out with affiliated clinics close by the area. There is strong leadership from physician and nursing leadership. The unit has been designed with input from patients and families to effectively meet the needs of a variety of populations within the area. Occupancy has been elevated during this fall due to the multiple upper respiratory infections.

Staff employed in the unit receive education and a very thorough orientation when hired. Education is available to the staff at any time if needed. Educators are available to provide support and education at any time.

The service meets all patient needs in the local area and transfer can occur when serious to a major

center such as the Hospital for Sick Children.

9 West medicine:

The leadership is effective and consists of a manager, director and Clinical Practice Leader. The team is cohesive and truly has the best interest of the organization and staff in mind. The unit is as effective as it can be due to the age of the building but does meet the needs of the existing population and has had input from patients and families in its design. The unit is busy with a high level of occupancy.

The team ensures that all staff receive a very thorough orientation at time of hire - both a general corporate orientation and a departmental orientation. A mentor is identified and is supportive to the staff person during their orientation and employment. Staff are very positive regarding their employment and many staff have been long term employees.

The census is approximately 35 beds and six telemetry beds. All units had the ability to surge during times of need. Education has been provided to staff on coronary care 1 as a need to work on the unit.

Patient outcomes are positive; patients feel extremely well cared for on this unit.

Birchmount site:

Cardiology - 3rd floor:

The unit is quite spacious and provides care to cardiology patients and related diseases. The leadership is cohesive and made up of a Manager, Director and Clinical Practice Leader - they effectively work together and are well accepted by their team. The unit is very effectively operated and meets the needs of all areas and constituents. The area is organized with feedback from clients and families and meets the needs of the clients and staff.

Staff are well orientated to their role on this unit and education is made available to them as needed. The staff feel very positive regarding their employment here and many are very long-term employees.

Few negative outcomes occur, and the area operates in a very positive fashion. Both patients and staff feel positive regarding their experience on the unit.

Inpatient Medicine 4th floor:

The unit has strong leadership: which is cohesive and made up of a Manager, Director and Clinical Practice Leader. The team has the best interests of patients, families and staff in their planning at all times. The area is organized and effectively laid out to meet the needs of the population they serve.

Competency is considered important and thus a thorough orientation both general and to the unit are provided to new staff. There are many long-term staff who are happy and feel valued by the organization.

This is an active medical and stroke unit. Rehabilitation is available and assists the population to transition to home.

Gentle persuasion is provided to the staff as education.

Bullet rounds are conducted daily with all professionals attending and discharge planning is initiated at the time of admission.

General site

Inpatient Cardiology Tower 9:

The unit has strong and effective leadership made up of a director, manager and Clinical Resource Leader. The leadership team is cohesive and has the focus of best care for the population of the area.

This unit has many new staff hired in the past two years and currently only has four vacancies which is extremely commendable. Education is provided to the new graduates including payment for the 12-week Humber College Critical Care Program. This is extremely commendable.

The unit has 15 level C beds, six level 2 beds, approximately eight step-down level 2 beds and was renovated approximately three years ago. Staff identified that they feel very positive with this work environment and do not wish to leave this work area.

This unit appears to be functioning at a high level of productivity and effectiveness. The renovation is positive, producing clear lines of sight for staff to visualize their patients.

Inpatient Nephrology Tower 2 - side 1 and 2:

The leadership is again very strong and cohesive, and truly has the focus of the best care for the population of the area. It is commendable to have the service operate 24/7 and it is suggested to document this as a Leading Practice. This initiative assists the younger population of the area to meet their life needs and maintain employment and a lifestyle. This has been a very effective program initiative.

Staff identified they are very happy working and feel totally supported in the area. They have many long-term patients and know their patients well.

The modifications to the unit have proved to be effective for the flow of patients and the workload.

Priority Process: Competency

--- VIRTUAL---

--- ON-SITE ---

Staff are well prepared for their roles and receive continued education in staff violence, ethical decision making, and safe use of all equipment. Infusion pump training is provided, and directions are available, for all staff using the pumps.

Staff receive education on how to report issues with pumps and other equipment should there be issues or failures. The Clinical Practice Leaders ensure that all staff receive education regarding EMR (electronic medical records). Education and training are provided to staff on how to determine end of life palliative needs. Team member performance is evaluated throughout the year in a just in time fashion.

Staff receive a brief training regarding pediatric care as the potential for pediatric surge is a potential.

Ongoing education is provided on all aspects of care and service.

Priority Process: Episode of Care

--- VIRTUAL---

--- ON-SITE ---

Patients and families are very actively engaged in their care. Translation services are available everywhere for family and patients. Patients and families are confirmed they understand the information they have been given. Clients and families are provided with information on how to file a complaint and to whom. An investigation process is in place.

Medication reconciliation is conducted at time of admission on all units.

A falls program is in place and utilized throughout the organization.

A wound and skin program is in place and is used throughout the organization. A program is in place for venous thromboembolism and utilized within the organization.

Communication is maintained regarding care of the patient. Two person identifiers are utilized by all staff in the organization.

Priority Process: Decision Support

--- VIRTUAL---

--- ON-SITE ---

Epic is being used throughout SHN at all three sites. Staff and managers report satisfaction with the program. There is a process to monitor and evaluate the record keeping processes used, and to evaluate the use of privacy and the use of the medical records.

