ACCREDITATION CANADA



Driving Quality Health Services

Accreditation Report

South Huron Hospital Association

Exeter, ON

On-site survey dates: October 28, 2013 - October 31, 2013

Report issued: November 14, 2013

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

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About the Accreditation Report

South Huron Hospital Association (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. As part of this ongoing process of quality improvement, an on-site survey was conducted in October 2013. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

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

Confidentiality

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

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

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

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A Message from Accreditation Canada's President and CEO

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

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

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

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

We look forward to our continued partnership.

Sincerely,

Wendy Nicklin
President and Chief Executive Officer

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Section 1 Executive Summary

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

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

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

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

1.1 Accreditation Decision

South Huron Hospital Association'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.

1.2 About the On-site Survey

- **On-site survey dates: October 28, 2013 to October 31, 2013**

- **Location**

  The following location was assessed during the on-site survey.

  1 South Huron Hospital Association

- **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 Customized Leadership
  2 Governance

  Service Excellence Standards

  3 Reprocessing and Sterilization of Reusable Medical Devices
  4 Emergency Department
  5 Infection Prevention and Control
  6 Biomedical Laboratory Services
  7 Diagnostic Imaging Services
  8 Laboratory and Blood Services
  9 Medicine Services
  10 Blood Bank and Transfusion Services
  11 Customized Managing Medications

- **Instruments**

  The organization administer:

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

1.3 Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
 Population Focus (Working with communities to anticipate and meet needs)	24	0	0	24
 Accessibility (Providing timely and equitable services)	46	0	0	46
 Safety (Keeping people safe)	274	2	14	290
 Worklife (Supporting wellness in the work environment)	63	0	0	63
 Client-centred Services (Putting clients and families first)	60	0	0	60
 Continuity of Services (Experiencing coordinated and seamless services)	19	0	0	19
 Effectiveness (Doing the right thing to achieve the best possible results)	475	8	6	489
 Efficiency (Making the best use of resources)	43	0	0	43
Total	**1004**	**10**	**20**	**1034**

1.4 Overview by Standards

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

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

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

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

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	44 (100.0%)	0 (0.0%)	0	34 (100.0%)	0 (0.0%)	0	78 (100.0%)	0 (0.0%)	0
Customized Leadership	42 (97.7%)	1 (2.3%)	0	13 (100.0%)	0 (0.0%)	0	55 (98.2%)	1 (1.8%)	0
Diagnostic Imaging Services	63 (100.0%)	0 (0.0%)	4	61 (100.0%)	0 (0.0%)	0	124 (100.0%)	0 (0.0%)	4
Infection Prevention and Control	38 (100.0%)	0 (0.0%)	5	39 (100.0%)	0 (0.0%)	1	77 (100.0%)	0 (0.0%)	6
Customized Managing Medications	32 (100.0%)	0 (0.0%)	1	13 (100.0%)	0 (0.0%)	0	45 (100.0%)	0 (0.0%)	1
Biomedical Laboratory Services **	16 (100.0%)	0 (0.0%)	0	36 (100.0%)	0 (0.0%)	0	52 (100.0%)	0 (0.0%)	0
Blood Bank and Transfusion Services **	40 (100.0%)	0 (0.0%)	2	17 (100.0%)	0 (0.0%)	0	57 (100.0%)	0 (0.0%)	2
Emergency Department	30 (96.8%)	1 (3.2%)	0	87 (91.6%)	8 (8.4%)	0	117 (92.9%)	9 (7.1%)	0
Laboratory and Blood Services **	81 (100.0%)	0 (0.0%)	0	95 (100.0%)	0 (0.0%)	0	176 (100.0%)	0 (0.0%)	0
Medicine Services	26 (100.0%)	0 (0.0%)	1	69 (100.0%)	0 (0.0%)	0	95 (100.0%)	0 (0.0%)	1

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Reprocessing and Sterilization of Reusable Medical Devices	37 (100.0%)	0 (0.0%)	3	56 (100.0%)	0 (0.0%)	3	93 (100.0%)	0 (0.0%)	6
Total	**449 (99.6%)**	2 (0.4%)	16	520 (98.5%)	8 (1.5%)	4	969 (99.0%)	10 (1.0%)	20

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

1.5 Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Safety Culture			
Adverse Events Disclosure (Customized Leadership)	Met	3 of 3	0 of 0
Adverse Events Reporting (Customized Leadership)	Met	1 of 1	1 of 1
Client Safety Quarterly Reports (Customized Leadership)	Met	1 of 1	2 of 2
Client Safety Related Prospective Analysis (Customized Leadership)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Communication			
Client And Family Role In Safety (Diagnostic Imaging Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Medicine Services)	Met	2 of 2	0 of 0
Dangerous Abbreviations (Customized Managing Medications)	Met	4 of 4	3 of 3
Information Transfer (Emergency Department)	Met	2 of 2	0 of 0
Information Transfer (Medicine Services)	Met	2 of 2	0 of 0
Medication Reconciliation As An Organizational Priority (Customized Leadership)	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 Admission (Emergency Department)	Met	4 of 4	1 of 1
Medication Reconciliation At Admission (Medicine Services)	Met	4 of 4	1 of 1
Medication Reconciliation at Transfer or Discharge (Emergency Department)	Met	4 of 4	1 of 1
Medication Reconciliation at Transfer or Discharge (Medicine Services)	Met	4 of 4	1 of 1
Two Client Identifiers (Customized Managing Medications)	Met	1 of 1	0 of 0
Two Client Identifiers (Diagnostic Imaging Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Emergency Department)	Met	1 of 1	0 of 0
Two Client Identifiers (Medicine Services)	Met	1 of 1	0 of 0
Patient Safety Goal Area: Medication Use			
Concentrated Electrolytes (Customized Managing Medications)	Met	1 of 1	0 of 0
Heparin Safety (Customized Managing Medications)	Met	4 of 4	0 of 0
Infusion Pumps Training (Emergency Department)	Met	1 of 1	0 of 0
Infusion Pumps Training (Medicine Services)	Met	1 of 1	0 of 0
Narcotics Safety (Customized Managing Medications)	Met	3 of 3	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Worklife/Workforce			
Client Safety Plan (Customized Leadership)	Met	2 of 2	2 of 2
Client Safety: Education And Training (Customized Leadership)	Met	1 of 1	0 of 0
Preventive Maintenance Program (Customized Leadership)	Met	3 of 3	1 of 1
Workplace Violence Prevention (Customized Leadership)	Met	5 of 5	3 of 3
Patient Safety Goal Area: Infection Control			
Hand Hygiene Audit (Infection Prevention and Control)	Met	1 of 1	2 of 2
Hand Hygiene Education And Training (Infection Prevention and Control)	Met	2 of 2	0 of 0
Infection Rates (Infection Prevention and Control)	Met	1 of 1	3 of 3
Sterilization Processes (Infection Prevention and Control)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Falls Prevention			
Falls Prevention Strategy (Diagnostic Imaging Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Medicine Services)	Met	3 of 3	2 of 2
Patient Safety Goal Area: Risk Assessment			
Pressure Ulcer Prevention (Medicine Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Medicine Services)	Met	3 of 3	2 of 2

