



Forecast Report

2009

***St. Michael's Hospital
Toronto, ON***



ACCREDITATION CANADA
AGRÉMENT CANADA

Accredited by ISQua

Report Issue Date: March 11, 2009

About this Report

The results of this accreditation survey are documented in the attached report, which was prepared by Accreditation Canada at the request of St. Michael's Hospital.

This report is based on information obtained from the organization. Accreditation Canada relies on the accuracy of this information to conduct the survey and to prepare the report. Any alteration of this report would compromise the integrity of the accreditation process and is strictly prohibited.

While this confidential report is intended for the organization, Accreditation Canada encourages that the information herein be disclosed and promoted, in the interest of transparency, to stakeholders, clients and their community.

Confidentiality

This Report is confidential and is provided by Accreditation Canada to St. Michael's Hospital only. Accreditation Canada does not release the Report to any other parties.

In the interests of transparency, Accreditation Canada encourages the dissemination of the information in this Report to staff, board members, clients, the community, and other stakeholders.

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About the Accreditation Report

The accreditation report describes the findings of the organization's accreditation survey. It is Accreditation Canada's intention that the comments and identified areas for improvement in this report will support the organization to continue to improve quality of care and services it provides to its clients and community.

This report provides guidance for future quality improvement initiatives by documenting the findings from the organization's recent accreditation survey. An initial report is left on site after the survey visit to give the organization the opportunity to immediately review results and address the areas needing attention directly after a survey visit. Shortly after the survey visit, a full report is sent to the organization, which includes the survey findings and a forecast of the accreditation decision. This report also contains a summary of the indicator and instrument data that the organization has collected. The forecast of the accreditation decision is provided to demonstrate the organization's current position within the accreditation program. The organization is then given further opportunity to follow-up on identified areas for improvement and submits further evidence of action taken to address these areas before an official accreditation status is given. Pending the organization's follow-up and submission of evidence, as well as the review by Accreditation Canada's accreditation review committee, the final report is sent to the organization, 6 months after the forecast report. The final report includes the official accreditation decision and updated information based on the organization's updated performance measures on indicator and instrument data and evidence of action taken.

Legend

A number of symbols are used throughout the report. Please refer to the legend below for a description of these symbols.



Items marked with a GREEN flag reflect areas that have not been flagged for improvements. Evidence of action taken is not required for these areas.



Items marked with a YELLOW flag indicate areas where some improvement is required. The team is required to submit evidence of action taken for each item with a yellow flag.



Items marked with a RED flag indicate areas where substantial improvement is required. The team is required to submit evidence of action taken for each item with a red flag.



Leading Practices are noteworthy practices carried out by the organization and tied to the standards. Whereas strengths are recognized for what they contribute to the organization, leading practices are notable for what they could contribute to the field.



Items marked with an arrow indicate a high risk criterion.



Accreditation Summary

This section of the report provides a summary of the survey visit and the status of the accreditation decision.

St. Michael's Hospital

Survey Date:	February 8, 2009 - February 13, 2009
Report Issue Date:	March 11, 2009
Forecast Accreditation Decision:	Accreditation with Condition
Official Accreditation Decision:	To Be Determined

The following locations were visited during this survey visit:

- 1 410 Sherbourne Health Care Centre
- 2 61 Queen Street Health Care Centre
- 3 Creative Works Studio
- 4 St. James Town Health Care Centre
- 5 St. Lawrence Health Care Centre
- 6 St. Michael's Hospital
- 7 Withdrawal Management Services

The following service areas were visited during this survey visit:

- 1 Acquired Brain Injury
- 2 Addictions/Gambling
- 3 Ambulatory Care
- 4 Cancer Care
- 5 Community Health Services
- 6 Diagnostic Imaging
- 7 Emergency Department
- 8 Hospice/Palliative Care
- 9 Intensive Care Unit/Critical Care
- 10 Managing Medications
- 11 Maternal/Perinatal
- 12 Medicine
- 13 Mental Health
- 14 Operating Room
- 15 Sterilization and Reprocessing of Medical Equipment
- 16 Surgical Care



Surveyor's Commentary

The following global comments regarding the survey visit are provided:

OVERALL STRENGTHS

There is a palpable focus on quality of care that is patient centred and there is an emphasis on care for the vulnerable. St. Michael's Hospital staff live the values of the hospital. The vision and values were explained to the surveyors by all levels of staff throughout the organization and even within the formal and informal affiliate organizations.

St. Michael's Hospital develops and maintains strong relationships with partner organizations and within the community. Many staff reported that they recommend St. Michael's to their friends and families.

St. Michael's is tightly connected with the community and through a variety of innovative arrangements it has continued to expand its services. An example is the development of a requirement for family medicine residents to do a rotation at the Seaton house men's shelter.

There is a well developed strategic direction with input from internal and external stakeholders.

The organization is financially stable.

There is a standardized approach to new projects and initiatives such as the quality improvement template.

The staff are highly engaged and positive at many levels.

There is an excellent greening strategy led by the green team.

Team members work to maintain the current environment and plan for a future patient care wing.

Excellent inter professional practice models are used.

The information technology strategy and roll out of electronic documentation was well done.

The strategic directions support the organization's vision and mission with respect to physical spaces. The Li Ka Shing Knowledge Institute supports research and education.

There are coordinated efforts by individuals across the organization to ensure an integrated approach to emergency preparedness.

The approach for documentation of all code procedures is standardized.

The organization has participated in emergency preparedness activities with key internal and external stakeholders.

The pandemic exercise in 2007 included 100 simulated patients. The pandemic influenza manual for 2009 is in draft format.

The organization actively works with the Toronto Academic Health Science Network (TAHSN) and Toronto Public Health.



OVERALL AREAS FOR IMPROVEMENT

A human resource strategic plan should be developed to proactively address future recruitment needs resulting from an aging workforce.

Emergency preparedness should be tested on a regular basis particularly code black which occurred recently.

The units and departments need more opportunities to be involved in tabletop exercises.

There is a need to increase collaboration with the neighbouring hospitals for sharing materials and approaches to emergency planning.

There is an opportunity to consolidate the emergency preparedness activities into a specialist role for the organization.

Continue efforts to maintain the current space and prioritize the short term needs to support patient care as space continues to be a challenge as the demand for services continues to increase.

Expand the projects in the operating room that improve the physical environment for staff satisfaction and safety.

Efforts are being made in the outpatient and ambulatory care areas to standardize clinical practice. There continues to be challenges with identifying which elements of physician practice should be standardized.

Performance measurement information is starting to be well utilized by clinical leaders. There is an opportunity to increase the availability of the data in the outpatient areas, especially in the areas of clinical outcomes. There is also an opportunity to increase the general understanding of when to react to the data and when not to react such as the special cause variation versus normal cause and control charts versus bar charts.

The cleaning and reprocessing of instruments in all locations should be done to the same standard as central processing and endoscopy, preferably with accountability to central processing.

The organization needs to develop processes to document patient education in the medical record, particularly related to patient safety issues.

Funding for programs is a challenge especially with resource intensive programs such as trauma, cardiac and EVAR.

SUCSESSES AND CHALLENGES

The leadership has successfully moved flow and capacity issues from being an emergency department problem addressed by projects to being a shared corporate initiative with the board's attention.

The change management approach that was employed during the merger and integration of the Wellesley Central Hospital and St. Michael's was stellar. Numerous staff and patients from both the Wellesley and St. Michael's wanted to acknowledge the leadership for this work. There was thoughtful attention to adding pride of achievement as an additional value to St. Michael's values and ensuring that Wellesley Central staff were well represented on the senior leadership team. This was noted and appreciated by all.

The nursing research strategy (RAP) is an outstanding initiative which should continue to be supported by the organization.

There are a number of corporate change initiatives currently planned that will affect direct care providers. These initiatives include the electronic health record, falls prevention programs, medication reconciliation projects, flow initiatives and other QI initiatives such as the office collaborative initiative. The leadership will have to carefully manage and monitor the deployment of these initiatives to prevent change fatigue and to ensure the maintenance of



gains in one initiative during the implementation of another.

Communication is maintained via the newsletters, e-mails, staff meetings, community advisory panels, town hall meetings, and coffee with the CEO.

Quality methodologies (Lean, 6 Sigma) are being used to implement quality improvement initiatives.

RELATIONSHIP BETWEEN THE ORGANIZATION AND THE COMMUNITY

There is a commitment to caring, innovation and service that is evident in every facet of this organization. St. Michael's Hospital lives up to the reputation of being an urban angel. No one is refused care.

The hospital's vision and mission have been shared with Community Partners.

Opportunities are provided to Community Partners to participate in strategic planning using various modes (email, focus groups).

Currently the CCAC is involved in operational planning. The mental health area has been involved in patient flow issues and planning.

The organization is well regarded and respected in the community. St. Michael's has a strong sense of advocacy and it takes a leadership role in the field of mental health.