Priority Process: Impact on Outcomes

--- VIRTUAL---

--- ON-SITE ---

The clinical practice leaders from each area select the evidence-based guidelines that are utilized. There are ethical research practices in place that guide when to seek approvals. Risk situations are identified by patients and families and dealt with to ensure safety.

Surge plans are in place which encompass every unit in the building (at each site) to ensure the ability to deal with times of overcapacity.

Client safety is monitored at all times and reported to the quality group for further analysis. Should a negative situation occur, a policy on disclosure is in place.

Standards Set: Medication Management (For Surveys in 2021) - 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

--- VIRTUAL---

--- ON-SITE ---

Medication management was completed at the Centenary site

The pharmacy department was very impressive with excellent lighting, space and up to date current equipment to complete bar coding on all medications which added to the safety features of the administrative process at the bed side. Epic is utilized throughout the organization for the EMR and is extremely complete with multiple checks and balances to ensure safety. The team of pharmacists and pharmacy assistants maintained a very effective, clean workspace within the pharmacy and must be commended for the efficiency observed during the visit. There was a specialty negative pressure area for the preparation of oncology medication for their oncology program. The pharmacy program was standardized in all sites.

Very few medication errors were recorded but all are reported including any near miss situations and the committee analyzes all for opportunities for improvement. Quality boards with indicator results are visible and quality initiatives are posted on the boards and discussed at huddles.

There is a very active Antimicrobial Stewardship Program with strong membership from all disciplines - very well done.

Physician order sets have been standardized across all seven Epic hospitals in the Central East LHIN area and a process is in place to review and alter them, if necessary, in a standardized fashion. High alert medications are handled in the same manner at all sites, which is very commendable.

Processes are in place and standardized for the safety of all controlled substances within the system.

The Interdisciplinary Committee reviews the hospital formulary regularly and ensures it is appropriate to the current needs of the patient population.

All staff receive education on the medication administration process at the time of hire and during their departmental orientation. Identification processes are completed during this time frame for newly hired staff by the educational team and all staff felt they were well educated for the use of the system.

The Epic system received positive reviews from all staff and pharmacy personnel throughout all steps and processes in the Medication Administration system.

Medication information is available to all staff handling the role of medication administration and Pharmacists are available as a resource at all times.

Policies are in place surrounding the use of CPOE (Computerized Physician Order Entry) system and utilized. All aspects of the system are effective.

Heparin concentrations are reduced on the units and mixing is completed by pharmacy to ensure safety. Narcotics are also controlled, and stock supplies are not available on units for added safety.

Pharmacy audits and checks all medication carts on units to ensure only current meds are on carts and those that are out of date are removed.

Infusion SMART pumps are utilized and maintained throughout SHN where needed. Orientation to the operation of these pumps is conducted by the educators and an annual review is conducted and recorded. Directions for operation are also available to all staff.

Acceptable abbreviations are identified and listed and available to all medication administration areas.

Concentrated electrolyte solutions are monitored and not allowed on the clinical areas to ensure patient safety.

The pharmacy program and department are commendable and extremely effective and efficient.

Medication Management validation completed at Birchmount site, 3rd floor and ICU

The Pharmacy at this site could benefit from increased lighting and is less spacious thus causing some clutter in the department. Adding a window in the narcotic room in the pharmacy department may be considered for safety reasons. Bar coding is a wonderful addition to optimize patient safety and mitigating strategies such as audits. Errors are discovered and information is shared with front line staff.

Validation of Medication Management was conducted in ICU at Scarborough General and 9th floor Scarborough General.

The team was very proud of their system and equipment, and it certainly met all needs. Space was limited slightly but equipment was well laid out producing good workflow and ease of work. Pyxis machines are

in place in each area at the General site and easily accessible to staff. Placement of medicine rooms is well thought out to support the work areas and type of patients located in the area. Well organized and well laid out.

The nineth floor General site medication room is small but due to the lay out of the unit is in the best location possible. Equipment meets the needs of staff and patients and is restocked daily by Pharmacy.

Medication Administration is conducted and observed by staff in the unit. Medication is crushed and added to applesauce for the patient. Medication is checked and validated using Epic. There are reminders of two-person identification, and it is completed.

Overall, an excellent system throughout all three sites with several safeguards built in.

Standards Set: Mental Health Services - Direct Service Provision

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

--- VIRTUAL---

--- ON-SITE ---

Clinical Leadership is very strong in the programs at Centenary and Birchmount with excellent engagement between the psychiatrist and clinical leadership of the units. Rounds are conducted with all staff and disciplines that review all patients every day which facilitates treatment and patient flow. This process assists in ensuring well planned treatment and discharge planning. The process is exceptional and with the community supports available to assists in reducing the readmissions. The Pathways program with Ontario Shores, CAMH and Durham Region is a commendable endeavour which truly supports the quality of life of the patients. It is suggested that the organization put this forward as a Leading Practice.

The partnerships with community partners that support the patients is exceptional and well planned.

The psychiatric program at Scarborough Health Network is well thought out, well planned out and truly is exceptional in all aspects.

Many plans are in place to increase partnerships -in the community to assist in avoiding re-admission, as

well as better quality of life and ongoing effective treatment. The partnership which will evolve with the University of Toronto at Scarborough will be an effective step into the future for SHN and will truly raise the profile of the department and units.

Congratulations!!!