1.6 Summary of Surveyor Team Observations

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

The organization, South Huron Hospital Association (SHHA) is commended on preparing for and participating in the Qmentum program. The dedication, commitment and enthusiasm of the board members is palpable. Board members are well versed in their fiduciary roles and responsibilities regarding quality, patient safety, risk management as well as the financial health of the organization. Replacement of board members takes into consideration a skills matrix in the recruitment and selection of new board members. There is a strategic plan in place for 2011 to 2014. The board is preparing to undertake a new strategic planning process for 2014 to 2017, which will involve broad consultation with the community, the Local Health Integrated Network (LHIN), staff members and physicians.

In March 2012, a Memorandum of Understanding (MOU) was signed between the South Huron Hospital Association (SHHA) and the Grand Bend Area Community Health Care Centre (GBACHC) boards of directors. This innovative model demonstrates how community health partners can work together to expand and improve services to the patient/client. Some of the benefits of this relationship include the shared positions of the executive director/chief executive officer, the director of human resources, director of ambulatory services, and the community health engagement worker and diabetes administrative support. The integration of the two organizations has also allowed for improved patient support in the home, as well as access to wellness programs and allied health services that would not otherwise be available.

The leadership team is strong and well-positioned to meet future challenges that will no doubt present. The leadership team has identified some of their key challenges for the future as aging infrastructure of the hospital, aging information technology and equipment as well as an inability to potentially fill staff position vacancies. The development of a succession plan with a talent management component is just being initiated. In addition, the prioritization of technologies and equipment requests as part of the capital planning process will assist the Foundation in proactively targeting its community fundraising activities.

Approximately three years ago, the current chief of staff realigned the management of physician services and introduced fair scheduling practices. This has proven most beneficial in ensuring the consistency of emergency coverage the SHHA now enjoys. While other hospitals in the region can struggle with emergency physician coverage, this is not an issue for this organization since the redesign. The SHHA is congratulated also for the consistently low number of incomplete health records. In the second quarter of this year there is only one incomplete chart at the end of 30 days. Compliance regarding chart completion is monitored closely by the health records department and the medical advisory committee.

The organization's website is an excellent source of information for the community and staff. The strategic plan is posted online as well as updates on the achievement of the plan goals and objectives. The website has a video entitled: "Think Rural", which is a tribute to physicians that choose to practice in a rural setting. The video is an excellent recruitment tool as is the welcoming learning environment provided to medical and nursing students alike. There are plans to refresh the website as it is a key component of the organization's communication plan. An evaluation of the communication plan and related strategies like email, newsletters, website, and media releases would prove beneficial in order to assess what mode(s) of communication are most meaningful to the community and staff.

The community partners have high praise for the organization's ongoing commitment to bring the mission and the values of the SHHA to life on a daily basis. During the on-site survey, the organization was cited for its consistent collaborative spirit and willingness to develop meaningful partnerships in support of the mission.

Responsive communication that is always done in a respectful manner was also highlighted. Those partners that regularly interface with the hospital appreciate that they are made to feel a part of the team and that there is no 'us or them' mentality. They appreciate being invited to participate on various committees and in the education and training programs that are made available to SHHA staff. Overall, there is a sense that SHHA is an organization that is always moving forward thinking strategically and 'out of the box'. The organizational opportunities that were highlighted included continuation of the commitment to grow more linkages and partnerships, to enhance support for the frail elderly and their quality of life when in hospital for long periods, to tapping into the wisdom of community experts in the development of policies/procedures related to infection prevention and control, and to provision of a dedicated space for the Foundation office.

There are numerous recognition programs offered during the year for physicians and staff. Everything from service recognition pins to barbecues are hosted to show support and appreciation for the work that they do. As well, staff members and physicians are recognized by way of positive feedback on patient satisfaction surveys and thank-you cards. There is a strong volunteer program that has been revised in 2011. In addition, there are education sessions offered during the year for all staff. Performance appraisals are routinely done with staff members having an opportunity for self-evaluation and identification of their developmental goals. Leadership rounding has recently been introduced and is now done on a routine basis. The rounding process has further enhanced the visibility and accessibility of the leadership team.

In recent months the hospital occupancy rate has often been greater than 95 percent. It is felt the pressure for beds is due in part to an aging population with multiple co-morbidities as well as a growing number of patients that are considered alternate level care (ALC) and awaiting placement. The SHHA has initiated a number of strategies to facilitate patient flow. The introduction of daily bullet rounds and white boards are examples of strategies the organization has employed to facilitate communication between members of the multidisciplinary team. There is an opportunity for the leadership team, in consultation with the medical advisory committee to identify meaningful performance indicators that will assist the SHHA to focus its energies on issues related to effective and efficient utilization of resources. Turnaround times for both the laboratory and the diagnostic imaging reports are good.

There is a well-defined quality and patient safety plan in place. Hand-hygiene compliance, patient falls, near miss reporting and readmission rates are areas of focus for the organization. In October 2012 the team has completed a patient safety needs assessment, with 52 potential safety needs identified. The findings and recommendations have been discussed with the board and approval has been given to implement the priority items. There are excellent processes in place relative to quality, patient safety and risk management. The team is encouraged to consider ways to further coordinate the good work that is already being done. The development and implementation of a comprehensive and integrated quality, utilization and risk management program/framework is a way to clearly demonstrate the inter-connectedness of quality, risk and utilization.

Client satisfaction in the emergency department (ED) has ranged from 72 to 81 percent in the past fiscal year. The inpatient satisfaction has ranged from 74 to 77 percent during the same period. There is a complaints management process in place with findings reported to the leadership team and the board. Active follow-up occurs with every concern identified. Compliments are also shared with physicians and staff. The chief executive officer sends a letter of acknowledgement to the individual(s) as well as the compliment that was received.