The mental health programs from St. Michael's are extremely innovative with the homeless housing initiative being an excellent example of a partner program. Staff link with community agencies to share ideas, education and future directions. St. Michael has taken the lead within the local health integration networks (LHIN) for mental health planning.

The homeless program developed a scorecard to monitor care and this scorecard has been shared with a number of other agencies.

The mobile crisis unit is truly a valuable service.

The community advisory committee is active in lobbying for client rights, for example an agency needed resources for an end of life client and St. Michael's was extremely helpful.

The organization is responsive to community feedback both positive and negative, including the board and senior leadership.

Other agencies are involved from the beginning of a project. They felt privileged to be working with the organization and were acknowledged by the organization and asked to participate in a planning retreat.

St. Michael's Hospital is an employer of choice.



Organization's Commentary

The organization has no comment at this time.



Leading Practice(s)

Leading practices are exemplary initiatives carried out by health organizations. Accreditation Canada surveyors identify these practices and processes during surveys. A leading practice is a noteworthy activity, practice, or process that is innovative and that is tied to Accreditation Canada standards. These practices are commendable for what they contribute to the field. Your organization is recognized for the following leading practice(s):

- ★ A community support worker works in emergency to provide support, advocate for the vulnerable population such as the homeless and facilitate their care, and provide a connection to community resources. This position has improved the overall care of these patients according to both the emergency department and the community groups. (Emergency Department Services)
- ★ The Rotary transition centre provides short term accommodations for up to seven patients who are at risk of harm or lack of follow up if discharged immediately from emergency. This enables access to follow-up appointments and CCAC services as well as contacts with community and social work services. (Emergency Department Services)
- ★ The methicillin-resistant staphylococcus aureus (MRSA) work flow engine integrates the laboratory information on cultures with the patient admission transfer database to allow real time flagging of cases of MRSA. This automation was developed by the infection prevention and control service and information technology.

This project provides rapid notification of MRSA status and improves the capacity to isolate appropriately. It also ensures that MRSA cases are identified. It is highly efficient and reduces the cost of surveillance resources. (Infection Prevention and Control)

- ★ The mobile crisis intervention team allows the mental health worker and the city police team to work together to help individuals with acute mental health issues in the community in response to 911 calls. This provides more timely access to mental health services. (Mental Health Services)



Overview by Quality Dimension

The following table provides an overview of the organization's results by quality dimension. The first column lists the quality dimensions used. The second, third and fourth columns indicate the number of criteria rated as met, unmet or not applicable. The final column lists the total number of criteria for each quality dimension.

Quality Dimension	Met	Unmet	N/A	Total
Population Focus (Working with communities to anticipate and meet needs)	89	1	1	91
Accessibility (Providing timely and equitable services)	128	0	2	130
Safety (Keeping people safe)	460	46	13	519
Worklife (Supporting wellness in the work environment)	172	1	0	173
Client-centred Services (Putting clients and families first)	204	2	2	208
Continuity of Services (Experiencing coordinated and seamless services)	78	0	0	78
Effectiveness (Doing the right thing to achieve the best possible results)	727	11	9	747
Efficiency (Making the best use of resources)	73	4	0	77
Total	1931	65	27	2023



Overview by Standard Section

The following table provides an overview of the organization by standard section. The first column lists the standard section used. The second, third and fourth columns indicate the number of criteria rated as met, unmet or not applicable. The final column lists the total number of criteria for that standard section.

Standard Section	Met	Unmet	N/A	Total
Sustainable Governance	91	0	0	91
Effective Organization	103	1	0	104
Infection Prevention and Control	98	1	3	102
Managing Medications	134	0	1	135
Acquired Brain Injury Services	102	5	0	107
Ambulatory Care Services	114	4	2	120
Cancer Care and Oncology Services	105	4	0	109
Community Health Services	63	5	0	68
Critical Care Services	106	3	0	109
Diagnostic Imaging Services	95	6	3	104
Emergency Department Services	102	3	0	105
Hospice, Palliative, and End-of-Life Services	123	8	4	135
Medicine Services	99	5	0	104
Mental Health Services	102	6	1	109
Obstetrics/Perinatal Care Services	109	6	4	119
Operating Rooms	102	0	0	102
Reprocessing and Sterilization of Reusable Medical Devices	92	2	3	97
Substance Abuse and Problem Gambling Services	90	5	6	101
Surgical Care Services	101	1	0	102
Total	1931	65	27	2023



Overview by Required Organizational Practices (ROPs)

Based on the accreditation review, the table highlights each ROP that requires attention and its location in the standards.

Criteria	Required Organizational Practices
Acquired Brain Injury Services 7.5	The team reconciles the client's medications upon admission to the organization, with the involvement of the client.
Acquired Brain Injury Services 11.3	The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.
Acquired Brain Injury Services 15.2	The team implements and evaluates a falls prevention strategy to minimize the impact of client falls.
Acquired Brain Injury Services 15.4	The team informs and educates its clients and families in writing and verbally about the client and family's role in promoting safety.
Ambulatory Care Services 8.3	The team reconciles the client's medications as part of the assessment process, with the involvement of the client.
Ambulatory Care Services 12.2	The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.
Cancer Care and Oncology Services 7.4	The team reconciles the client's medications upon admission to the organization, with the involvement of the client.
Cancer Care and Oncology Services 11.3	The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.
Critical Care Services 7.4	The team reconciles the client's medications upon admission to the organization, with the involvement of the client.
Critical Care Services 11.5	The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.
Diagnostic Imaging Services 14.5	The team informs and educates its clients and families in writing and verbally about the client and family's role in promoting safety.
Emergency Department Services 8.3	The team reconciles the client's medications following triage, with the involvement of the client.
Emergency Department Services 10.5	The team reconciles medications with the client at referral or transfer and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.
Hospice, Palliative, and End-of-Life Services 16.2	The team implements and evaluates a fall prevention strategy to minimize the impact of client falls.
Hospice, Palliative, and End-of-Life Services 16.4	The team informs and educates its clients and families in writing and verbally about the client and family's role in promoting safety.
Medicine Services 7.4	The team reconciles the client's medications upon admission to the organization, with the involvement of the client.



Criteria	Required Organizational Practices
Medicine Services 11.3	The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.
Medicine Services 15.2	The team implements and evaluates a falls prevention strategy to minimize the impact of client falls.
Medicine Services 15.4	The team informs and educates its clients and families in writing and verbally about the client and family's role in promoting safety.
Mental Health Services 7.6	The team reconciles the client's medications upon admission to the organization, with the involvement of the client.
Mental Health Services 11.3	The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.
Mental Health Services 15.3	The team implements and evaluates a falls prevention strategy to minimize the impact of client falls.
Mental Health Services 15.5	The team informs and educates its clients and families in writing and verbally about the client and family's role in promoting safety.
Obstetrics/Perinatal Care Services 7.11	The team reconciles the client's medications upon admission to the organization with the involvement of the client.
Obstetrics/Perinatal Care Services 11.3	The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.
Obstetrics/Perinatal Care Services 16.3	The team informs and educates its clients and families in writing and verbally about the client and family's role in promoting safety.
Substance Abuse and Problem Gambling Services 7.5	The team reconciles the client's medications upon admission to the organization, with the involvement of the client.
Substance Abuse and Problem Gambling Services 11.3	The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.
Substance Abuse and Problem Gambling Services 15.4	The team informs and educates its clients and families in writing and verbally about the client and family's role in promoting safety.
Surgical Care Services 15.3	The team informs and educates its clients and families in writing and verbally about the client and family's role in promoting safety.



Detailed Accreditation Results

System-Wide Processes and Infrastructure

This part of the report speaks to the processes and infrastructure needed to support service delivery. In the regional context, this part of the report also highlights the consistency of the implementation and coordination of these processes across the entire system. Some specific areas that are evaluated include: integrated quality management, planning and service design, resource allocation, and communication across the organization.

Findings

The table below indicates the specific criteria that require attention, based on the accreditation review. Following the survey, once the organization has the opportunity to address the unresolved criteria and provide evidence of action taken, the results will be updated to show that they have been addressed.

Criteria	Location	Priority for Action
Effective Organization		
The organization's physical space meets applicable laws, regulations, and codes.	10.1	↑
Reprocessing and Sterilization of Reusable Medical Devices		
When planning and designing the layout of the sterilization unit or area, the organization considers the volume and types of reprocessing and sterilization services, flow of devices and equipment, and traffic patterns.	3.1	
The organization regulates the air quality, ventilation, temperature, and relative humidity, and lighting in decontamination, reprocessing, and storage areas.	3.5	



Surveyor Comments

SUSTAINABLE GOVERNANCE

The board receives information about St. Michael's Hospital through many sources including management meeting minutes, research activities updates, and community advisory groups. The board is composed of a broad cross section of the community and includes academics. The hospital has a long history of outreach to the community and the culture of outreach helps to ensure that the board understands the community. There are good communication channels in place and the views of the community representatives are expressed fully at board meetings. The academic community is involved in the hospital and the hospital is a part of a team that promotes service design and planning with its academic partners.