Priority Process: Competency

--- VIRTUAL---

--- ON-SITE ---

Education and mentorship are available to staff as well as an onsite Clinical Practice Leader which is excellent. Staff indicate they are extremely happy to be part of the programs and feel well supported by leadership and credentialed staff. All staff interviewed were positive regarding the program and had been in the program for extended periods of time and were not planning to leave or retire. Students of all levels and disciplines are welcomed and supported at both sites which assists in the recruitment of future staff for the programs. The educators ensure all staff receive training and certification regarding infusion pumps, seclusion and the use of restraints. Education is intended to provide them with knowledge and skills should they be required to deal with off service admissions in times of surge - this is commendable.

The patients interviewed feel well cared for and safe within both sites and speak highly of the staff for their professional and respectful treatment.

The units are psychiatrist led with the psychiatrist being the MRP (most responsible physician) which maintains continuity of care while the patients are inpatients.

The use of Epic supports the thorough assessment of the client and ensures the flow of accurate communication regarding the patients. Quality improvement is evident on the units and is demonstrated on the huddle boards with indicator results as well as quality initiatives. Staff can speak easily regarding the quality work that is being accomplished on the units and are proud of what they accomplish. An excellent collaborative relationship is evident between the staff and psychiatrist and both parties are complementary of the other when speaking about their programs. They speak openly regarding the PFAC relationship on their units and how well this works to support the patient through their journey.

Evaluation of the program and staff is a continuous process with specific indicators being monitored and evaluated to ensure positive outcomes are achieved.

This is a truly dynamic program with excellent strategies to implement in the future to enhance the program and ensure more positive outcomes for all.

Priority Process: Episode of Care

--- VIRTUAL---

--- ON-SITE ---

The Child and Adolescent Program at Centenary is bright, well lit, and open, providing a safe and effective environment for this population. The Inpatient unit at Centenary is well laid out, safe and comfortable. The units at Birchmount although aging are spacious, comfortable and safe.

The MRP being the psychiatrist, provides prompt and 24-hour care, with few barriers to care and or admission as needed. The team identify that they feel the patients are better being treated on the units in a prompt fashion than to remain in the ER so thus responds to calls in a quick and efficient manner. The team has strong relationships with Ontario Shores and CAMH and can seek out their support if required to assist in the care and treatment of a difficult patient.

Whenever possible, patient families are encouraged to be involved in the care and planning for the patient. The patient's wishes regarding family involved are always considered and adhered to by the team.

Legislation is supported should the patient/family refuse specifics of care and alternative options are offered as necessary.

Priority Process: Decision Support

--- VIRTUAL---

--- ON-SITE ---

Addition of the EMR (Electronic Medical Record), Epic has been very positive with patient files being extremely complete. All assessments are in place, completed as per policy, and extremely well done and comprehensive. Policies are in place for retention, storage and destruction of the records. Staff receive training in privacy and confidentiality and policies are in place to support this.

Priority Process: Impact on Outcomes

--- VIRTUAL---

--- ON-SITE ---

Centenary site: Adult Psychiatry

This is a strong program with excellent leadership and extremely engaged psychiatrists. Risk assessments of the unit have been conducted to determine any areas of risk that might affect the patient and or staff.

All incidents are reported and tracked, based on the policy, and management is able to track and analyze the incidents.

Quality improvement initiatives are conducted by the team based on indicators collected and posted to the huddle boards on the units for discussion and observation.

Centenary site: Pediatric Psychiatry

Census of up to seven patients - six is actual but can surge to seven. Psychiatrists engage in the program extensively.

Crisis workers can provide crisis intervention to children and adults in the ER at both the Centenary and Birchmount sites. Very impressive program and staff.

Average length of stay for the Paediatric Psychiatry department is approximately four to five days with the patient and family usually being linked to a variety of community programs and resources.

Birchmount Adult:

The same management and psychiatrists operate in this program. Staff and psychiatrists are all extremely engaged in the program with a great desire to always improve. Quality huddle boards are posted, and indicator data and initiatives are visible on these boards.

Although the units are older and repurposed, they are clean and neat.

Photographs are obtained of patients who will give permission in place of a patient armband which is not lasting.

Overall plans in place to co-ordinate psychiatric services will be at the new Birchmount site. Patients will be admitted to all ER sites and transported to this site if the decision to admit occurs.

A 25,000 square foot area will be secured and revamped to host psychiatric services for outpatient services. Very commendable initiative.

The team indicated that PFAs were involved in both of these initiatives and made several positive suggestions. The multiple positive program suggestions are commendable and will also be very effective and forward thinking. The plans are excellent for the future programs and with links to such places as Ontario Shores, CAMH, and Durham Mental Health Services, this program with become a Pathway to Ontario Shores.

Standards Set: Obstetrics Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

--- VIRTUAL---

--- ON-SITE ---

During the early waves of the COVID-19 pandemic, the decision was made to consolidate Obstetrical Services at the Centenary and General sites. Both sites were assessed during this survey.

The obstetrical department has very strong administrative and clinical leadership that supports the team in demonstrating excellence in care delivery with a focus on quality and patient safety. The engagement and commitment of the director, managers, clinical practice leaders and physician leaders in supporting mothers, babies and families were evident in the way they support their teams from a patient care perspective and a staff wellness perspective.

The patients and families come from a diverse community and the individual cultural needs of patients is embraced by the team. There is a Patient Family Advisor who is well integrated into the team and her input is valued and respected. She is often consulted by the team and led the development of the Welcome to NICU booklet for families.

Priority Process: Competency

--- VIRTUAL---

--- ON-SITE ---

All new staff are offered comprehensive orientations, supported by the Clinical Practice Leaders. The staff commented on feeling supported in their learning both as new staff and for ongoing professional development.