This organization's logo: "The little hospital that does" is a well-suited logo. It speaks to the relentless energy the board, the leadership, the staff members and the physicians bring each and every day to fulfilling the mission, vision and values of the South Huron Hospital Association.

Section 2 Detailed On-site Survey Results

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

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

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

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

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

See Appendix B for a list of priority processes.

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

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

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

2.1 Priority Process Results for System-wide Standards

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

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

2.1.1 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)

A consultative process wad used to develop the 2011 to 2014 strategic plan, and it included staff members, physicians and the community at large. The development of the mission, vision and values had significant input from all parties. The board and the senior team plan to use a similar consultative approach as they begin the next strategic planning cycle. Extensive community outreach is envisioned that will entail feedback from the community on the services currently offered by the South Huron Hospital Association (SHHA) and the identification of services that the community identifies as important for the future. The feedback will be collated and form the equivalent of a community needs assessment that will help inform the next strategic plan.

Given the aging demographic and the pressures associated with an increasing number of alternate level care (ALC) patients the organization is encouraged to use this data to consider potential service delivery changes that might support the needs of this clientele over time. For example, access to a geriatrician or nurse practitioner with a geriatric specialty may help in further supporting a senior friendly environment that will optimize elderly patient outcomes as well as optimize resource utilization.

There are well-defined processes related to the development of the operational and capital budgets. At this time there is not a budget line for a contingency funds should they be needed. If an urgent need presents the practice has been to approach the Foundation for funding. While it is recognized that this approach has worked well in the past, the organization is cognizant that it may not be the most nimble of approaches. As a business practice the organization is encouraged to ensure that there is a defined contingency fund available for use should an urgent/emergent need arises.

2.1.2 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)

Board members are enthusiastic, mature and well informed. The board uses a skills-based matrix approach to the recruitment of new board members. There is a process in place for the orientation of new board members. Discussions are occurring regarding potential changes to the process of recruitment of new members as well as the potential to introduce a board mentoring program for new members. The board conducts self-evaluation annually. Board members undertake a self-evaluation. Each of the board committees evaluates their functioning annually as well. Feedback from recent board evaluation cited the need for ongoing education. As a result, monthly education sessions are now offered at every board meeting. A calendar of educational topics to be offered is under development. A recent board education session was on the use and intent of the new white boards on the inpatient units. In the New Year, social work will provide an information session. Another outcome of the board evaluation has been the development of an annual work plan to focus and guide board energies over the course of the year.

A patient safety needs assessment was undertaken in November 2012. The results of the assessment identified 52 opportunities for the organization to improve patient safety in the organization. Key findings were related to aging equipment, patient sensors for falls prevention and enhanced lighting for facilities lighting. The report, along with a funding proposal was presented to the board and approval received to proceed with the acquisition of priority items.

The current strategic plan covers the years 2011 to 2014. The board is now preparing to enter into a full strategic planning process to guide the hospital for the next three years. Shortly, the board will begin a community consultation process to gain insights and perspectives on future directions the South Huron Hospital Association (SHHA) should consider. Staff members and physicians will be integral to this process as they are community members as well as staff. At this time, the board is aware of and gathering information it will need to guide the strategic process. The board members are aware of the changing community demographics and the impact an older population may have on service delivery. In addition, the steady increase in occupancy levels and patient complexities will pose ongoing challenges for the SHHA as it balances its desire to provide primary and acute health care needs with those of alternate level care (ALC) patients.

The board has approved the new formalized ethics framework. Education and training has been provided hospital-wide on the utility of the framework. The board has also received education and training on the use of the ethics framework. The board and leadership teams are encouraged to formally use the ethics framework to guide decision making. This could prove useful in the future as the board contends with issues related to resource allocation and/or other sensitive issues that may challenge the organization.

The board bylaws are reviewed annually, with changes made as required. Both the board bylaws and the medical staff bylaws were formally approved in June 2012.

2.1.3 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)

The organisation enjoyed a successful staff influenza vaccination rate of 87 percent last year. The organization is currently gearing up for this season's vaccination program. The chief of staff has played an influential role in encouraging vaccinations with his "bat doc" role.

There is no formal human resources (HR) plan in place at this time. Currently, there is work being done to develop a succession and talent management plan. The first stage of doing an inventory of services is underway, with a second stage to follow to develop an actual leadership and staff plan, such as the: "SHH University". The succession plan and talent management plan will form the basis for an HR plan that will predict the future staffing and skill mix needs of the organization. As the staff HR plan takes shape consideration and alignment with the physician resources plan is also advised to ensure that there continues to be alignment between the two plans.

There is a shared director between South Huron Hospital Association (SHHA) and the Grand Bend Area Community Health Care Centre (GBACHC). This is a successful relationship that has been in place for approximately three years. The GBACHC site is
non-unionized whereas the SHHA site is approximately 76 percent unionized. The paramedics group recently certified so there is ongoing work to finalize the collective agreement with this service group.

The organization has introduced a number of creative initiatives to provide staff members with flexibility and control over their work schedules. There are other creative ideas being explored that if brought to fruition, will ensure that future professional staffing needs are met. There is a number of staff members trained to work in more than one area of the hospital. For example, there is one staff member that works as a dietary aide and as a housekeeper, and there is another that works as a ward unit aide and in sterile processing. These arrangements allow for staffing and organizational stability.

Staff quality of worklife is a key focus. Numerous events are held during the year that recognize and support staff/physicians. Examples include staff Christmas parties, children's Christmas parties and the annual service awards for physicians and staff. The development of the wellness program a year ago was a result of staff feedback. Staff members were surveyed for topics they would like to see covered by a wellness program. There is a calendar of wellness events, which have included financial management, healthy lifestyles coaching, smoking cessation and massage therapy. The sessions are open to all staff members, physicians and community partners.

The Worklife Pulse Tool and feedback from performance reviews has led at least in part to the implementation of the bullet rounds that occur on the inpatient unit daily. As a result, staff members report a higher level of communication among members of the multidisciplinary team and overall satisfaction with their day-to-day work. The establishment of the wellness committee was also a direct outcome of the staff feedback received.

Job descriptions have recently been reviewed. Many are currently in the administrative queue ready to be updated into the new format. Several job descriptions were reviewed and staff members reported they were

involved in the review discussion. One staff member reported having input to the selection of job title. Each of the job descriptions has a section included on the SHHA's patient and safe safety culture roles and responsibilities of staff.