The board members receive presentations on the various activities of the hospital at the regular board meetings.

The various committees of the hospital provide their feedback directly to board members and not through the chief executive officer (CEO).

The board members are able to interact with the hospital community in a number of ways including sitting on various committees with staff and participating in social events such as St. Michael's Day where board members greet staff in the mornings as they come to work.

The board reported that there is a strong cultural component of caring that pervades St. Michael's and there is a strong connection between the board and management.

Board members reported that there is a bottom-up approach to strategic planning and they receive a broad range of information to support their strategic planning initiatives. Each strategic plan builds on other plans and achievements. Strategic planning involves many committees that report to an overall committee.

Succession planning is in place and they are presently searching for a new CEO due to the approaching retirement of the present CEO.

The bylaw review committee is actively working on an extensive review of the bylaws. It is using the Ontario Hospital Association (OHA) bylaw template and is reviewing other hospitals bylaws in the process.

Education is a regular item on the board's agenda. Education is matched to the current issues facing the board. The board receives regular updates from the OHA and it holds an annual one and a half day retreat each year where the members receive education on appropriate topics. There is a systematic approach to the board's education and they receive materials well in advance of the board meetings in order to prepare.

Orientation of board members is a mandatory process.

There is an annual formal board evaluation process in place as well as informal processes to ensure that the board is being evaluated regularly. The CEO also receives an annual evaluation.

The board reported that there is a strong cultural component of fiscal responsibility and that the budget shall be balanced. Everyone works diligently to ensure that the hospital is financially sound.

The board receives regular updates using a balanced scorecard approach from management to ensure they are aware of risk and quality improvement (QI) initiatives throughout the hospital.

Board members noted major risk areas including funding, the emergency department (ED) and infection control and prevention. The board members feel that the major risk areas are strategically managed and that they receive excellent reports from the CEO.

The board members noted that the hospital demonstrate caring, pride, and transparency.



EFFECTIVE ORGANIZATION

Leadership reported they have many formats to keep in touch with the population they serve. They have numerous networks set up throughout the hospital and outside.

Communication strategies used to validate issues and concerns with front line staff include: intranet, staff newsletters, monthly town hall meetings with the CEO, Java with Jeff, quarterly newsletters and a media relations program. All of these channels of communication go through regular evaluations to ensure they are effective.

There is a well developed staff development program with management development certificates in place. As well, there is a Leadership Academy program which has been well received. Leadership and staff development have incorporated change management processes into their training.

The implementation of e- health records in the hospital was started in the fall 2008.

The hospital has implemented program management and the department of Medicine has 13 divisions which meet regularly. There is a physician and administrator pairing for the various programs who report directly to an executive steering committee.

There is an initiative to ensure that physicians are intricately involved in all aspects of the organization.

It was noted that the response rate from the last staff satisfaction survey was 65% for staff and 55% from physicians.

Leadership has several initiatives to ensure staffs are safe and to promote a culture of safety. There is a safe walk program for staff in the evenings and nights to go to their cars, There is an event tracking tool which allows for easy follow-up of events, there is a Quality of Care committee.

They are actively looking at recruitment and retention strategies for their staff.

Managers receive a 360 performance appraisal and these are done annually. Front line staff PAs are done every 2 years. Physician performance appraisals are part of a QI initiative – step 1 is a peer review, at present physicians do not have a 360 PA format.

There are formal and informal processes to deal with harassment within the workplace. Generally harassment issues are resolved at the informal level.

The hospital has worked collaboratively to develop an RNAO Healthy Work Environments BPGs.

Staff receive updates on QI initiatives throughout the hospital.

Patients are consulted through various means including grand rounds and a Patient Education committee.

The organization needs to review its practices to ensure that all soiled utility rooms across the organization have a clear separation of soiled and clean material. This was noted by the surveyors in the patient units and the emergency department. (Effective Organization 10.1)

Review practices to ensure that clutter is removed and equipment is stored properly to reduce the risks to patients and staff particularly in the Vascular unit in the Bond wing and in the Emergency Department. (Effective Organization 10.1)

Address preventative maintenance with a consistent tagging process.



REPROCESSING AND STERILIZATION OF REUSABLE MEDICAL DEVICES

The distance of the supply processing department (SPD) department from the main operating room (OR) is not ideal as clean and soiled linens have to move a fair distance and this decreases system efficiency.
(Reprocessing and Sterilization of Reusable Medical Devices 3.1)

Currently there is an issue with respect to humidity and heat in the SPD area however this is under repair.
(Reprocessing and Sterilization of Reusable Medical Devices 3.5)



Direct Service Provision

This part of the report provides information on the delivery of high quality, safe services. Some specific areas that are evaluated include: the episode of care, medication management, infection control, and medical devices and equipment.

Findings

The table below indicates the specific criteria that require attention, based on the accreditation review. Following the survey, once the organization has the opportunity to address the unresolved criteria and provide evidence of action taken, the results will be updated to show that they have been addressed.

Criteria	Location	Priority for Action
Infection Prevention and Control		
Information provided to clients and families is documented in the client record.	7.3	
Acquired Brain Injury Services		
The team reconciles the client's medications upon admission to the organization, with the involvement of the client.	7.5	↑
There is a demonstrated, formal process to reconcile client medications upon admission.	7.5.1	
The process includes generating a comprehensive list of all medications the client has been taking prior to admission.	7.5.2	
The process includes a timely comparison of the prior-to-admission medication list with the list of new medications ordered at admission.	7.5.3	
The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made where necessary.	7.5.4	
The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff, and pharmacists, as appropriate.	7.5.5	
Medication Reconciliation at Admission		
The team follows Accreditation Canada's protocols and definitions to collect and submit data on medication reconciliation at admission.	7.6.1	
The team does not have any unaddressed priority for action flags based on their medication reconciliation at admission indicator results.	7.6.2	



The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.	11.3	↑
There is a demonstrated, formal process to reconcile client medications at referral or transfer.	11.3.1	
The process includes generating a comprehensive list of all medications the client has been taking prior to referral or transfer.	11.3.2	
The process includes a timely comparison of the prior-to-referral or prior-to-transfer medication list with the list of new medications ordered at referral or transfer.	11.3.3	
The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made.	11.3.4	
The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff and pharmacists, as appropriate.	11.3.5	
The organization has a documented plan to implement throughout the organization, and before the next accreditation survey, a medication reconciliation process at referral and transfer.	11.3.6	
The team implements and evaluates a falls prevention strategy to minimize the impact of client falls.	15.2	↑
The team evaluates the falls prevention strategy on an ongoing basis to identify trends, causes, and degree of injury.	15.2.4	
The team uses the evaluation information to make improvements to its falls prevention strategy.	15.2.5	
The team informs and educates its clients and families in writing and verbally about the client and family's role in promoting safety.	15.4	↑
Written and verbal information is provided to clients and families about their role in promoting safety.	15.4.1	
Staff uses written and verbal approaches to inform and educate clients about their role in promoting safety.	15.4.2	
Clients indicate that they have received written and verbal communication about their role in promoting safety.	15.4.3	
Ambulatory Care Services		
The organization provides sufficient workspace to support interdisciplinary team functioning and interaction.	3.5	
The team reconciles the client's medications as part of the assessment process, with the involvement of the client.	8.3	↑
There is a demonstrated, formal process to reconcile client medications upon admission.	8.3.1	
The process includes generating a comprehensive list of all medications the client has been taking prior to admission.	8.3.2	
The process includes a timely comparison of the prior-to-admission medication list with the list of new medications ordered at admission.	8.3.3	
The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made where necessary.	8.3.4	
The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff, and pharmacists, as appropriate.	8.3.5	
The organization has a documented plan to implement throughout the organization, and before the next accreditation survey, a medication reconciliation process upon admission.	8.3.6	



Medication Reconciliation at Admission	8.4	
The team follows Accreditation Canada's protocols and definitions to collect and submit data on medication reconciliation at admission.	8.4.1	
The team does not have any unaddressed priority for action flags based on their medication reconciliation at admission indicator results.	8.4.2	
The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.	12.2	↑
There is a demonstrated, formal process to reconcile client medications at referral or transfer.	12.2.1	
The process includes generating a comprehensive list of all medications the client has been taking prior to referral or transfer.	12.2.2	
The process includes a timely comparison of the prior-to-referral or prior-to-transfer medication list with the list of new medications ordered at referral or transfer.	12.2.3	
The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made.	12.2.4	
The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff and pharmacists, as appropriate.	12.2.5	
The organization has a documented plan to implement throughout the organization, and before the next accreditation survey, a medication reconciliation process at referral and transfer.	12.2.6	
Cancer Care and Oncology Services		
The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	3.8	
The team reconciles the client's medications upon admission to the organization, with the involvement of the client.	7.4	↑
There is a demonstrated, formal process to reconcile client medications upon admission.	7.4.1	
The process includes generating a comprehensive list of all medications the client has been taking prior to admission.	7.4.2	
The process includes a timely comparison of the prior-to-admission medication list with the list of new medications ordered at admission.	7.4.3	
The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made where necessary.	7.4.4	
The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff, and pharmacists, as appropriate.	7.4.5	
Medication Reconciliation at Admission	7.5	
The team follows Accreditation Canada's protocols and definitions to collect and submit data on medication reconciliation at admission.	7.5.1	
The team does not have any unaddressed priority for action flags based on their medication reconciliation at admission indicator results.	7.5.2	