All the interdisciplinary teams surveyed were highly motivated and engaged in their work, in quality and patient safety, and in supporting their community.

Competencies are updated through the iLearn system and tracked by the CPLs and managers. Staff will receive an email notification when they are due for a competency update. Staff spoke of feeling well supported in their practice and have training and education when new equipment is introduced, or when new care processes are developed.

The MORE OB program has provided opportunities for ongoing education that is consistent, based on best practice guidelines for managing risk, and creating a culture of patient safety.

The birthing unit identified a need with respect to the hiring of new nurses and the skill mix level on the unit so created a mentor nurse role. This role has been integral in supporting the team to ensure new and existing staff are successful in providing high quality care to families.

There is a commitment to staff safety and wellness, with education provided on workplace violence prevention and de-escalation. SHN has a commitment to staff wellness, and this is evident in the resilience of the teams through the pandemic.

Performance appraisals have been replaced by VIP (valuing individual performance) chats and most staff reported having had a VIP chat within the last year.

Priority Process: Episode of Care

--- VIRTUAL---

--- ON-SITE ---

The staff in the birthing unit and NICU are very committed to safe, quality care for mothers, babies and families. They actively engage in team huddles where they could celebrate their work and review opportunities for continuous quality improvement.

The quality board has several key performance indicators that are regularly reviewed and opportunities

for quality improvement explored.

There are good protocols for emergency care requirements as evidenced by the quick response to emergency c-section requirements for two labouring mothers.

The team actively promotes skin to skin and breast feeding for mothers/babies and has developed a Best Feeding app to help support breast feeding mothers after discharge. A Maternal Fetal Triage tool has been developed as well as an oxytocin safety checklist as part of continuous quality improvement.

The team uses an online patient safety reporting system to report and review patient safety issues and near misses. Patient and family disclosure and interdisciplinary quality reviews are done for serious reportable events.

The MORE OB program has provided opportunities for ongoing education that is consistent, based on best practice guidelines for managing risk, and creating a culture of patient safety. The team has set unit priorities using the MORE OB program that include high risk care planning and harmonizing across organizations. The team is using simulation as part of their ongoing education. It may be beneficial to include the PFA in these exercises to provide the patient perspective.

There have been some challenges with the new Epic documentation system for areas such as the Birthing Unit Operating Room where several nurses are assigned to one mother and baby pair.

The team is encouraged to do a review on the four moments of hand hygiene as there were some inconsistent practices observed, despite the high compliance reported on the hand hygiene audits.

Priority Process: Decision Support

--- VIRTUAL---

--- ON-SITE ---

With the introduction of Epic, patient information is accurate, up to date, and standardized so a consistent approach to patient information is used across all areas.

Patients have access to the Best Feeding app to help support ongoing breast-feeding following discharge from hospital.

Patients have access to their health information through MyChart. Although this feature isn't well used by patients at this time, there is tremendous opportunity in promoting this to patients and families in the future.

Priority Process: Impact on Outcomes

--- VIRTUAL---

--- ON-SITE ---

Both the Birthing Units and NICUs have huddle boards where key performance indicators are shared and discussed during team huddles. The KPIs are tracked and strategies for quality improvement are identified by the team.

Standardized policies and procedures ensure safe, consistent care across the sites. A focus on breast feeding, skin to skin, and measuring these outcomes is a priority for the team.

The physical infrastructure in the Birthing Unit Operating Rooms is challenging with respect to the layout. A second OR was added following a quality review. The new OR is located very close to the door that opens into the birthing unit, making privacy a challenge. Both ORs open into a non-sterile corridor with the PACU bays in the same area.

Sterile and dirty instruments enter and exit the OR through the same pathway. Utilizing covered, enclosed case carts would assist with managing the infrastructure challenges.

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

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

--- VIRTUAL---

--- ON-SITE ---

The Perioperative on-site survey included the Day Surgery Operating Room, PACU and the Surgical inpatient areas at all three hospitals.

Collectively, there are strong and engaged clinical leaders who are respected by their staff and report feeling supported in their professional development. Service-specific goals and objectives are seen for all the areas of the perioperative services.

SHN collects and uses health care data which drives planning for surgical care throughout the surgical program. Centres of excellence or specialty care in each of the hospitals have been developed to help

standardize and improve outcomes.

There are 23 operating rooms throughout SHN: four at Birchmount and two eye rooms, eight at the General, and seven at Centenary.

There are approximately 110 surgeons and 50 anesthesiologists across SHN. The Chief of Surgery and the Chief of Anesthesiology has oversight for all three sites. Each surgical division has a Medical Lead that is responsible for Educational Rounds, M&M (morbidity and mortality) rounds and conducting performance appraisals on their members.

Of note, the Surgical Program continued to function during COVID-19, on a priority basis. The model of care for Total Joint was revamped so that the vast majority of cases were being done as same day surgeries; this continues today. Extensive education and information are provided to those patients that are deemed appropriate for the same day procedure.

Priority Process: Competency

--- VIRTUAL---

--- ON-SITE ---

All team members are required to complete the organizational core curriculum annually, and compliance is tracked. Additional training and education are provided as necessary, such as to work in the operating room or PACU (post-anesthesia care unit). Ethics training is provided, and staff spoken with during the on-site survey knew how to access the service and were able to provide examples of their personal involvement in ethical decision making at work. Infusion pump training is provided and tracked for nursing staff.