2.1.4 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)

There is an established quality, utilization and risk committee of the board. The committee reports to the board six or seven times per year. The quality, utilization and risk committee has developed an annual work plan, which it will focus on during the next year. There is a quarterly report on quality and patient safety that is presented to the board on the elements detailed in the quality improvement plan. A draft risk assessment worksheet has been prepared for 2013-2014. The risk assessment has identified risk issues related to the operational, financial and strategic functions of the organization. Each of the risks has been plotted using a severity and frequency table and strategies identified to mitigate the potential risk. Target dates and responsible persons have been identified for each of the strategies.

South Huron Hospital Association (SHHA) is enthusiastic about the introduction and implementation of Lean principles into the organization. The SHHA has successfully obtained funds to support the training of staff. It is anticipated that white belt training will begin the end of November 2013, with green belt training to commence some time in January 2014. Two to three quality improvement projects will be selected to begin the Lean journey.

The Patient Safety Culture Tool results have been shared and discussed with staff, and feedback obtained on the findings and elements of the results have been incorporated into the 'Nursing Skills Day' training. Staff members spoken with during the on-site survey feel they would benefit from more education and communication regarding near misses. It was suggested that near misses be shared in the newsletter, Information Highway, to reinforce what is meant by a near miss, as well as to acknowledge and praise the staff members and physicians for the 'good catch'. Staff members are looking forward to the enhancements to the Risk Monitor Pro software reporting system, which will make reporting a much easier process. Staff members stated their awareness of the disclosure policy however, also stated that they have not had occasion to use it. As the organization updates the Risk Monitor Pro system to a more user-friendly version there is opportunity to reinforce the policy and procedure related to adverse event/near miss reporting, as well as disclosure with physicians and staff.

Although the quality plan and the risk assessments are well developed, there is an opportunity to further coordinate the elements of quality, risk and utilization into an integrated framework. An integrated framework acts as an overarching umbrella to demonstrate overall linkages and connectedness. It is suggested that the team consider development of an integrated framework that will formally tie together all of the good work currently being done in the organization, as well as depict the roles and responsibilities of all members of the organization in the provision of quality, risk management and optimal utilization of resources.

The team is also encouraged to collaborate with the medical advisory committee (MAC) in the identification of two or three meaningful clinical indicators as part of the quality, risk and utilization committee focus. Currently, the majority of indicators being tracked are volume indicators. The utilization indicators being tracked need to be meaningful and guide the quality, utilization and risk committee to hone in and focus on processes that impact risk or quality. For example, discussion regarding data from the current indicators

being tracked suggested that a drill down of the number of patient transfers for the purpose of having a computed tomography scan (CT Scan) may prove a beneficial exercise. The organization is encouraged to ensure that the indicators it tracks are, in fact, meaningful and are being used to further quality, risk and process improvements that will lead to the efficient and effective use of hospital resources.

2.1.5 Priority Process: Principle-based Care and Decision Making

Identifying and decision making regarding ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

A new ethics framework was approved by the board in October 2013. A previous ethics process that used the mission, vision and values of the organization as a base is currently utilized. The newly approved ethics framework is more comprehensive and formalized. Education and training by an ethicist on ethical dilemmas and the use of the ethical framework has occurred in recent months. Consideration is being given to inviting the ethicist to attend one of the board retreats to further the education and discussion regarding ethical scenarios pertinent to board functioning.

The organization is encouraged to use the new ethics framework as a guide to facilitate clinical as well as non-clinical decision making. The next step in the implementation of the framework will be to build staff capacity to recognize and manage ethics issues on an ongoing basis. Consideration may be given to hosting ethical rounds that deal with real issues or scenarios related to possible topics such as of end-of-life decisions, resource allocation and so on. Ethics rounds and/or the sharing of possible scenarios that demonstrate the utility of an ethics framework will prove helpful in building staff capacity in their abilities to both recognize and managing ethics issues that present from time to time.

Health records, personnel files and medical files are located in secure areas with key card access. Key cards are coded to allow access to certain areas of the hospital facility on an individual basis.

There is a rigorous research ethics board (REB) process in place. There is a process for the release of health care information to patients. In the Cerner system there is a process for accessing health records information from other organizations. This process is privacy protected and privacy audits are conducted to verify that the process ensures integrity of the information being shared. If any concerns do arise there is capacity to conduct trigger audits if needed.

2.1.6 Priority Process: Physical Environment

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

Unmet Criteria	High Priority Criteria
Standards Set: Customized Leadership	
7.4 The organization restricts access to high-risk areas and labels these areas.	!

Surveyor comments on the priority process(es)

The South Huron Hospital Association (SHHA) has an older facility that is well maintained. In addition, the organization is proactive and thoughtful in terms of planning improvements to the physical environment. The organization is concerned about not having a formal walkway between the South Huron Medical Centre and the hospital facility, and this does seem to be a potential risk to patient safety.

2.1.7 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)

There is an active code committee that meets monthly. Fire and police are represented and participate on the committee on an ad hoc basis. All codes have been recently revised and are compiled in a single emergency preparedness binder. Every service area has a copy of this binder for their reference. Each of the revised codes is now being tested. Most recently, the code yellow and code white protocols were tested. Staff members were given training in non-violent interventions and strategies prior to the code white drill. For a test of code yellow, a retired employee pretended to be a 'wandering' patient for the code yellow drill. Staff members were provided feedback on their response to the drills and the learning was shared. Communication included using e-mail and the Information Highway newsletter.

There is an annual schedule for code testing. Dates and the location of the code drill are identified. Code red drills that include evacuation (code green) sequences are conducted monthly in a variety of locations in the hospital. Observers are stationed at strategic points to monitor staff member response to the code. Observations are recorded and discussed at the code committee. Feedback and learning are shared across the organization.

There is also an annual education calendar that identifies what training and education will occur monthly. For example, in March and October of 2013 de-escalation, communication and self-defence training occurred as part of the code white review and drill.

A code orange drill has not been conducted since the previous accreditation survey however, there are plans to host a code orange exercise in 2014/15. The organization is encouraged to conduct a table-top code orange drill and/or mock code orange exercise as soon as possible to ensure that staff members and the community are prepared for the unexpected.

The pandemic plan was last revised in July 2010. The pandemic plan requires review and revision annually to ensure there continues to be alignment with the municipal plan as well as to Local Health Integrated Network (LHIN) planning. The organization is encouraged to share its plan with the municipality and the LHIN.