The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.	11.3	↑
There is a demonstrated, formal process to reconcile client medications at referral or transfer.	11.3.1	
The process includes generating a comprehensive list of all medications the client has been taking prior to referral or transfer.	11.3.2	
The process includes a timely comparison of the prior-to-referral or prior-to-transfer medication list with the list of new medications ordered at referral or transfer.	11.3.3	
The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made.	11.3.4	
The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff and pharmacists, as appropriate.	11.3.5	
Community Health Services		
The team develops standardized processes and procedures to improve teamwork and minimize duplication.	3.4	
The organization provides sufficient workspace to support interdisciplinary team functioning and interaction.	3.5	
The team shares benchmark and best practice information with its community partners and other organizations.	10.6	
The team identifies and monitors process and outcome measures for its community health services.	11.5	↑
The team compares its results with other similar interventions, programs, or organizations.	11.8	↑
Critical Care Services		
The team reconciles the client's medications upon admission to the organization, with the involvement of the client.	7.4	↑
There is a demonstrated, formal process to reconcile client medications upon admission.	7.4.1	
The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made where necessary.	7.4.4	
Medication Reconciliation at Admission	7.5	
The team follows Accreditation Canada's protocols and definitions to collect and submit data on medication reconciliation at admission.	7.5.1	
The team meets Accreditation Canada's recommended target for medication reconciliation at admission.	7.5.2	
The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.	11.5	↑
The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made.	11.5.4	
Diagnostic Imaging Services		
The organization properly controls the temperature and ventilation of the facility.	4.5	↑
The team identifies and verifies the education and competency of staff involved in reprocessing of diagnostic imaging equipment and devices.	7.4	



All DI reprocessing areas are equipped with separate clean and decontamination work areas as well as separate storage, dedicated plumbing and drains, and proper air ventilation.	7.6	↑
For each contaminated DI device and piece of equipment, a trained staff person uses a recognized classification system to determine the type of reprocessing that is required, i.e. sterilization, or high- or low-level disinfection.	7.7	↑
If disinfection is required, a trained and competent staff member follows detailed procedures for cleaning or disinfecting the DI device or piece of equipment.	7.8	↑
The team informs and educates its clients and families in writing and verbally about the client and family's role in promoting safety.	14.5	↑
Written and verbal information is provided to clients and families about their role in promoting safety.	14.5.1	
Staff uses written and verbal approaches to inform and educate clients about their role in promoting safety.	14.5.2	
Clients indicate that they have received written and verbal communication about their role in promoting safety.	14.5.3	
Emergency Department Services		
The team reconciles the client's medications following triage, with the involvement of the client.	8.3	↑
There is a demonstrated, formal process to reconcile client medications following triage.	8.3.1	
The process includes a timely comparison of the prior-to-admission medication list with the list of new medications ordered at admission.	8.3.3	
The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made where necessary.	8.3.4	
Medication Reconciliation following Triage.	8.4	
The team follows Accreditation Canada's protocols and definitions to collect and submit data on medication reconciliation following triage.	8.4.1	
The team does not have any unaddressed priority for action flags based on their medication reconciliation at admission indicator results.	8.4.2	
The team reconciles medications with the client at referral or transfer and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.	10.5	↑
There is a demonstrated, formal process to reconcile client medications at referral or transfer.	10.5.1	
The process includes a timely comparison of the prior-to-referral or prior-to-transfer medication list with the list of new medications ordered at referral or transfer.	10.5.3	
The process requires documentation that differences between the two lists have been identified, discussed, and resolved, and that appropriate modifications to the new medications have been made.	10.5.4	
Hospice, Palliative, and End-of-Life Services		
Pain and Symptom Assessment.	7.6	
The team collects data on the percentage of clients who were administered the ESAS upon admission.	7.6.1	
The team collects data on the percentage of clients where a standardized pain assessment tool was used.	7.6.3	



Medication Reconciliation at Admission.	7.9	
The team follows Accreditation Canada's protocols and definitions to collect and submit data on medication reconciliation at admission.	7.9.1	
The team does not have any unaddressed priority for action flags based on their medication reconciliation at admission indicator results.	7.9.2	
Documentation of client and family goals.	8.2	
The team collects data on the percentage of clients where client and family goals are documented.	8.2.1	
Collaborative care planning.	8.4	
The team collects data on the percentage of clients where a collaborative care plan was documented.	8.4.1	
The team implements and evaluates a fall prevention strategy to minimize the impact of client falls.	16.2	↑
The team has implemented a fall prevention strategy.	16.2.1	
The strategy identifies the populations at risk for falls.	16.2.2	
The strategy addresses the specific needs of the populations at risk for falls.	16.2.3	
The team evaluates the fall prevention strategy on an ongoing basis to identify trends, causes, and degree of injury.	16.2.4	
The team uses the evaluation information to make improvements to its fall prevention strategy.	16.2.5	
Staff and service providers participate in regular safety briefings to share information about potential safety problems, reduce the risk of error, and improve the quality of service.	16.3	↑
The team informs and educates its clients and families in writing and verbally about the client and family's role in promoting safety.	16.4	↑
Written and verbal information is provided to clients and families about their role in promoting safety.	16.4.1	
Staff uses written and verbal approaches to inform and educate clients about their role in promoting client safety.	16.4.2	
Clients indicate that they have received written and verbal communication about their role in promoting client safety.	16.4.3	
FAMCARE Instrument.	17.3	
The team collects data on the family and caregiver satisfaction with various components of care and services, using the FAMCARE instrument.	17.3.1	
Medicine Services		
The team reconciles the client's medications upon admission to the organization, with the involvement of the client.	7.4	↑
There is a demonstrated, formal process to reconcile client medications upon admission.	7.4.1	
The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made where necessary.	7.4.4	
Medication Reconciliation at Admission	7.5	
The team follows Accreditation Canada's protocols and definitions to collect and submit data on medication reconciliation at admission.	7.5.1	
The team does not have any unaddressed priority for action flags based on their medication reconciliation at admission indicator results.	7.5.2	



The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.	11.3	↑
There is a demonstrated, formal process to reconcile client medications at referral or transfer.	11.3.1	
The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made.	11.3.4	
The team implements and evaluates a falls prevention strategy to minimize the impact of client falls.	15.2	↑
The team has implemented a falls prevention strategy.	15.2.1	
The strategy identifies the populations at risk for falls.	15.2.2	
The strategy addresses the specific needs of the populations at risk for falls.	15.2.3	
The team evaluates the falls prevention strategy on an ongoing basis to identify trends, causes, and degree of injury.	15.2.4	
The team uses the evaluation information to make improvements to its falls prevention strategy.	15.2.5	
The team informs and educates its clients and families in writing and verbally about the client and family's role in promoting safety.	15.4	↑
Written and verbal information is provided to clients and families about their role in promoting safety.	15.4.1	
Staff uses written and verbal approaches to inform and educate clients about their role in promoting safety.	15.4.2	
Clients indicate that they have received written and verbal communication about their role in promoting safety.	15.4.3	
Mental Health Services		
The team reconciles the client's medications upon admission to the organization, with the involvement of the client.	7.6	↑
There is a demonstrated, formal process to reconcile client medications upon admission.	7.6.1	
The process includes generating a comprehensive list of all medications the client has been taking prior to admission.	7.6.2	
The process includes a timely comparison of the prior-to-admission medication list with the list of new medications ordered at admission.	7.6.3	
The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made where necessary.	7.6.4	
The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff, and pharmacists, as appropriate.	7.6.5	
Medication Reconciliation at Admission	7.7	
The team follows Accreditation Canada's protocols and definitions to collect and submit data on medication reconciliation at admission.	7.7.1	
The team does not have any unaddressed priority for action flags based on their medication reconciliation at admission indicator results.	7.7.2	