VIP Chats are the method of performance appraisals at SHN and are conducted on a regular basis for the Surgical Program.

The program has a Clinical Practice Leader who is very much a part of the day-to-day operations of the perioperative program and provides good support to the staff's learning needs and ongoing education.

Despite difficulty in recruitment of health human resources for the Surgical Program, SHN has been successful in ramping up beyond 100 percent to address the surgical backlog that accrued during COVID-19 through robust surgical backlog management. There is weekly review of waitlist and wait times through SHN's enterprise analytics system called the Power Business Intelligence Tool, including oversight on case prioritization and elective bookings.

Priority Process: Episode of Care

--- VIRTUAL---

--- ON-SITE ---

The surgical tracers were observed at all three SHN hospitals. The entire process from preop to anesthetic assessment, to the surgical checklist and pause, and eventual return to the recovery room followed the same high standards. The involvement and support of family was noted. Each staff member knew their job and completed it in a very professional way. The patient's family felt very reassured and comforted by the whole procedure.

There are some challenges with use of physical space, especially in the main corridor between the main ORs. Once in the operating area all aspects of the patient experience meet or exceed required standards. There is good communication amongst the staff and the patient is certainly the priority. The team works well in the operating room to reduce risk and harm to the patient. Great care is taken with positioning and monitoring. There are good processes for shaving, prepping the skin, draping the patient, collecting and labelling specimens.

Transfer of Accountability (TOA) is done very well at SHN. The anesthetic hand over in the recovery room is clearly verbalized by the anesthetists to the PACU staff. The anesthetist remains until the patient is safely breathing and allows the PACU staff to extubate if defined criteria are met. Epic allows for just-in-time data capture regarding completion of TOA interventions screens. Incidents that occur due to TOA are reflected in S.A.F.E.T.Y. reports. The patient and family surveys done post discharge evaluate whether they received all necessary information at care transitions. Quality checks are used on units to audit compliance with TOA documentation and handover.

The Surgical Safety Checklist (SSCL) was most impressive when assessed during the on-site tracer. It was used by the entire surgical team at three key points: i. Briefing – before the induction of anesthesia, ii. Time out – before skin incision, and iii. Debriefing – before the patient leaves the operating room. The team has diligently worked on the implementation of best practices for the SSCL. This has been a remarkable undertaking with collaborative and focused work. There is buy-in across locations and team members. Daily audits are completed in each clinical area and results are shared with clinical leads (manager/CPL) on a weekly basis and reported on quality huddle boards. Noncompliance to the SSCL process is escalated to respective divisional leads with the expectation that practice concerns are addressed.

At the Eye Centre at the Birchmount site, the team has demonstrated innovation in response to an anesthesia shortage. Registered nurses have been trained to deliver procedural sedation in the eye procedural rooms with oversight from an anesthetist that can rove between suites. This allows for skill task alignment to optimize human resources through team-based care.

The team actively works to identify and overcome barriers to access services and monitors their wait list and wait times. The team prides themselves on avoiding cancellation of surgery whenever possible and

have developed overflow strategies to accommodate incoming surgical patients. Documentation of consent was complete, and patients acknowledge a robust consenting process with their physicians.

Patients are provided with verbal and written information before admission and at discharge. There is a process in place to ensure that consultations and investigations done preoperatively are available to the team on the day of surgery. Medication reconciliation is conducted across transitions and charts reviewed during the on-site review were complete in that regard.

All furniture in the waiting room areas in wipeable and in good condition. The OR is encouraged to consider putting dashboard monitors in all the waiting room so families can view what stage of the operation their loved one is at, whether in Day Surgery, OR, or PACU. This will keep the family informed and engaged in care.

Overall, good solid work is done here.

Priority Process: Decision Support

--- VIRTUAL---

--- ON-SITE ---

The new Epic HIS (Hospital Information System) has dramatically improved and streamlined the collection and processing of patient health information. Information about patients is readily available to all professionals involved in patient care.

Standardized health information is collected on each patient at appropriate points along their journey through perioperative services. The information is captured in paper, electronic, and digital formats, and is available to team members as necessary to provide optimal clinical care. Patients are able to access their medical record if desired.

There is easy flow of information and patients from the preop area to the day and same day surgery areas, to the OR and eventually home or to the inpatient area. Documentation flows easily and the patient has a clear sense of what is next and who will look after them. Some patients who are under diagnosis have specific clinical pathways, and this results in a formal plan of action that supports the patient and relevant care givers such as physiotherapy and expected date of discharge. This information is clearly shared with the patient via a white board in each patient's room.

Priority Process: Impact on Outcomes

--- VIRTUAL---

--- ON-SITE ---

Evidence-informed clinical care pathways exist for most procedures to standardize care and improve outcomes. SHN is encouraged to continue to develop pathways and order sets for common procedures/diagnoses to further reduce unnecessary variation in service delivery. Staff are familiar with

the incident reporting system and feel safe reporting incidents to improve quality and safety. Results are regularly shared with the team.

The expansion of same-day joint replacement surgeries for hips and knees is an advancement that has simultaneously created inpatient capacity while shortening surgical waitlists. The teams are to be commended for their work on this initiative. Impressively, roughly 70 percent of these joint replacements occur as day surgeries. The goal is to achieve 80 percent.