2.1.8 Priority Process: Patient Flow

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization manages patient flow effectively. Inpatient bed occupancy has trended toward full occupancy and only rarely have admitted patients required overnight stays in the emergency department. Nevertheless, this may eventually pose a patient flow problem for the organization. Currently, this is being addressed by improving discharge rates and length of stay of alternate level of care patients.

2.1.9 Priority Process: Medical Devices and Equipment

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization is committed to reprocessing and sterilization activities following policy and procedures and documentation. Reprocessing and sterilization facilities are excellent. Staff members are well-trained, knowledgeable and take pride in their work.

2.2 Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Clinical Leadership

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

Competency

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

Episode of Care

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

Decision Support

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

Impact on Outcomes

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

Medication Management

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

Organ and Tissue Donation

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

Infection Prevention and Control

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

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

Blood Services

- Handling blood and blood components safely, including donor selection, blood collection, and transfusions

2.2.1 Standards Set: Biomedical Laboratory Services

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

The organization has met all criteria for this priority process.

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

The staff members have a good understanding of adverse event reporting as well for the identification of near misses including the use of the Risk Monitor Pro system reporting tool. Laboratory personnel gave an excellent example of a near miss that recently occurred. They cited the process they followed to report the near miss and the follow-up that has occurred. As a result of this near miss report, the Inter-Hospital Laboratory Partnership (IHLP) is reviewing policies and the South Huron Hospital Association (SHHA) incorporated the learning into the recent nursing skills training day. Although staff members are familiar with the Risk Monitor Pro system they tend to use the IHLP occurrence reporting tool. The laboratory team, in consultation with the IHLP and the SHHA leadership are encouraged to look at ways to streamline/consolidate the reporting of adverse events and/or near misses. The intent would be to reduce the duplication of reporting and to ensure that both SHHA and the IHLP are well informed of events and the remedial actions taken that directly or indirectly involve the laboratory.

At this time, analysis of laboratory utilization is done informally. When utilization trends become apparent, issue(s) are brought by the director to the medical advisory committee (MAC) for discussion and action. The team may wish to identify key performance indicators related to laboratory utilization and report findings to the MAC at least on a quarterly basis to ensure that the laboratory resources are utilized in the most appropriate manner.

2.2.2 Standards Set: Blood Bank and Transfusion Services

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

Surveyor comments on the priority process(es)
Priority Process: Blood Services
Blood is supplied from the Stratford Blood Service Laboratory. The South Huron Hospital Association (SHHA) blood inventory consists of two units of O negative blood at all times. The availability of platelets is arranged on an as needed basis. In the past, platelets have been kept on hand for chemotherapy patients in particular. There is a monthly audit of the administration of blood/blood products. The transfusion bedside audit is based on direct patient observation as well as chart review. Information is shared with the Inter Hospital Laboratory Partnership (IHLP) transfusion committee as well as with the nursing unit concerned. There is a standardized transfusion consent form signed by the requesting physician and laboratory personnel. The patient consent is kept on the chart and is signed by the patient.

2.2.3 Standards Set: Customized Managing Medications

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

Surveyor comments on the priority process(es)
Priority Process: Medication Management
The organization excels at medication management. The pharmacy program has undergone recent major changes and now utilizes NorthWest Telepharmacy Services, with improved patient safety processes in place and decreased costs. The organization appreciates the importance of good antimicrobial stewardship. The organization is encouraged to develop a policy and process and perhaps even a checklist for routine international normalized ratios (INR) monitoring for patients on Coumadin.

2.2.4 Standards Set: Diagnostic Imaging Services

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

The diagnostic imaging (DI) services provided by South Huron Hospital Association (SHHA) include x-ray, ultrasound, bone mineral density and fluoroscopy specifically, barium swallow, upper gastroenterology (GI), barium enemas and small bowel follow through. In addition, the service provides pulmonary function testing and electrocardiograms (EKGs). Approximately 800 x-rays, 350 ultrasounds, 20 fluroscopies and 50 bone mineral density tests are done per month. The majority, 95 percent of patients, are outpatient clients.

The service has a medical lead (chief) who is a radiologist from the London X-ray Associates Group. The chief is also the designated Radiation Protection Officer. Fluoroscopy is only done when the radiologist is on site.

The team has an eye on the life span of key diagnostic imaging (DI) equipment, such as the seven year old x-ray machine and has already begun to discuss replacement needs. The director has informed the chef executive officer and will ensure that the needed equipment has a place-holder on the capital budget. Other equipment in the service is anywhere from three to 10 years old and is well supported with preventive maintenance (PM) service agreements and support from the Regional Shared Services which oversee the picture archiving communications system (PACs) and the Cerner systems.

There is a two to three week wait-list for ultrasound. There is one ultrasound that is used for general ultrasound as well as trans vaginal ultrasound. The wait-list is monitored especially as it pertains to shoulder ultrasound. The team hopes to have two ultrasound machines in the future to manage the demand. There is a well-defined process for the cleaning and disinfecting of the ultrasound probes. The vaginal probe is reprocessed after use and the ultrasound machine and probes are cleaned with antibacterial wipes. It is the staffs' responsibility to clean all of the diagnostic equipment after patient use. There are protocols for the cleaning of flat services and a checklist is kept of the cleaning and disinfection of every piece of equipment.

During the on-site survey, the chart of a patient that had recently undergone a thyroid biopsy was reviewed. The informed consent was signed by both the radiologist and the patient. The monitoring of the patient post procedure was documented as was the discharge of the patient home.

The staff members conduct regular patient and physician satisfaction surveys. The most recent survey was done in 2012. The responses were positive overall. Patients consistently cited the respectful treatment they received. They mentioned the poor lighting in the waiting area and the time they waited for their ultrasound as their main areas of concern. Physicians also felt the service and support they received was excellent. The relationship with the technologists and the availability of the radiologist was also rated as excellent.

Staff members are well educated, informed and patient centred. They maintain their hours of competency as per their college guidelines and an electronic record is kept of the educational activities that they attend.

They feel that they provide an important service to the community and commented it can be frustrating when patients do not show up for their diagnostic tests. The number of no- shows varies from day to day however, in one day there were two no-shows for ultrasound. Given that there is a two to three week wait-time it is unfortunate when this occurs. The team does track the number of no shows. The team is encouraged to analyze the data and to discuss ways and means to resolve, or at least minimize the number of no shows.