The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.	11.3	↑
There is a demonstrated, formal process to reconcile client medications at referral or transfer.	11.3.1	
The process includes generating a comprehensive list of all medications the client has been taking prior to referral or transfer.	11.3.2	
The process includes a timely comparison of the prior-to-referral or prior-to-transfer medication list with the list of new medications ordered at referral or transfer.	11.3.3	
The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made.	11.3.4	
The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff and pharmacists, as appropriate.	11.3.5	
The team implements and evaluates a falls prevention strategy to minimize the impact of client falls.	15.3	↑
The team has implemented a falls prevention strategy.	15.3.1	
The strategy identifies the populations at risk for falls.	15.3.2	
The strategy addresses the specific needs of the populations at risk for falls.	15.3.3	
The team evaluates the falls prevention strategy on an ongoing basis to identify trends, causes, and degree of injury.	15.3.4	
The team uses the evaluation information to make improvements to its falls prevention strategy.	15.3.5	
The team informs and educates its clients and families in writing and verbally about the client and family's role in promoting safety.	15.5	↑
Written and verbal information is provided to clients and families about their role in promoting safety.	15.5.1	
Staff uses written and verbal approaches to inform and educate clients about their role in promoting safety.	15.5.2	
Clients indicate that they have received written and verbal communication about their role in promoting safety.	15.5.3	
The team monitors clients' perspectives on the quality of its mental health services.	16.2	
Obstetrics/Perinatal Care Services		
The team reconciles the client's medications upon admission to the organization with the involvement of the client.	7.11	↑
There is a demonstrated formal process to reconcile client medications upon admission.	7.11.1	
The process includes generating a documented, comprehensive list of the current medications that the client has been taking prior to admission to the organization.	7.11.2	
The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made where necessary.	7.11.4	
Medication Reconciliation at Admission.	7.12	
The team follows Accreditation Canada's protocols and definitions to collect and submit data on medication reconciliation at admission.	7.12.1	
The team does not have any unaddressed priority for action flags based on their medication reconciliation at admission indicator results.	7.12.2	
Before delivery to the delivery room or sterile field, the team verifies all medications verbally and visually.	9.4	↑



The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.	11.3	↑
There is a demonstrated, formal process to reconcile client medications at referral or transfer.	11.3.1	
The process includes generating a single documented, comprehensive list all medications the client has been taking prior to referral or transfer.	11.3.2	
The process includes a timely comparison of the prior-to-referral or transfer medication list with the list of new medications ordered at referral or transfer.	11.3.3	
The process requires documentation that differences between the two lists have been identified, discussed, and resolved, and that appropriate modifications to the new medications have been made.	11.3.4	
Following transition or end of service, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning.	11.5	↑
The team informs and educates its clients and families in writing and verbally about the client and family's role in promoting safety.	16.3	↑
Written and verbal information is provided to clients and families about their role in promoting safety.	16.3.1	
Staff uses written and verbal approaches to inform and educate clients about their role in promoting safety.	16.3.2	
Clients indicate that they have received written and verbal communication about their role in promoting safety.	16.3.3	
Substance Abuse and Problem Gambling Services		
The team reconciles the client's medications upon admission to the organization, with the involvement of the client.	7.5	↑
There is a demonstrated, formal process to reconcile client medications upon admission.	7.5.1	
The process includes generating a comprehensive list of all medications the client has been taking prior to admission.	7.5.2	
The process includes a timely comparison of the prior-to-admission medication list with the list of new medications ordered at admission.	7.5.3	
The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made where necessary.	7.5.4	
The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff, and pharmacists, as appropriate.	7.5.5	
The organization has a documented plan to implement throughout the organization, and before the next accreditation survey, a medication reconciliation process upon admission.	7.5.6	
Medication Reconciliation at Admission	7.6	
The team follows Accreditation Canada's protocols and definitions to collect and submit data on medication reconciliation at admission.	7.6.1	
The team does not have any unaddressed priority for action flags based on their medication reconciliation at admission indicator results.	7.6.2	



The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.	11.3	↑
There is a demonstrated, formal process to reconcile client medications at referral or transfer.	11.3.1	
The process includes a timely comparison of the prior-to-referral or prior-to-transfer medication list with the list of new medications ordered at referral or transfer.	11.3.3	
The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made.	11.3.4	
The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff and pharmacists, as appropriate.	11.3.5	
The organization has a documented plan to implement throughout the organization, and before the next accreditation survey, a medication reconciliation process at referral and transfer.	11.3.6	
The team informs and educates its clients and families in writing and verbally about the client and family's role in promoting safety.	15.4	↑
Written and verbal information is provided to clients and families about their role in promoting safety.	15.4.1	
Staff uses written and verbal approaches to inform and educate clients about their role in promoting safety.	15.4.2	
Clients indicate that they have received written and verbal communication about their role in promoting safety.	15.4.3	
The team uses the information it collects about the quality of its services to identify successes and opportunities for improvement, and makes improvements in a timely way.	16.4	↑
Surgical Care Services		
The team informs and educates its clients and families in writing and verbally about the client and family's role in promoting safety.	15.3	↑
Written and verbal information is provided to clients and families about their role in promoting safety.	15.3.1	
Staff uses written and verbal approaches to inform and educate clients about their role in promoting safety.	15.3.2	
Clients indicate that they have received written and verbal communication about their role in promoting safety.	15.3.3	



Surveyor Comments

MENTAL HEALTH SERVICES

The new graduate nurse internship program was cited by staff in the care units as a positive contributor to the quality of care, recruitment and retention. (Mental Health Services 3.3)

The 17th floor has dedicated space for interdisciplinary team interaction. (Mental Health Services 3.5)

Although there is a policy, the staff members could not remember the work refusal policy being implemented. (Mental Health Services 5.5)

There are both unit and organizational reward and recognition policies. (Mental Health Services 5.7)

They plan to roll the medication reconciliation program out to Mental Health Services in the first quarter. (Mental Health Services 7.6.1)

The team contacts referral agencies routinely but it has difficulty in following up with patients and families. It has tried surveys in the past but there were very low response rates. (Mental Health Services 11.5)

There is a planned roll out for the fall prevention strategy although it has not yet been implemented on this unit. (Mental Health Services 15.3)

Patients were aware of how to raise concerns with staff but they could not articulate their role in safety. Patients did not report receiving any written information about their role in safety. The surveyor did not identify any written material that could be used to convey this to the clients however in some cases it would not be appropriate to provide patients with written material to read in the ED, ambulatory care unit or intensive care unit. (Mental Health Services 15.5.2)

The staff use the community advisory panel to solicit past patient/client input into care delivery, however they do not routinely follow up with clients related to their perceptions of the care they received. Staff reported that their particular client group was difficult to engage in post-care follow up. They tried post-discharge surveys in the past and had very low response rates. (Mental Health Services 16.2)

CANCER CARE AND ONCOLOGY SERVICES

The team has informal processes including staff meetings to discuss the team but they do not have a formal process. (Cancer Care and Oncology Services 3.8)

Some aspects of medication reconciliation are followed but there is no formal process in place. A plan to disseminate a formal process throughout the organization is in place. (Cancer Care and Oncology Services 7.4)

Radiation therapy is not utilized at this site. (Cancer Care and Oncology Services 10.7)

The team has established numerous partnerships and relationships within the hospital as well as with key community resources. (Cancer Care and Oncology Services 12.5)

The team talks specifically about safety with respect to chemotherapy. Other aspects of safety are only covered verbally including the client's role in patient safety. (Cancer Care and Oncology Services 15.3)



HOSPICE, PALLIATIVE AND END-OF-LIFE SERVICES

Although cancer care and palliative care are not clinical programs, they are considered major cross hospital themes and so they are directly accountable to the executive team. (Hospice, Palliative and End of Life Services 1.3)

The consultation services that the PCU provides to other inpatient areas, such as the 14th floor GIM unit, appear to be well utilized and appreciated.

The staff are comfortable when discussing how to assign employed staff members however they have some questions and concerns about the deployment of agency nursing, although they are rarely used on this unit according to staff. (Hospice, Palliative and End of Life Services 5.1)

There is a ten-bed 24 hour palliative care inpatient unit at this site. (Hospice, Palliative and End of Life Services 6.3)

One of the strategic plans for the PCU is to implement the Edmonton Symptom Assessment Scale (ESAS). (Hospice, Palliative and End of Life Services 7.6.1)

The team uses a Likert scale for pain assessment. (Hospice, Palliative and End of Life Services 7.6.3)

The staff reported and the chart review suggests that the team is collecting data on client and family goals for every patient. (Hospice, Palliative and End of Life Services 8.2.1)

This is a standard part of the intake process to develop a collaborative care plan as part of the admission to the unit. (Hospice, Palliative and End of Life Services 8.4.1)

Advance directives are a requirement for admission to the unit, although members of the team may be involved in these conversations while the patient is being cared for elsewhere. (Hospice, Palliative and End of Life Services 10.2)

Admission criteria is 18 years and older. (Hospice, Palliative and End of Life Services 11.2)

Given the nature of this client group it would be extremely rare for a patient to be transferred elsewhere. If this did happen the clinical pharmacist is involved in reconciling medications upon transfer. (Hospice, Palliative and End of Life Services 12.2)

Support is offered but given the size of the unit a client who decides to leave the unit may not be able to get back into the PCU if they later change their mind. (Hospice, Palliative and End of Life Services 12.3)

It is extremely rare for patients or family to change their mind and request life sustaining interventions in this care environment. (Hospice, Palliative and End of Life Services 12.4)

Monthly staff meetings provide a venue to discuss quality and safety issues however it was unclear whether safety was a regular agenda item at these meetings. (Hospice, Palliative and End of Life Services 16.3)

Some verbal information is offered however there is no written information. (Hospice, Palliative and End of Life Services 16.4.1)

The team has made a purposeful decision to use another survey tool to meet the needs of this care environment. (Hospice, Palliative and End of Life Services 17.3.1)

Information is posted in a common area and is available to be viewed by staff, volunteers, patients and families. (Hospice, Palliative and End of Life Services 17.6)



There is a defined process for internal and external referrals to the PCU. The external process uses the Toronto Palliative Care Network common referral form.