In this time of scarce resources (staff, time, and everything else), discovering innovative ways to provide quality services that require less resources, is an immense benefit to organizations. The endoscopy team at the Birchmount site are piloting a virtual type of procedure where a patient ingests a pill, wears a monitor for 24 hours, and has all areas of their GI tract visualized in real time. This is commendable!

Priority Process: Medication Management

--- VIRTUAL---

--- ON-SITE ---

The anesthetists go to the automated medicine cabinets and sign out their own medications for their cases.

The anesthetic carts are standardized. Outdated medications are monitored, and anesthetic carts are stocked by the OR staff.

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

--- VIRTUAL---

--- ON-SITE ---

Point of Care testing was assessed during Accreditation Canada's lab survey in May 2022.

SHN is commended for its commitment to ensuring service excellence in Point of Care testing (POCT). The Laboratory Medicine Program has a well-established quality management system and has worked hard to ensure quality assurance for POCT in clinical areas is maintained. There is an onboarding process for new staff learning POCT and ongoing yearly recertification for all staff which is 99 percent automated with an annual auto expiry which prompts staff to recertify. If the staff do not maintain the standards, they are de-certified to use POCT until they are up to date. A qualified Lab Manager provides oversight, and a policy is in place which defines roles and responsibilities for POCT. An interdisciplinary committee oversees the scope of service and delivery of point of care testing and the committee reviews quality data annually, making improvements as necessary.

Electronic versions of Standard Operating Procedures (SOPs), updated annually, are readily available to staff responsible for point of care testing, and staff are trained on SOPs through online learning as well as annual recertification. Staff must demonstrate competence as part of their recertification process, and this is documented.

Standards Set: Rehabilitation Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

--- VIRTUAL---

--- ON-SITE ---

Leadership teams from the Restorative Care Unit, Short Term Rehab Unit and the Integrated Stroke Unit participated in this review. These are high functioning programs that are supportive of the mission, vision and values of the organization and evidenced through quality patient care delivery.

Clinical leadership throughout these areas is very strong, with Managers, Directors, Physician Leaders, and Clinical Practices Leaders actively engaged in continuous quality improvement.

The team actively engages their patients and families as partners in care and work closely with many external partners to ensure patients are connected to appropriate resources on discharge.

Priority Process: Competency

--- VIRTUAL---

--- ON-SITE ---

All new members of the three rehabilitation teams receive an orientation that is overseen by the Clinical Practice Leaders. Ongoing annual competencies are completed using the iLearn system and tracked by the Managers and CPLs, including infusion pump safety. Staff feel supported in the ongoing professional development.

Staff have received education on workplace violence prevention and de-escalation.

Annual performance appraisals have been replaced by VIP chats to provide feedback on employee performance and identify opportunities for growth. VIP chats are reported to be up to date for most employees and confirmed by the staff on the units. Staff are recognized for their contributions and feel supported in their ongoing professional development. Several Registered Practical Nursing staff said they felt very supported in recently completing their BScN, acknowledging support from both their manager and their colleagues.

Priority Process: Episode of Care

--- VIRTUAL---

--- ON-SITE ---

The staff in the Rehabilitation Program are engaged, compassionate and knowledgeable in the care of their patient populations. They were extremely positive about their job and spoke of being a family.

Patients and families spoke very positively about their experience with the care provided in all three areas. They spoke of the fabulous team, all caring and compassionate, and credited the staff with helping them recover and reach their goals. The Integrated Stroke Unit has a wall of patient feedback, with countless messages of thanks from patients and families.

Evidence is being used to inform care design in all areas as evidenced by the establishment of the single site Integrated Stroke Unit and the relocation of Short-term Rehabilitation to the 5th floor, opposite the Orthopedic Unit.

The Restorative Care Unit uses best practice guidelines from the rehab alliance, the senior friendly care guidelines, and frailty guidelines, and when conflicts in evidence arise, will access Cochrane reviews for further evidence. Using best practice guidelines from these resources, the team has successfully reduced indwelling catheter rates by 50 percent and delirium by 42 percent.

Key performance indicators have been identified for the rehab teams and are reported through the quality teams but also on the unit quality boards and reviewed during team huddles. The huddles boards are used to identify and facilitate quality improvement activities.

There are numerous partnerships that support the rehab teams, both internally and external to the network. The partnership the Restorative Care Team has established with the Slaight Community Reintegration Initiative is an excellent example of the way that community partnerships work to support patients and families after discharge.

The integrated stroke unit has provided an excellent new space for patients and families. The design which includes informative and educational walls along with the gym space and activities of independent daily living demonstrates a focus on patients and families in the design.

Priority Process: Decision Support

--- VIRTUAL---

--- ON-SITE ---

The implementation of Epic has provided great opportunity for standardization of assessments and documentation, standardizing the health information collected, and ensuring a complete record for all patients.

The team has key performance indicators that they monitor and report on. These are posted on the huddle boards on each unit.

Chart audits are performed using the Epic documentation system and compliance with Required Organization Practices are monitored.

A focused effort on increasing the patient and family utilization of MyChart would improve and strengthen the families' involvement in care planning and goals.

Priority Process: Impact on Outcomes

--- VIRTUAL---

--- ON-SITE ---

The teams monitor many key performance indicators, including hand hygiene, pressure injury, falls, readmission rates, and many more. They report these results on their quality boards. The staff report patient safety incidents electronically, the reports are reviewed, and recommendations are shared with the teams.