2.2.5 Standards Set: Emergency Department

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		
7.10	The team has a policy and process to ensure that client CTAS scores are re-assessed.	
7.11	The team has a policy and process to ensure pediatric client P-CTAS scores are re-assessed.	
11.1	The team applies standardized criteria to determine whether a client is fit for transfer of care.	!
Priority Process: Decision Support		
8.7	The team uses evidence-based protocols to select diagnostic imaging services for pediatric clients.	
Priority Process: Impact on Outcomes		
	The organization has met all criteria for this priority process.	
Priority Process: Organ and Tissue Donation		
9.2	The organization has established clinical referral triggers to identify potential organ and tissue donors.	
9.3	The team receives training and education on the definition of imminent death, the use of clinical referral triggers, who to contact when potential organ and tissue donation opportunities arise, how to approach families about donation and other donation issues.	
9.4	The organization has a policy on neurological determination of death (NDD).	
9.5	The team follows a written protocol for NDD that includes accessing the people qualified to determine neurological death.	
9.9	The team checks the provincial donor registry, where one exists, to determine if the patient is a registered donor.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The clinical leadership of the emergency department (ED) is exemplary. Leadership is focussed on patient care and safety and appears well-aligned with the strategic plan of the organization. The chief of staff who is also head of the ED is a significant asset to the organization.

Priority Process: Competency

The emergency department (ED) team is well orientated and trained and as well, receives ongoing education regularly, the Fall-for-All day and the Canadian triage acuity scale (CTAS), and pediatric CTAS training are just a few examples. The organization is in the process of having staff members trained to provide the CTAS and pediatric CTAS training in-house. The organization is encouraged to maintain regular de-escalation of the violent patient education and training, along with practising mock code white patient encounters.

Priority Process: Episode of Care

The ED team delivers safe and effective high-quality emergency patient care. The organization is encouraged to develop a formal policy and process to ensure CTAS and pediatric CTAS scores are reassessed and as well, develop standardized criteria to determine whether a client is fit for transfer of care.

Priority Process: Decision Support

The ED team utilizes evidence-based care protocols for adult clients and is encouraged to develop similar protocols for pediatric clients. Encouragement is also offered to develop these protocols for high frequency medical problems in their adult population such as for urosepsis. The ED team needs to utilize evidence-based protocols to select diagnostic imaging services for pediatric clients.

Priority Process: Impact on Outcomes

The ED team monitors quality of care delivered as well as patient satisfaction, with excellent results. Patient and staff safety are a priority for the organization and this is evidenced in the violent client training and mock code white exercise and as well the monthly safety leadership walkabouts.

Priority Process: Organ and Tissue Donation

The organization does not have established clinical referral triggers to identify potential organ and tissue donors. The ED team does not receive formal training and education with regards to organ donation. The organization does not have a policy and written protocol on neurological determination of death. The ED team does not routinely check the online provincial donor registry to determine if the patient is a registered donor.

2.2.6 Standards Set: Infection Prevention and Control

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

The organization has met all criteria for this priority process.

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

The organization has a strong infection prevention and control program. The glow-germ audits highlight the organization's commitment to evaluating processes, and also education for staff. The hand-hygiene alcohol-based hand rub flag system highlights the organization's creativity and ingenuity for improving patient care and safety.

2.2.7 Standards Set: Laboratory and Blood Services

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

The organization has met all criteria for this priority process.

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

The South Huron Hospital Association (SHHA) laboratory is one of 12 laboratories that comprise the Inter-Hospital Laboratory Partnership (IHLP). This is a long standing partnership, with Stratford as the hub laboratory. Laboratory policies and procedures as well as equipment and preventive maintenance are standardized by way of this partnership. The laboratory medical director and the IHLP regional liaison are shared positions within the partnership. There is an IHLP education committee as well as an over arching quality assurance program that all of the laboratories follow to ensure accuracy of reports and analysis.

The SHHA laboratory offers a wide array of analysis including urinalysis, blood gases, chemistry, hematology, troponins and coagulation. Microbiology and pathology are offered by the Stratford laboratory.

There are several ways in which the laboratory monitors satisfaction of the services it offers. This occurs via audits, satisfaction questionnaires, IHLP occurrence reporting and feedback from the laboratory liaison meetings and the medical advisory committee (MAC), all of which provide feedback on the delivery of services. The staff members cited a recent quality improvement that occurred as a result of feedback. Approximately three months ago it was brought to the attention of the laboratory personnel that requests sent by facsimile (faxed) were not always legible. In response, the team undertook a trial of a number of font sizes in order to allow for improved integrity of the request when faxed. To date, the feedback received is that the increase in the font size chosen has greatly improved the legibility of the faxed requests.

Each member of the laboratory team has been delegated a task related to infection control practices, quality control, supply and inventory control, and Ontario Laboratory Accreditation (OLA) coordination. In speaking with the staff members for each of the tasks, they are well-informed of their respective duties and responsibilities and takes great pride in the work that they have been given.

New processes and protocols are introduced at the level of the IHLP, with input from each of the partners. Prior to new protocols being put in place or new equipment coming on line, staff members received education and the necessary training. There is an evaluation of the new protocol or equipment to ensure user satisfaction and that the desired outcomes are achieved.

2.2.8 Standards Set: Medicine Services

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Medicine services are well-connected to the needs of the community, and this is reflected across the organization as well. The leadership is particularly thoughtful, organized, and thorough. The professional practice team is a significant asset to the organization. The team ensures that medicine services' goals and objectives are measurable and specific.

Priority Process: Competency

The medicine services interdisciplinary team are 'laser-focused' on patient care and safety. The ongoing staff education and training are superb. New nursing graduates are required to complete a checklist to ensure their successful orientation and training.

Priority Process: Episode of Care

The medicine services team delivers care that is timely, safe, and comprehensive for an organization of this size. The team might consider consolidating the venous thrombo-embolism (VTE) checklist and the VTE order sheet onto one page to streamline the process.

Priority Process: Decision Support

This service excels at communication, as evidenced by the detailed and up-to-date patient white board, thorough medical records, and daily interdisciplinary team rounds.

Priority Process: Impact on Outcomes

Medicine services are focused and driven by patient outcomes and safety. The team delivers high-quality patient care and this is reflected in the high patient satisfaction scores received.

Section 3 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.