The clinical pharmacist has the opportunity to do complete medication reconciliation on admission for all patients admitted to the PCU given the unit size and the average length of stay of 17 days.

The PCU had one volunteer (aged 90) who has been volunteering for over 40 years as well as a volunteer who has just completed more than 40 years of work in the organization.

SUBSTANCE ABUSE AND PROBLEM GAMBLING

The surveyor visited one community health centre, the Health Centre at 410 Sherbourne St. and spoke with the staff working with patients with substance abuse issues including a physician, patient, family and three addictions counselors. This area does not deal with problem gambling. As such, the ratings are specific to the Health Centre at 410 Sherbourne St approach to substance abuse.

Services are Monday to Friday and they do link with the ED at St. Michael's Hospital and there is a doctor on call. (Substance Abuse and Problem Gambling 6.3)

This appears to be a function of the patient/provider relationship rather than a specific hospital policy such as a patient having access to the staff's home number in case of urgent need. (Substance Abuse and Problem Gambling 6.8)

They do not dispense medications in this area but they do partner with local pharmacists. (Substance Abuse and Problem Gambling 10.3)

This is not a 24-hour operation. St. Michael's provides 24 hour access via the ED. (Substance Abuse and Problem Gambling 10.4)

This is an outpatient service. (Substance Abuse and Problem Gambling 10.5)

This service only prescribes medications. (Substance Abuse and Problem Gambling 10.7)

This area is not part of the medication reconciliation deployment. (Substance Abuse and Problem Gambling 11.3.6)

Clients understand some of the safety concerns with respect to their addiction however they do not receive written information with respect to hazards and potential harm related to the care provided or information on steps to make care safer. (Substance Abuse and Problem Gambling 15.4.3)

This team does not participate in the patient satisfaction survey. They receive information through other means such as personal communication, complaints, and CAP. (Substance Abuse and Problem Gambling 16.4)

ACQUIRED BRAIN INJURY SERVICES

This is a strong team with a focus on interprofessional care and education. They demonstrate pride in their work. The team should build on its current success in education and research.

There is seamless integration of care along the continuum. The team has a focus on quality of care and data.

There are integrated neurosurgical and diagnostic interventional services.

Education and research is done for prevention and for staff and families.



Further collaboration and integration is needed with stroke care and neurology.

Medication reconciliation is being piloted in another area of the hospital and is not implemented in the acquired brain injury (ABI) service. Currently the unit pharmacist reviews medications that the patients are on but this is not formalized with the program for medication reconciliation. (Acquired Brain Injury Services 7.5.1)

The fall prevention pilot unit is in the early phase of implementation. (Acquired Brain Injury Services 15.2.4)

The team is currently the pilot unit for the fall prevention program which has recently being implemented and an evaluation will follow. (Acquired Brain Injury Services 15.2.5)

They provide patient education for many aspects of care but the patient's role in safety is not clearly identified. (Acquired Brain Injury Services 15.4.1)

There was no evidence that clients are receiving written and verbal communication about their role in promoting safety. (Acquired Brain Injury Services 15.4.3)

AMBULATORY CARE SERVICES

The space for the ambulatory clinics is maximized and the team would benefit from more space. There are more than 350,000 visits annually and this is growing as many of this client population become long term patients. (Ambulatory Care Services 3.5)

COMMUNITY HEALTH SERVICES

There are a large number of service providers and the practices are not fully standardized within the unit due to physician preference. (Community Health Services 3.4)

There is insufficient space for efficient flow and work in this area. For example, the staff meetings must be held on another floor to accommodate the number of staff attending. (Community Health Services 3.5)

There are no benchmarks at present but they are involved with the Institute for Healthcare Improvement (IHI) initiative to develop performance indicators for this area. (Community Health Services 10.6)

There are no indicators at present but they are working on developing some such as through the IHI initiative. (Community Health Services 11.5)

CRITICAL CARE SERVICES

Medication reconciliation is not fully implemented in the MSICU at this time. Many of the components are in place and there is a plan to fully roll this out. (Critical Care Services 7.4.1)

The formal documentation for medical reconciliation is not yet in place but there is a plan to roll this out. (Critical Care Services 7.4.4)

The medication reconciliation procedure is not fully rolled out at this time but many components are in place. (Critical Care Services 7.5.1)

Formal medication reconciliation has not yet been completely rolled out in MSICU but there is a plan to get this done. (Critical Care Services 11.5.4)



DIAGNOSTIC IMAGING (DI) SERVICES

The diagnostic imaging department has had temperature control problems with rooms over heating due to machinery, technology and the high volume of utilization. The hospital's engineering department is evaluating the problem to find a resolution. (Diagnostic Imaging Services 4.5)

Reprocessing of ultrasound endocavity probes and biopsy trigger guns is performed by diagnostic imaging staff in the imaging department. The ultrasound endocavity probe cleaning and high level disinfection should be done under the direct supervision of the central reprocessing department using protocols developed with the central processing department. The biopsy trigger guns should be rinsed and soaked in diagnostic imaging but the further reprocessing should be done in the central reprocessing department by certified reprocessing staff. (Diagnostic Imaging Services 7.4)

The reprocessing of ultrasound endocavity probes was carried out in a combined clean storage and dirty work room. This function should be in a dedicated separate space under the direct supervision of the central reprocessing department. (Diagnostic Imaging Services 7.6)

The reprocessing of DI instruments should be done directly in the central reprocessing department or in DI under the direct supervision and control of central reprocessing staff and procedures. (Diagnostic Imaging Services 7.7)

There is no written standardized material for patients or families in DI regarding their role in safety. (Diagnostic Imaging Services 14.5.1)

The patients interviewed did not receive any written information. (Diagnostic Imaging Services 14.5.3)

EMERGENCY DEPARTMENT SERVICES

There is no formal process for medication reconciliation at this time. There is a plan to implement this across the corporation in the coming year. (Emergency Department Services 8.3.1)

There is no formal process for medication reconciliation at this time. There is a plan to implement this across the corporation in the coming year. (Emergency Department Services 8.4.1)

There is no formal process for medication reconciliation at this time. There is a plan to implement this across the corporation in the coming year. (Emergency Department Services 10.5.1)

INFECTION PREVENTION AND CONTROL

Education on infection control for patients was not documented in the medical records that were reviewed. (Infection Prevention and Control 7.3)

The organization does not contract with external providers for re-processing. (Infection Prevention and Control 12.19)

MANAGING MEDICATIONS

Computerized physician order entry (CPOE) is currently being designed and the software requirements are being finalized as part of the Gemini electronic health record. There is a paper medication administrative record in use. (Managing Medications 10.3)



The organization should ensure that when multi-dose vials are used the processes to label the vials with the date and time of opening are done on a consistent basis.

Refrigerators on the patient care floors that are designated for medication have been used to also store lunches and drinks.

The medication reconciliation corporate roll out should include ambulatory care and the family health units that are affiliated with St. Michael's hospital.

The PAF is involved in the medication reconciliation pilot project that is being piloted in the heart and vascular program. In the PAF the nurse completes the reconciliation of medication and the pharmacist is involved as needed or if there are concerns about the number of medications that a patient is taking. The surgery component is focused on medication reconciliation in the heart and vascular program as process has begun in the preadmission area.

MEDICINE SERVICES

The medication reconciliation process is not yet fully rolled out. (Medicine Services 7.4.1)

Medication reconciliation not fully rolled out (Medicine Services 7.5.1)

Medication reconciliation is not fully rolled out yet. (Medicine Services 11.3.1)

The falls prevention strategy is in progress and it will be completed by April 2009. (Medicine Services 15.2.1)

There are no written materials for patients and families about patient safety. (Medicine Services 15.4.1)

OBSTETRICS/PERINATAL CARE SERVICES

Medication reconciliation has not been rolled out in the Obstetrics/Perinatal Care program yet. (Obstetrics/Perinatal Care Services 7.11.1)

All-in-one birthing rooms are used. (Obstetrics/Perinatal Care Services 10.1)

There is no evidence that this is occurring. (Obstetrics/Perinatal Care Services 11.5)

All disinfection occurs in central reprocessing. (Obstetrics/Perinatal Care Services 12.7)

There are no flash sterilizers on this unit. (Obstetrics/Perinatal Care Services 12.8)

No flash sterilization occurs on this unit. (Obstetrics/Perinatal Care Services 12.9)

There is no written information available for patients. (Obstetrics/Perinatal Care Services 16.3.1)

SURGICAL CARE SERVICES

There was no evidence of this in the patient education material. (Surgical Care Services 15.3.1)

Regional anaesthesia block is done.