The restorative care unit utilizes best practice guidelines from the rehabilitation alliance, the senior friendly care guidelines, and frailty guidelines, and when conflicts in evidence arise, will access Cochrane reviews for further evidence. Using best practice guidelines from these resources, the team has successfully reduced indwelling catheter rates by 50 percent and delirium by 42 percent.

Standards Set: Transfusion Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Episode of Care

--- VIRTUAL---

--- ON-SITE ---

Universal fall precautions are in place and assessed during Lab Accreditation.

Priority Process: Transfusion Services

--- VIRTUAL---

--- ON-SITE ---

The Lab is currently accredited by Accreditation Canada (previously IQMH), assessed in May 2022 and therefore, a limited number of criteriawere evaluated during the on-site survey. All three of the SHN labs underwent the Lab Accreditation and achieved great success, with no major unmet criterion.

Transfusion Medicine services supports the conservation of blood products through regular monitoring and management of their blood products. The team reviews monthly utilization data and uses the results to make improvements in their service provision. The Transfusion Medicine Team works closely with Canadian Blood Services in the management and the tracking of blood products.

An interdisciplinary Transfusion Committee supports transfusion practices and activities within SHN including the development and review of policies and procedures, review of adverse events, as well as education and training. A massive hemorrhage protocol was rolled out this year.

Consent is obtained for transfusion of blood and blood products and is carried out as per organizational policies and procedures. There is a policy in place for management of transfusion related adverse events. A letter is provided to patients notifying them that they have received blood and/or blood products.

Nursing staff are well educated on the procedure for administering blood and/or blood products to patients within the patient care areas.

SHN is supportive of the Choosing Wisely Canada utilization management campaign and monitors indicators across all three sites as it relates to appropriateness of blood usage. In addition, Ontario Nurse Transfusion Coordinators (ONTraC) identify patients at risk of transfusion ahead of surgery in order to allow for the detection and correction of anemia and the development of an appropriate patient blood management plan.

Good solid work is done here.

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: July 20, 2022 to September 8, 2022**
- **Number of responses: 11**

Governance Functioning Tool Results

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1. We regularly review and ensure compliance with applicable laws, legislation, and regulations.	0	9	91	93
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	0	0	100	94
3. Subcommittees need better defined roles and responsibilities.	64	9	27	69
4. As a governing body, we do not become directly involved in management issues.	0	0	100	85
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	9	0	91	94

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
6. Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	97
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	0	100	93
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	9	0	91	95
9. Our governance processes need to better ensure that everyone participates in decision making.	64	18	18	63
10. The composition of our governing body contributes to strong governance and leadership performance.	0	0	100	94
11. Individual members ask for and listen to one another's ideas and input.	0	0	100	96
12. Our ongoing education and professional development is encouraged.	9	9	82	82
13. Working relationships among individual members are positive.	0	0	100	96
14. We have a process to set bylaws and corporate policies.	0	9	91	96
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	98
16. We benchmark our performance against other similar organizations and/or national standards.	9	9	82	76
17. Contributions of individual members are reviewed regularly.	18	18	64	63
18. As a team, we regularly review how we function together and how our governance processes could be improved.	9	27	64	79
19. There is a process for improving individual effectiveness when non-performance is an issue.	10	10	80	57

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	9	0	91	79
21. As individual members, we need better feedback about our contribution to the governing body.	9	36	55	40
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	9	9	82	76
23. As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	96
24. As a governing body, we hear stories about clients who experienced harm during care.	0	0	100	74
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	0	9	91	87
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	0	0	100	90
27. We lack explicit criteria to recruit and select new members.	91	0	9	79
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	9	0	91	90
29. The composition of our governing body allows us to meet stakeholder and community needs.	0	0	100	89
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	94
31. We review our own structure, including size and subcommittee structure.	0	0	100	90
32. We have a process to elect or appoint our chair.	0	27	73	93

Overall, what is your assessment of the governing body's impact over the past 12 months, in terms of driving improvements to:	% Poor / Fair	% Good	% Very Good / Excellent	%Agree * Canadian Average
	Organization	Organization	Organization	
33. Patient safety	0	18	82	82
34. Quality of care	9	18	73	83

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2022 and agreed with the instrument items.