3.1 Governance Functioning Tool

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

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

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

- **Data collection period: October 16, 2012 to November 13, 2012**
- **Number of responses: 9**

Governance Functioning Tool Results

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1 We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations.	0	0	100	92
2 Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	0	0	100	95
3 We have sub-committees that have clearly-defined roles and responsibilities.	0	0	100	96
4 Our roles and responsibilities are clearly identified and distinguished from those delegated to the CEO and/or senior management. We do not become overly involved in management issues.	0	11	89	93
5 We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decision-making.	0	0	100	92

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
6 Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	93
7 Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	98
8 Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	0	0	100	95
9 Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	0	11	89	94
10 Our governance processes make sure that everyone participates in decision-making.	0	0	100	93
11 Individual members are actively involved in policy-making and strategic planning.	0	11	89	90
12 The composition of our governing body contributes to high governance and leadership performance.	0	0	100	92
13 Our governing body’s dynamics enable group dialogue and discussion. Individual members ask for and listen to one another’s ideas and input.	0	22	78	95
14 Our ongoing education and professional development is encouraged.	0	0	100	86
15 Working relationships among individual members and committees are positive.	0	0	100	96
16 We have a process to set bylaws and corporate policies.	0	0	100	95
17 Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	96
18 We formally evaluate our own performance on a regular basis.	0	0	100	76
19 We benchmark our performance against other similar organizations and/or national standards.	0	22	78	68
20 Contributions of individual members are reviewed regularly.	11	11	78	66

		% Disagree	% Neutral	% Agree	%Agree * Canadian Average
		Organization	Organization	Organization	
21	As a team, we regularly review how we function together and how our governance processes could be improved.	11	0	89	77
22	There is a process for improving individual effectiveness when nonperformance is an issue.	11	22	67	59
23	We regularly identify areas for improvement and engage in our own quality improvement activities.	0	11	89	82
24	As a governing body, we annually release a formal statement of our achievements that is shared with the organization's staff as well as external partners and the community.	11	11	78	84
25	As individual members, we receive adequate feedback about our contribution to the governing body.	11	11	78	68
26	Our chair has clear roles and responsibilities and runs the governing body effectively.	0	0	100	94
27	We receive ongoing education on how to interpret information on quality and patient safety performance.	0	0	100	86
28	As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	96
29	As a governing body, we hear stories about clients that experienced harm during care.	0	0	100	83
30	The performance measures we track as a governing body give us a good understanding of organizational performance.	0	0	100	91
31	We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	0	0	100	91
32	We have explicit criteria to recruit and select new members.	0	11	89	83
33	Our renewal cycle is appropriately managed to ensure continuity on the governing body.	0	0	100	88

		% Disagree	% Neutral	% Agree	%Agree * Canadian Average
		Organization	Organization	Organization	
34	The composition of our governing body allows us to meet stakeholder and community needs.	0	0	100	93
35	Clear written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	92
36	We review our own structure, including size and sub-committee structure.	0	0	100	87
37	We have a process to elect or appoint our chair.	0	11	89	92

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2012 and agreed with the instrument items.

3.2 Patient Safety Culture Tool

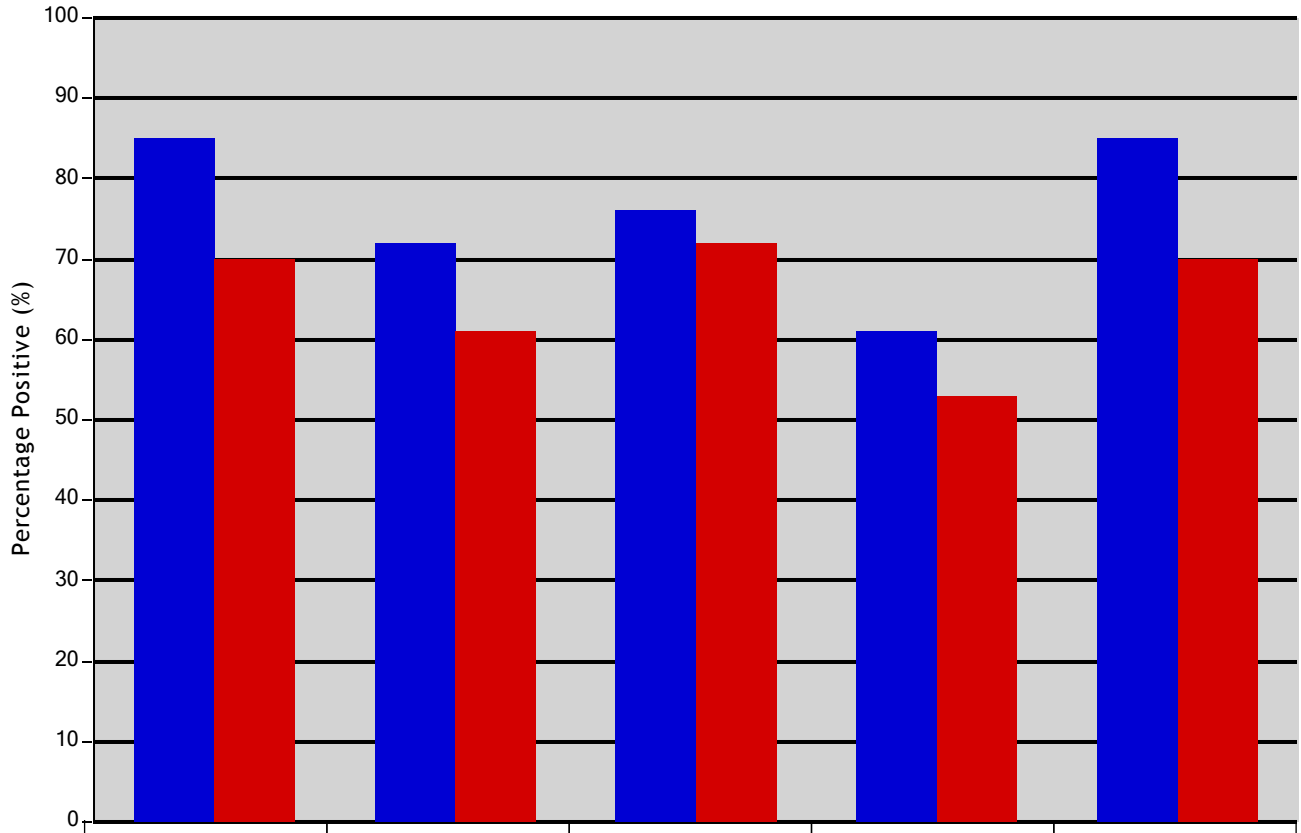
Organizational culture is widely recognized as a significant driver in changing behavior and expectations in order to increase safety within organizations. A key step in this process is the ability to measure the presence and degree of safety culture. This is why Accreditation Canada provides organizations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

Results from the Patient Safety Culture Tool allow the organization to identify strengths and areas for improvement in a number of areas related to patient safety and worklife.