There is a commitment to quality and safety with many Safer Healthcare Now initiatives taking place including



implementing the four components of SSI.

Innovation includes the robotics and the future hybrid surgical suite for open surgical and endovascular procedures.

Patient flow and work flow need to be improved, there is the need to streamline the ICU bed request process.

MOBILITY CLINIC

The outpatient record uses information from the hospital information system to ensure that demographic and allergy information is at the top of each sheet. The mobility program's outpatient team does not have access to change any of this information. Their records are scanned into the computer. This results in an outpatient clinical record that is often inconsistent with respect to allergies. In one case the demographic information on the outpatient chart states that the allergies were not assessed. Immediately below this is a scanned physician note from the outpatient visit that says the patient is allergic to penicillin. This inconsistency creates a safety hazard.

Safety initiatives were put in place on the inpatient mobility program unit such as tall man lettering and computerized pharmacy labels to differentiate read-alike medications. In the case of similar sounding medications such as dimenhydrinate versus diphenhydramine, the outpatient setting did not have the same process. In the mobility clinic these two medications were kept in separate containers and were identified by hand written labels.



Performance Measure Results

The following section provides an overview of the performance measures collected for the entire organization. These measures consist of both instrument and indicator results, which are valuable components of evaluation and quality improvement.

Instrument Results

The instruments are questionnaires completed by a representative sample of clients, staff, leadership and/or other key stakeholders that provide important insight into critical aspects of the organization's services. The following tables summarize the organization's results and highlight each item that requires attention. Results are presented in three main areas: governance functioning, patient safety culture and worklife.



Governance Functioning Tool

The Governance Functioning Tool is intended for members of the governing body to assess their own structures and processes and identify areas for improvement. The results reflect the perceptions and opinions of the governing body regarding the status of its internal structures and processes.

Summary of Results

Governance Structures and Processes	% Agree	% Neutral	% Disagree	Priority for Action
1 We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	100	0	0	
2 We have explicit criteria to recruit and select new members.	100	0	0	
3 Our renewal cycle is appropriately managed to ensure continuity on the governing body.	100	0	0	
4 The composition of our governing body allows us to meet stakeholder and community needs.	100	0	0	
5 Clear written policies define term lengths and limits for individual members, as well as compensation.	100	0	0	
6 We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations.	86	0	14	
7 Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	100	0	0	
8 We review our own structure, including size and sub-committee structure.	93	0	7	
9 We have sub-committees that have clearly-defined roles and responsibilities.	100	0	0	
10 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.	100	0	0	



Governance Structures and Processes	% Agree	% Neutral	% Disagree	Priority for Action
11 We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decision-making.	100	0	0	
12 Disagreements are viewed as a search for solutions rather than a “win/lose”.	100	0	0	
13 Our meetings are held frequently enough to make sure we are able to make timely decisions.	100	0	0	
14 Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	100	0	0	
15 Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	100	0	0	
16 Our governance processes make sure that everyone participates in decision-making.	93	0	7	
17 Individual members are actively involved in policy-making and strategic planning.	100	0	0	
18 The composition of our governing body contributes to high governance and leadership performance.	100	0	0	
19 Our governing body’s dynamics enable group dialogue and discussion. Individual members ask for and listen to one another’s ideas and input.	100	0	0	
20 Our ongoing education and professional development is encouraged.	100	0	0	
21 Working relationships among individual members and committees are positive.	100	0	0	
22 We have a process to set bylaws and corporate policies.	100	0	0	
23 Our bylaws and corporate policies cover confidentiality and conflict of interest.	100	0	0	
24 We formally evaluate our own performance on a regular basis.	93	0	7	
25 We benchmark our performance against other similar organizations and/or national standards.	93	0	7	
26 Contributions of individual members are reviewed regularly.	86	0	14	
27 As a team, we regularly review how we function together and how our governance processes could be improved.	100	0	0	
28 There is a process for improving individual effectiveness when non-performance is an issue.	75	0	25	
29 We regularly identify areas for improvement and engage in our own quality improvement activities.	100	0	0	
30 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.	69	0	31	
31 As individual members, we receive adequate feedback about our contribution to the governing body.	71	0	29	
32 We have a process to elect or appoint our chair.	93	0	7	



Governance Structures and Processes	% Agree	% Neutral	% Disagree	Priority for Action
33 Our chair has clear roles and responsibilities and runs the governing body effectively.	100	0	0	













Patient Safety Culture Survey

The patient safety culture survey results provide valuable insight into staff perceptions of patient safety, as well as an indication of areas of strength, areas of improvement, and a mechanism to monitor changes within the organization.

Summary of Results

Number of survey respondents = 551 respondents


A. Patient Safety: Activities to avoid, prevent, or correct adverse outcomes which may result from the delivery of health care	% Disagree	% Neutral	% Agree	Priority for Action
1 Patient safety decisions are made at the proper level by the most qualified people	7	13	80	
2 Good communication flow exists up the chain of command regarding patient safety issues	12	13	75	
3 Reporting a patient safety problem will result in negative repercussions for the person reporting it	80	10	10	
4 Senior management has a clear picture of the risk associated with patient care	13	16	71	
5 My unit takes the time to identify and assess risks to patients	9	11	81	
6 My unit does a good job managing risks to ensure patient safety	6	11	83	
7 Senior management provides a climate that promotes patient safety	8	17	74	
8 Asking for help is a sign of incompetence	91	4	5	
9 If I make a mistake that has significant consequences and nobody notices, I do not tell anyone about it	93	3	4	
10 I am sure that if I report an incident to our reporting system, it will not be used against me	19	19	63	
11 I am less effective at work when I am fatigued	12	10	78	
12 Senior management considers patient safety when program changes are discussed	7	26	67	
13 Personal problems can adversely affect my performance	32	16	51	
14 I will suffer negative consequences if I report a patient safety problem	85	9	6	
15 If I report a patient safety incident, I know that management will act on it	8	17	75	
16 I am rewarded for taking quick action to identify a serious mistake	27	41	32	
17 Loss of experienced personnel has negatively affected my ability to provide high quality patient care	40	22	37	
18 I have enough time to complete patient care tasks safely	17	20	63	
19 I am not sure about the value of completing incident reports	70	15	15	








A. Patient Safety: Activities to avoid, prevent, or correct adverse outcomes which may result from the delivery of health care	% Disagree	% Neutral	% Agree	Priority for Action
20 In the last year, I have witnessed a co-worker do something that appeared to me to be unsafe for the patient in order to save time	59	14	28	
21 I am provided with adequate resources (personnel, budget, and equipment) to provide safe patient care	25	21	54	
22 I have made significant errors in my work that I attribute to my own fatigue	82	9	9	
23 I believe that health care error constitutes a real and significant risk to the patients that we treat	8	9	83	
24 I believe health care errors often go unreported	22	21	57	
25 My organization effectively balances the need for patient safety and the need for productivity	12	23	65	
26 I work in an environment where patient safety is a high priority	8	12	81	
27 Staff are given feedback about changes put into place based on incident reports	28	24	47	
28 Individuals involved in patient safety incidents have a quick and easy way to report what happened	16	21	64	
29 My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures	18	23	59	
30 My supervisor/manager seriously considers staff suggestions for improving patient safety	9	17	74	
31 Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts	73	15	12	
32 My supervisor/manager overlooks patient safety problems that happen over and over	75	13	12	
33 On this unit, when an incident occurs, we think about it carefully	8	15	78	
34 On this unit, when people make mistakes, they ask others about how they could have prevented it	15	19	66	
35 On this unit, after an incident has occurred, we think about how it came about and how to prevent the same mistake in the future	9	14	78	
36 On this unit, when an incident occurs, we analyze it thoroughly	14	22	65	
37 On this unit, it is difficult to discuss errors	67	17	15	
38 On this unit, after an incident has occurred, we think long and hard about how to correct it	17	24	59	

B. These questions are about your perceptions of overall patient safety	% Good/Excellent	% Acceptable	% Poor/Failing	Priority for Action
39 Please give your unit an overall grade on patient safety	71	26	3	



B. These questions are about your perceptions of overall patient safety		% Good/Excellent	% Acceptable	% Poor/Failing	Priority for Action
40	Please give the organization an overall grade on patient safety	68	27	5	

C. These questions are about what happens after a Major Event		% Disagree	% Neutral	% Agree	Priority for Action
41	Individuals involved in major events contribute to the understanding and analysis of the event and the generation of possible solutions	7	18	75	
42	A formal process for disclosure of major events to patients/families is followed and this process includes support mechanisms for patients, family, and care/service providers	10	29	61	
43	Discussion around major events focuses mainly on system-related issues, rather than focusing on the individual (s) most responsible for the event	16	30	53	
44	The patient and family are invited to be directly involved in the entire process of understanding: what happened following a major event and generating solutions for reducing re-occurrence of similar events	17	39	43	
45	Things that are learned from major events are communicated to staff on our unit using more than one method (e.g. communication book, in-services, unit rounds, emails) and / or at several times so all staff hear about it	13	18	69	
46	Changes are made to reduce re-occurrence of major events	5	16	79	












Worklife Pulse

The concept of 'quality of worklife' is central to Accreditation Canada's accreditation program. The Pulse Survey enables health service organizations to monitor key worklife areas. The survey takes the 'pulse' of quality of worklife, providing a quick and high level snapshot of key work environment factors, individual outcomes, and organizational outcomes. Organizations can then use the findings to identify strengths and gaps in their work environments, 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.

Summary of Results

Number of survey respondents = 606 respondents

How would you rate your work environment	% Disagree	% Neutral	% Agree	Priority for Action
1 I am satisfied with communications in this organization.	10	18	72	
2 I am satisfied with communications in my work area.	16	16	68	
3 I am satisfied with my supervisor.	12	16	72	
4 I am satisfied with the amount of control I have over my job activities.	13	17	70	
5 I am clear about what is expected of me to do my job.	4	9	88	
6 I am satisfied with my involvement in decision making processes in this organization.	19	27	54	
7 I have enough time to do my job adequately.	23	21	56	
8 I feel that I can trust this organization.	7	23	70	
9 This organization supports my learning and development.	7	15	77	
10 My work environment is safe.	12	15	74	
11 My job allows me to balance my work and family/personal life.	12	21	67	

Individual Outcomes	% Not Stressful	% A bit Stressful	% Quite or Extremely Stressful	Priority for Action
12 In the past 12 months, would you say that most days at work were...	18	43	39	

	% Very Good/Excellent	% Good	% Fair/Poor	Priority for Action
13 In general, would you say your health is...	66	0	34	
14 In general, would you say your mental health is...	71	0	29	




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	% Very Good/Excellent	% Good	% Fair/Poor	Priority for Action
15 In general, would you say your physical health is...	63	0	37	

	% Very Satisfied	% Somewhat Satisfied	% Not Satisfied	Priority for Action
16 How satisfied are you with your job?	93	7	0	

	% < 10	% 10 - 15	% > 15	Priority for Action
17 In the past 12 months, how many days were you away from work because of your own illness or injury? (counting each full or partial day as 1 day)	93	4	4	
18 During the past 12 months, how many days did you work despite an illness or injury because you felt you had to (counting each full or partial day as 1 day)?	89	7	3	

	% Never/Rarely	% Sometimes	% Often/Always	Priority for Action
19 How often do you feel you can do your best quality work in your job?	3	15	83	

	% Disagree	% Neutral	% Agree	Priority for Action
20 Overall, I am satisfied with this organization.	6	15	79	
21 Working conditions in my area contribute to patient safety.	10	22	68	



Indicator Results

The table(s) below illustrate the overall performance of the organization based on data submitted by the organization for each indicator.

Medication Reconciliation at Admission

Transition points in the care continuum are particularly prone to risk, and the communication of medication information has been identified as a priority area for improving the safety of healthcare service delivery. This performance measure will provide a practical guide for organizations as medication reconciliation is conducted more widely throughout the organization.

Medication Reconciliation at Admission

Low Performers				
Service areas	Site	Team	% Formal medication reconciliation at admission	Timeframe
Surgical Care Services	St. Michael's Hospital	Heart and Vascular Program Surgical Care Services	66	Oct 1, 2008 - Dec 31, 2008
Surgical Care Services	St. Michael's Hospital	Heart and Vascular Program Surgical Care Services	59	Oct 1, 2008 - Dec 31, 2008

High Performers

There are no teams or sites performing above the threshold.

Thresholds:

High Performers: $\geq 90\%$

Low Performers: $\leq 75\%$



Health Care Associated Infection Rates

Health care associated C. difficile and MRSA infections represent a significant risk to the individuals receiving care and are a substantial resource burden to organizations and the health care system. Measuring infection control performance measures has the additional benefit of informing and shaping the staff's view of safety. Evidence suggests that as staff become more aware of infection control rates and the evidence related to infection control there is a change in behaviour to reduce the perceived risk.

C. difficile

Low Performers

There are no teams or sites performing above the threshold.

High Performers

Service areas	Site	Team	# cases of infection / 1000 patient days	Timeframe
Infection Prevention and Control	St. Michael's Hospital	Infection Prevention and Control Team	0.48	Jan 1, 2008 - Mar 31, 2008
Infection Prevention and Control	St. Michael's Hospital	Infection Prevention and Control Team	0.67	Apr 1, 2008 - Jun 30, 2008

Thresholds:

High Performers: ≤ 6

Low Performers: ≥ 8

Surgical Site Infection: Post-Surgical Infection

Post-surgical infection rate is a key outcome measure that reflects process interventions.

Different SSI rate are associated with different surgical procedures. The thresholds for the different surgical procedures are currently in development. Performance ratings will be provided when the thresholds are finalized.



Surgical Site Infection: Prophylactic Antibiotics

Timeliness of administering antibiotic prophylaxis is a universal process measure applicable to many surgical procedures and with widely recognized benefits in reducing post-surgical infections in selected high risk procedures.

Cardiac Surgery

Low Performers

There are no teams or sites performing below the threshold.

High Performers

There are no teams or sites performing above the threshold.

Thresholds:

High Performers: $\geq 90\%$

Low Performers: $\leq 80\%$



Next Steps

The forecast decision has been provided to demonstrate the organization's current position in the accreditation program. The organization is to provide evidence to follow-up on identified areas for improvement through the organization portal by September 11, 2009.

Pending the organization's follow-up and submission of evidence, as well as the review by Accreditation Canada's Accreditation Review Committee, the final report will be sent to the organization. The final report will include the official accreditation decision as well as the organization's updated indicator and instrument data and evidence of action taken.

Please contact your Accreditation Specialist or access the organization portal for more information on the accreditation report and decision.



Appendix A - Qmentum Accreditation Recognition Guidelines

Quality improvement continues to be a key principle of Accreditation Canada's Qmentum program. Accreditation Canada's standards assess the quality of services provided by an organization and are constructed around eight dimensions of quality:

1. population focus
2. accessibility
3. safety
4. worklife
5. client-centred services
6. continuity of services
7. effectiveness
8. efficiency

Each standard criterion is related to a quality dimension. Organizations participating in Accreditation Canada's Qmentum program are eligible for the recognition awards: Accreditation; Accreditation with Condition (Report and/or Focused Visit) and Non-Accreditation.

Under the Qmentum accreditation program, Accreditation Canada High Priority Criteria and Required Organization Practices (ROPs) are the two main factors that are considered in determining the appropriate recognition award.

Accreditation Canada High Priority Criteria

Accreditation Canada recognizes High Priority Criteria in several key areas:

- Quality Improvement
- Safety
- Risk
- Ethics

Required Organization Practices (ROPs)

A Required Organizational Practice is defined as an essential practice that organizations must have in place to enhance patient/client safety and minimize risk. It is a specific requirement for health care organizations in the accreditation program.

Based on the above, the three accreditation decisions for 2009 Qmentum surveys are:

Option 1: Accreditation

An organization is eligible for full accreditation (with a resurvey in three years) if all of the following criteria are met:

- (a) 10% or less of high priority criteria unmet per standard section, and
- (b) compliance with all of the Required Organizational Practices, and
- (c) compliance with collection of all the performance measures

Option 2: Accreditation with Condition: Report or Focused Visit

An organization will receive Accreditation with Condition: Report or Focused Visit if any of following



criteria is met:

- (a) More than 10% and less than 30% of high priority criteria unmet per standard section,
OR
- (b) Non-compliance with any one of the Required Organizational Practices.
OR
- (c) non-compliance with any one of the collection of Accreditation Canada's performance measures.

The condition and time frame for submission of the report or visit is based on the nature of the recommendations.

Organizations are required to submit follow up reports as a condition of maintaining accreditation status. If a satisfactory report is not submitted within the required timeline Accreditation Canada may grant a one time extension of 6 months, based on surveyor input, proof of progress and a plan to meet the conditions. Failure to comply with these requirements within the maximum allotted time extension will result in removal of accreditation status, at the discretion of Accreditation Canada.

Option 3: Non Accreditation

An organization will not be accredited if the following conditions exist:

- (a) More than 30% of high priority criteria unmet per standard section and
- (b) More than 20% of unmet criteria for the organization