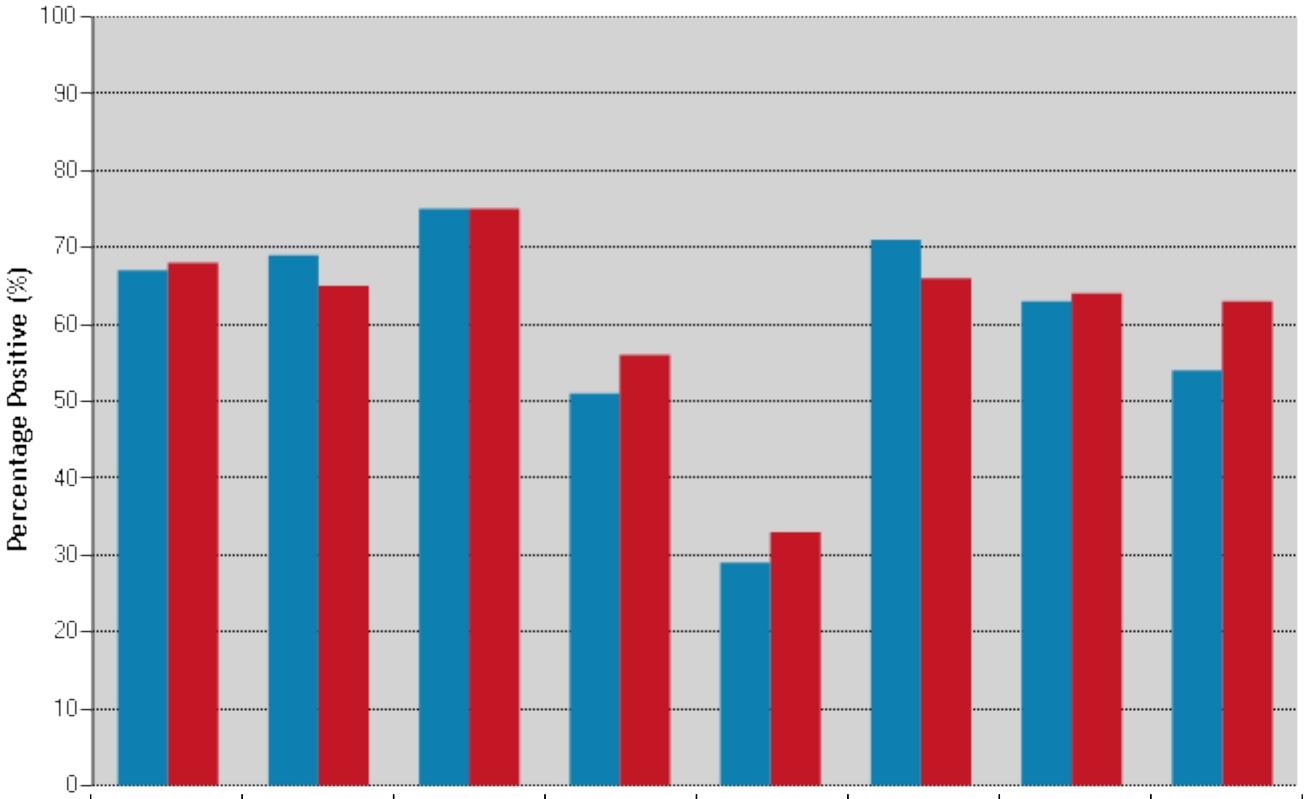
Canadian Patient Safety Culture Survey Tool

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

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

- **Data collection period: June 8, 2021 to July 5, 2021**
- **Minimum responses rate (based on the number of eligible employees): 360**
- **Number of responses: 373**

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
	67%	69%	75%	51%	29%	71%	63%	54%
	68%	65%	75%	56%	33%	66%	64%	63%

Legend

Scarborough Health Network

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2022 and agreed with the instrument items.

Worklife Pulse

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

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

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

Client Experience Tool

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

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

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

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

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

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

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

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

Organization's Commentary

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

Since coming together in 2016, Scarborough Health Network (SHN) has been on a journey like few other hospitals. Our Accreditation Canada survey culminates five years of exceptional care and groundbreaking initiatives — including the launch of a new Strategic Plan, master planning and clinical services planning; implementing our new regional clinical information system; and serving one of the hardest hit communities throughout the COVID-19 pandemic. We are honoured by this 2022 final report, which recognizes SHN for our commitment to quality, safety, and innovation during our first Accreditation as one connected network.

Notably, as part of this year's survey process, we had our first opportunity to engage a Patient Partner who provided many insights on the culture and practice of Patient- and Family-Centred Care (PFCC) within SHN. We were pleased to share how our adoption of PFCC across multiple levels is shaping how we deliver services and the overall patient care experience across our health network.

This report also captures many other successes, including: our incredible resilience throughout the pandemic and our robust management of COVID-19; our expanded team-based model of care; our leadership in the development of the new Scarborough Ontario Health Team (SOHT); our clinical information system (Epic) transformation; our incredibly engaged staff and physician network; our focus on equity, diversity, and inclusion as an integral part of who we are at SHN; and much more.

In addition, the Survey Team has recognized how we are responding to many of the challenges facing our organization, as well as highlighted opportunities for improvement. This includes addressing our aging infrastructure by prioritizing redevelopment projects; finding new ways to ensure better adherence to visitor and patient personal protective equipment (PPE); and meeting the needs of our growing and increasingly diverse and complex patient population by enhancing wayfinding, embedding patients and families more widely within clinical projects/initiatives, and continuing on our journey to become a High Reliability Organization. Our focus remains on shaping the patient experience, resulting in real changes within the lives of people who receive care from our organization.

SHN has learned that by participating in the Accreditation Canada process, we ensure the highest achievable quality care for our patients and their families, and continuous improvement where possible. Now, we look forward to moving to the next Accreditation phase — Qmentum Global. This continuous assessment cycle will help us to further build our unwavering focus on quality, safety, planning, implementing and evaluating improvements into everything that we do.

In this way, SHN will work to ensure ongoing compliance with Accreditation Canada's Standards and Required Organizational Practices (ROPs), advance our mission to improve lives through exceptional care, and continue to take bold steps towards shaping the future of care for our Scarborough community.

Appendix A - Qmentum

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

As part of the Qmentum accreditation process, client organizations complete self-assessment questionnaires, submit performance measure data, and undergo an on-site survey during which trained peer surveyors assess their services against national standards. The surveyor team provides preliminary results to the organization at the end of the on-site survey. Accreditation Canada reviews these results and issues the Accreditation Report within 15 business days.

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

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

Action Planning

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

Appendix B - Priority Processes

Priority processes associated with system-wide standards

Priority Process	Description
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
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

Priority Process	Description
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
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