Accreditation Canada provided the organization with detailed results from its Patient Safety Culture Tool prior to the on-site survey through the client organization portal. The organization then had the opportunity to address areas for improvement. During the on-site survey, surveyors reviewed progress made in those areas.

- **Data collection period: September 3, 2012 to November 12, 2012**
- **Minimum responses rate (based on the number of eligible employees): 55**
- **Number of responses: 55**

Patient Safety Culture: Results by Patient Safety Culture Dimension



	Senior leadership support for safety (valuing safety)	Supervisory leadership support for safety	Patient safety learning culture	Communication barriers/talking about errors	Overall perception of patient safety
	85%	72%	76%	61%	85%
	70%	61%	72%	53%	70%

Legend

South Huron Hospital Association

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2012 and agreed with the instrument items.

3.3 Worklife Pulse Tool

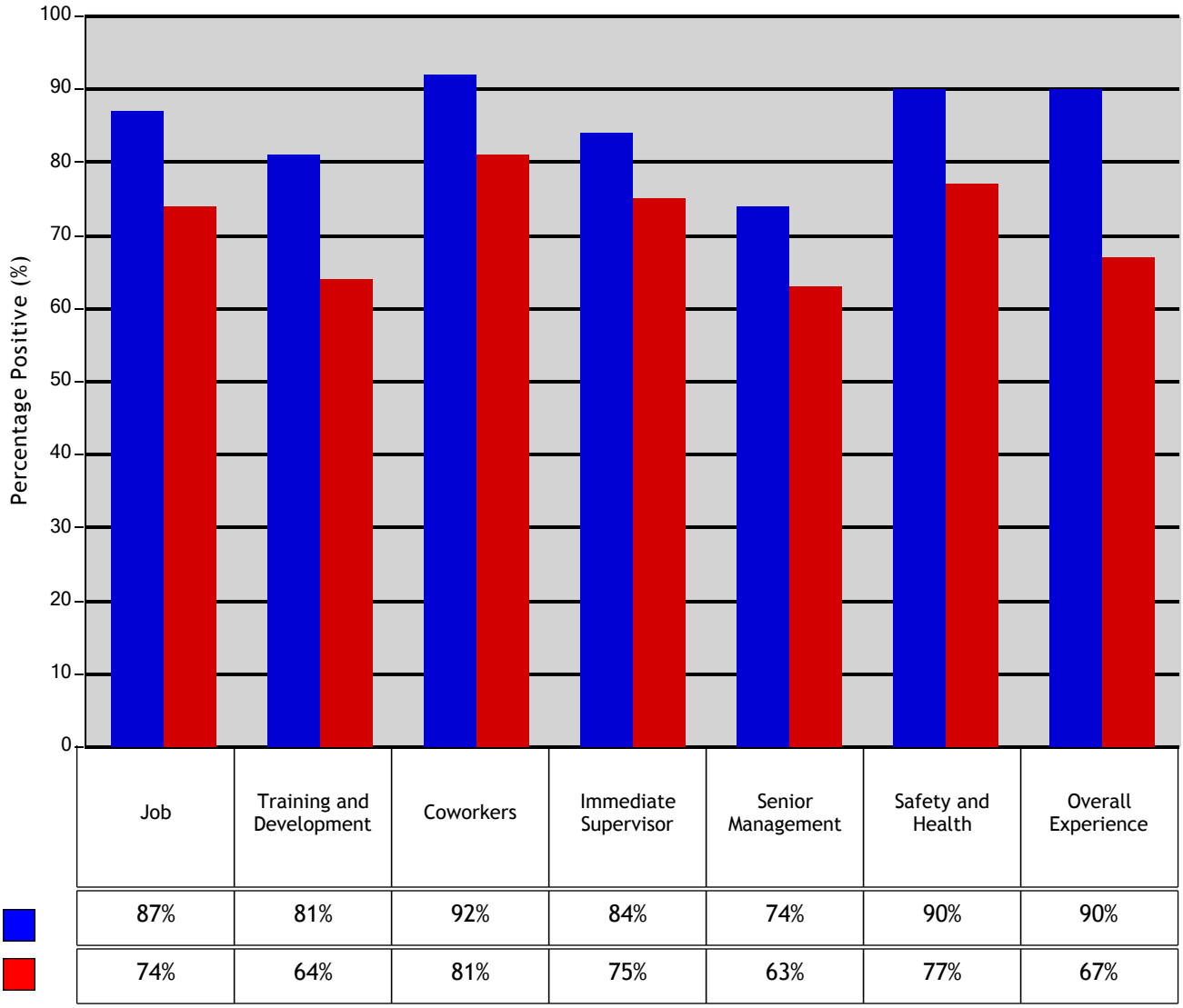
Accreditation Canada helps organizations create high quality workplaces that support workforce wellbeing and performance. This is why Accreditation Canada provides organizations with the Worklife Pulse Tool, an evidence-informed questionnaire that takes a snapshot of the quality of worklife.

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.

Accreditation Canada provided the organization with detailed results from its Worklife Pulse Tool prior to the on-site survey through the client organization portal. The organization then had the opportunity to address areas for improvement. During the on-site survey, surveyors reviewed progress made in those areas.

- **Data collection period: September 3, 2012 to November 12, 2012**
- **Minimum responses rate (based on the number of eligible employees): 73**
- **Number of responses: 73**

Worklife Pulse Tool: Results of Work Environment



	Job	Training and Development	Coworkers	Immediate Supervisor	Senior Management	Safety and Health	Overall Experience
	87%	81%	92%	84%	74%	90%	90%
	74%	64%	81%	75%	63%	77%	67%

Legend

South Huron Hospital Association

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2012 and agreed with the instrument items.

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 to discuss related initiatives with surveyors during the on-site survey.

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

Appendix A Qmentum

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

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

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

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

Action Planning

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

Evidence Review and Ongoing Improvement

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

Appendix B Priority Processes

Priority processes associated with system-wide standards

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

Priority processes associated with population-specific standards

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

Priority processes associated with service excellence standards

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

Priority Process	Description
Primary Care Clinical Encounter	Providing primary care in the clinical setting, including making primary care services accessible, completing the encounter, and coordinating services
Surgical Procedures	Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge