ACCREDITATION
AGRÉMENT
CANADA
Qmentum

Accreditation Report

St. Michael's Hospital

Toronto, ON

On-site survey dates: May 15, 2016 - May 20, 2016

Report issued: June 2, 2016

About the Accreditation Report

St. Michael's Hospital (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. As part of this ongoing process of quality improvement, an on-site survey was conducted in May 2016. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

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

Confidentiality

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

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

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

A Message from Accreditation Canada

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

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

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

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

We look forward to our continued partnership.

Sincerely,

Leslee Thompson
Chief Executive Officer

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Executive Summary

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

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

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

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

Accreditation Decision

St. Michael's Hospital's accreditation decision is:

Accredited with Exemplary Standing

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

About the On-site Survey

- **On-site survey dates: May 15, 2016 to May 20, 2016**

- **Locations**

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

  1. 30 Bond St, St. Michael's Hospital
  2. 73 Regent Park, Sumac Creek Health Centre
  3. 80 Bond, Health Centre

- **Standards**

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

  System-Wide Standards

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

  Service Excellence Standards

  13. Acquired Brain Injury Services - Service Excellence Standards
  10. Ambulatory Care Services - Service Excellence Standards
  15. Ambulatory Systemic Cancer Therapy Services - Service Excellence Standards
  5. Biomedical Laboratory Services - Service Excellence Standards
  20. Cancer Care and Oncology Services - Service Excellence Standards
  18. Critical Care - Service Excellence Standards
  6. Diagnostic Imaging Services - Service Excellence Standards
  14. Emergency Department - Service Excellence Standards
  19. Hospice, Palliative, End-of-Life Services - Service Excellence Standards
  11. Medicine Services - Service Excellence Standards
  16. Mental Health Services - Service Excellence Standards
  24. Obstetrics Services - Service Excellence Standards
  23. Organ and Tissue Donation Standards for Deceased Donors - Service Excellence Standards
  21. Organ and Tissue Transplant Standards - Service Excellence Standards

22. Organ Donation Standards for Living Donors - Service Excellence Standards
17. Perioperative Services and Invasive Procedures - Service Excellence Standards
7. Point-of-Care Testing - Service Excellence Standards
12. Primary Care Services - Service Excellence Standards
8. Reprocessing and Sterilization of Reusable Medical Devices - Service Excellence Standards
9. Transfusion Services - Service Excellence Standards

- **Instruments**

  The organization administered:

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

Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
Population Focus (Work with my community to anticipate and meet our needs)	69	0	0	69
Accessibility (Give me timely and equitable services)	140	0	1	141
Safety (Keep me safe)	811	12	10	833
Worklife (Take care of those who take care of me)	185	3	1	189
Client-centred Services (Partner with me and my family in our care)	669	8	1	678
Continuity of Services (Coordinate my care across the continuum)	135	0	2	137
Appropriateness (Do the right thing to achieve the best results)	1438	12	11	1461
Efficiency (Make the best use of resources)	78	0	0	78
Total	**3525**	**35**	**26**	**3586**

Overview by Standards

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

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

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

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

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	49 (98.0%)	1 (2.0%)	0	35 (97.2%)	1 (2.8%)	0	84 (97.7%)	2 (2.3%)	0
Leadership	49 (100.0%)	0 (0.0%)	0	96 (100.0%)	0 (0.0%)	0	145 (100.0%)	0 (0.0%)	0
Infection Prevention and Control Standards	40 (97.6%)	1 (2.4%)	0	31 (100.0%)	0 (0.0%)	0	71 (98.6%)	1 (1.4%)	0
Medication Management Standards	77 (98.7%)	1 (1.3%)	0	56 (98.2%)	1 (1.8%)	7	133 (98.5%)	2 (1.5%)	7
Acquired Brain Injury Services	46 (100.0%)	0 (0.0%)	0	88 (100.0%)	0 (0.0%)	0	134 (100.0%)	0 (0.0%)	0
Ambulatory Care Services	43 (97.7%)	1 (2.3%)	2	74 (94.9%)	4 (5.1%)	0	117 (95.9%)	5 (4.1%)	2
Ambulatory Systemic Cancer Therapy Services	63 (100.0%)	0 (0.0%)	3	89 (96.7%)	3 (3.3%)	0	152 (98.1%)	3 (1.9%)	3
Biomedical Laboratory Services **	71 (100.0%)	0 (0.0%)	0	105 (100.0%)	0 (0.0%)	0	176 (100.0%)	0 (0.0%)	0

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Cancer Care and Oncology Services	46 (100.0%)	0 (0.0%)	0	81 (96.4%)	3 (3.6%)	0	127 (97.7%)	3 (2.3%)	0
Critical Care	50 (100.0%)	0 (0.0%)	0	115 (100.0%)	0 (0.0%)	0	165 (100.0%)	0 (0.0%)	0
Diagnostic Imaging Services	67 (100.0%)	0 (0.0%)	0	68 (98.6%)	1 (1.4%)	0	135 (99.3%)	1 (0.7%)	0
Emergency Department	68 (95.8%)	3 (4.2%)	0	107 (100.0%)	0 (0.0%)	0	175 (98.3%)	3 (1.7%)	0
Hospice, Palliative, End-of-Life Services	45 (100.0%)	0 (0.0%)	0	108 (100.0%)	0 (0.0%)	0	153 (100.0%)	0 (0.0%)	0
Medicine Services	45 (100.0%)	0 (0.0%)	0	77 (100.0%)	0 (0.0%)	0	122 (100.0%)	0 (0.0%)	0
Mental Health Services	50 (100.0%)	0 (0.0%)	0	92 (100.0%)	0 (0.0%)	0	142 (100.0%)	0 (0.0%)	0
Obstetrics Services	71 (100.0%)	0 (0.0%)	2	88 (100.0%)	0 (0.0%)	0	159 (100.0%)	0 (0.0%)	2
Organ and Tissue Donation Standards for Deceased Donors	54 (100.0%)	0 (0.0%)	0	93 (97.9%)	2 (2.1%)	1	147 (98.7%)	2 (1.3%)	1
Organ and Tissue Transplant Standards	84 (100.0%)	0 (0.0%)	3	118 (100.0%)	0 (0.0%)	0	202 (100.0%)	0 (0.0%)	3
Organ Donation Standards for Living Donors	66 (100.0%)	0 (0.0%)	0	117 (100.0%)	0 (0.0%)	0	183 (100.0%)	0 (0.0%)	0
Perioperative Services and Invasive Procedures	112 (97.4%)	3 (2.6%)	0	109 (100.0%)	0 (0.0%)	0	221 (98.7%)	3 (1.3%)	0
Point-of-Care Testing **	38 (100.0%)	0 (0.0%)	0	46 (100.0%)	0 (0.0%)	2	84 (100.0%)	0 (0.0%)	2
Primary Care Services	57 (98.3%)	1 (1.7%)	0	89 (97.8%)	2 (2.2%)	0	146 (98.0%)	3 (2.0%)	0

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Reprocessing and Sterilization of Reusable Medical Devices	49 (92.5%)	4 (7.5%)	0	60 (95.2%)	3 (4.8%)	0	109 (94.0%)	7 (6.0%)	0
Transfusion Services **	70 (100.0%)	0 (0.0%)	5	68 (100.0%)	0 (0.0%)	1	138 (100.0%)	0 (0.0%)	6
Total	**1410 (98.9%)**	15 (1.1%)	15	2010 (99.0%)	20 (1.0%)	11	3420 (99.0%)	35 (1.0%)	26

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

Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Safety Culture			
Accountability for quality (Governance)	Met	4 of 4	2 of 2
Patient safety incident disclosure (Leadership)	Met	4 of 4	2 of 2
Patient safety incident management (Leadership)	Met	6 of 6	1 of 1
Patient safety quarterly reports (Leadership)	Met	1 of 1	2 of 2
Patient safety-related prospective analysis (Leadership)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Communication			
Client Identification (Acquired Brain Injury Services)	Met	1 of 1	0 of 0
Client Identification (Ambulatory Care Services)	Met	1 of 1	0 of 0
Client Identification (Ambulatory Systemic Cancer Therapy Services)	Met	1 of 1	0 of 0
Client Identification (Biomedical Laboratory Services)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client Identification (Cancer Care and Oncology Services)	Met	1 of 1	0 of 0
Client Identification (Critical Care)	Met	1 of 1	0 of 0
Client Identification (Diagnostic Imaging Services)	Met	1 of 1	0 of 0
Client Identification (Emergency Department)	Met	1 of 1	0 of 0
Client Identification (Hospice, Palliative, End-of-Life Services)	Met	1 of 1	0 of 0
Client Identification (Medicine Services)	Met	1 of 1	0 of 0
Client Identification (Mental Health Services)	Met	1 of 1	0 of 0
Client Identification (Obstetrics Services)	Met	1 of 1	0 of 0
Client Identification (Organ and Tissue Transplant Standards)	Met	1 of 1	0 of 0
Client Identification (Organ Donation Standards for Living Donors)	Met	1 of 1	0 of 0
Client Identification (Perioperative Services and Invasive Procedures)	Met	1 of 1	0 of 0
Client Identification (Point-of-Care Testing)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client Identification (Transfusion Services)	Met	1 of 1	0 of 0
Information transfer at care transitions (Acquired Brain Injury Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Ambulatory Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Ambulatory Systemic Cancer Therapy Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Cancer Care and Oncology Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Critical Care)	Met	4 of 4	1 of 1
Information transfer at care transitions (Emergency Department)	Met	4 of 4	1 of 1
Information transfer at care transitions (Hospice, Palliative, End-of-Life Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Medicine Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Mental Health Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Obstetrics Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Organ and Tissue Transplant Standards)	Met	4 of 4	1 of 1

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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Hospice, Palliative, End-of-Life Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Medicine Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Mental Health Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures)	Met	8 of 8	0 of 0
Safe surgery checklist (Obstetrics Services)	Met	3 of 3	2 of 2
Safe surgery checklist (Organ and Tissue Transplant Standards)	Met	3 of 3	2 of 2
Safe surgery checklist (Organ Donation Standards for Living Donors)	Met	3 of 3	2 of 2
Safe surgery checklist (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
The “Do Not Use” list of abbreviations (Medication Management Standards)	Met	4 of 4	3 of 3

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Antimicrobial stewardship (Medication Management Standards)	Met	4 of 4	1 of 1
Concentrated electrolytes (Medication Management Standards)	Met	3 of 3	0 of 0
Heparin safety (Medication Management Standards)	Met	4 of 4	0 of 0
High-alert medications (Medication Management Standards)	Met	5 of 5	3 of 3
Infusion pump safety (Ambulatory Care Services)	Met	4 of 4	2 of 2
Infusion pump safety (Ambulatory Systemic Cancer Therapy Services)	Met	4 of 4	2 of 2
Infusion pump safety (Cancer Care and Oncology Services)	Met	4 of 4	2 of 2
Infusion pump safety (Critical Care)	Met	4 of 4	2 of 2
Infusion pump safety (Emergency Department)	Met	4 of 4	2 of 2
Infusion pump safety (Hospice, Palliative, End-of-Life Services)	Met	4 of 4	2 of 2
Infusion pump safety (Medicine Services)	Met	4 of 4	2 of 2
Infusion pump safety (Mental Health Services)	Met	4 of 4	2 of 2
Infusion pump safety (Obstetrics Services)	Met	4 of 4	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Infusion pump safety (Organ and Tissue Transplant Standards)	Met	4 of 4	2 of 2
Infusion pump safety (Organ Donation Standards for Living Donors)	Met	4 of 4	2 of 2
Infusion pump safety (Perioperative Services and Invasive Procedures)	Met	4 of 4	2 of 2
Narcotics safety (Medication Management Standards)	Met	3 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Client Flow (Leadership)	Met	7 of 7	1 of 1
Patient safety plan (Leadership)	Met	2 of 2	2 of 2
Patient safety: education and training (Leadership)	Met	1 of 1	0 of 0
Preventive maintenance program (Leadership)	Met	3 of 3	1 of 1
Workplace violence prevention (Leadership)	Met	5 of 5	3 of 3
Patient Safety Goal Area: Infection Control			
Hand-hygiene compliance (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Infection Control			
Hand-hygiene education and training (Infection Prevention and Control Standards)	Met	1 of 1	0 of 0
Infection rates (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Patient Safety Goal Area: Risk Assessment			
Falls prevention (Acquired Brain Injury Services)	Met	3 of 3	2 of 2
Falls prevention (Ambulatory Care Services)	Met	3 of 3	2 of 2
Falls prevention (Ambulatory Systemic Cancer Therapy Services)	Met	3 of 3	2 of 2
Falls prevention (Cancer Care and Oncology Services)	Met	3 of 3	2 of 2
Falls prevention (Critical Care)	Met	3 of 3	2 of 2
Falls prevention (Diagnostic Imaging Services)	Met	3 of 3	2 of 2
Falls prevention (Emergency Department)	Met	3 of 3	2 of 2
Falls prevention (Hospice, Palliative, End-of-Life Services)	Met	3 of 3	2 of 2
Falls prevention (Medicine Services)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Falls prevention (Mental Health Services)	Met	3 of 3	2 of 2
Falls prevention (Obstetrics Services)	Met	3 of 3	2 of 2
Falls prevention (Organ and Tissue Transplant Standards)	Met	3 of 3	2 of 2
Falls prevention (Organ Donation Standards for Living Donors)	Met	3 of 3	2 of 2
Falls prevention (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
Pressure ulcer prevention (Cancer Care and Oncology Services)	Met	3 of 3	2 of 2
Pressure ulcer prevention (Critical Care)	Met	3 of 3	2 of 2
Pressure ulcer prevention (Hospice, Palliative, End-of-Life Services)	Met	3 of 3	2 of 2
Pressure ulcer prevention (Medicine Services)	Met	3 of 3	2 of 2
Pressure ulcer prevention (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
Suicide prevention (Emergency Department)	Met	5 of 5	0 of 0
Suicide prevention (Mental Health Services)	Met	5 of 5	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Venous thromboembolism prophylaxis (Cancer Care and Oncology Services)	Met	3 of 3	2 of 2
Venous thromboembolism prophylaxis (Critical Care)	Met	3 of 3	2 of 2
Venous thromboembolism prophylaxis (Medicine Services)	Met	3 of 3	2 of 2
Venous thromboembolism prophylaxis (Organ and Tissue Transplant Standards)	Met	3 of 3	2 of 2
Venous thromboembolism prophylaxis (Organ Donation Standards for Living Donors)	Met	3 of 3	2 of 2
Venous thromboembolism prophylaxis (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2

Summary of Surveyor Team Observations

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

“Excellence every day” is how St. Michael’s Hospital (SMH) approached the Accreditation Canada on-site survey and how they embed quality improvement into their daily work. With a large, diverse, growing, and aging population, St. Michael’s is working at addressing the increased demands for care and services with the province, the Central Local Health Integration Network (LHIN), and the Mid-East Toronto Health Link (METHL), while holding true to its mission of serving the disadvantaged.

The board of directors of St. Michael’s Hospital is a highly regarded, highly skilled group of prominent community members who have dedicated themselves to and set the tone for a high-functioning organization. The board ensures its fiduciary responsibilities by providing oversight and accountability for fiscal as well as quality and safety requirements. The board is responsive and helpful to St. Michael’s in ensuring positive outcomes and implementing safeguards in all matters. The directors of the board dedicate significant time and resources to St. Michael’s Hospital and are proud of the achievements of the past and the future directions.

The legacy for St. Michael’s began when the hospital was first founded by the Sisters of St. Joseph in 1892 to care for the sick and poor of Toronto's inner city. As the “urban angel,” St. Michael’s is rooted in providing exceptional patient care. As well, it is Toronto’s downtown adult trauma centre and a hub for neurosurgery, complex cardiac and cardiovascular care, diabetes, osteoporosis, multiple sclerosis care, and minimally invasive surgery and care across the continuum, particularly for the marginalized, homeless, and disadvantaged. SMH is also one of the province’s critical care centres.

St. Michael’s has a strong history in working with its community partners. Organizations, programs, facilities, and networks are proud to partner with SMH to expedite care, offer innovative opportunities, and create the best experience for patients and families. A number of success stories have resulted through St. Michael’s collaboration with others, such as a focus on senior friendly hospitals, staff secondments, educational opportunities for community-based organizations, and strong networks and relationships across all levels of staff. Community partners report feeling “welcomed in” to the expertise St. Michael’s can offer.

A new patient and family engagement program has been created to strengthen the partnership with patients and ensure their voices are heard. There is an impetus to build on existing work and increase organizational capacity for patient engagement. As well, strategies to measure patient experience are being enhanced to provide more timely feedback. At the centre of SOAPEE (safety, outcomes, access, patient-centredness, equity, efficiency), St. Michael’s quality framework, is the letter P for patient centredness.

The leadership of St. Michael’s is commended for their commitment of service to the community. In 1992, St. Michael’s established the Community Advisory Panels (CAPs), and since then has continued the significant impact on care and innovation for over 60 projects in the inner-city community. The four CAPs focus on

women and children, people who are homeless and under-housed, people with severe mental illness, and Aboriginal health.

A new Local Resident's Health Services Panel has been created to engage the citizens within St. Michael's local area. This panel of 28 resident advisors represents the local community. The plan is to have the panel work on identifying guiding principles and priorities for local health services and offer input into specific services being designed by St. Michael's within their strategic plan. This may potentially serve as a model for other LHIN sub-regions.

Other ways SMH engages with patients is the Family Health Team Check-Up pilot project in public engagement. Thirty-six randomly selected patients were asked to spend a day with staff to rethink and redesign the process of medical appointments. An interprofessional strategic plan retreat was held recently which included patients and families as well as doctors, nurses, and health disciplines. The intent was to use the opinions and feedback to inform the development of the 2016–2019 interprofessional strategic plan. And another example of the organization's commitment to patient- and family-centred care is a new corporate Patient and Family Advisory Council, which held its first meeting in April. The meeting was held in the early evening to maximize patient and family participation.

When describing their workplace, everyone says "it's a great place to work" and many physicians, staff and volunteers find it hard to leave … even to retire. As an academic teaching centre many of the students and trainees want to work at SMH on completion of their professional designations, because "there is something special about St. Mike's." There are many opportunities for staff development, and the Knowledge Institute, comprised of the Keenan Research Centre and Li Ka Shing International Healthcare Education Centre, helps bring researchers, educators, and clinicians together to take best practices and research discoveries to the patient faster.

The values are truly lived and modelled each day, and acknowledged by the patients. Patients and families are extremely grateful for the compassionate care they receive at St. Michael's. The corporate quality and safety priorities are written in a patient-focused manner and include patient input to address the things that matter most to patients, including safety, involvement in care planning, and seamless transitions. The patient engagement focus group, a new element of the accreditation survey, indicated they felt St. Michael's is working hard with some of the current initiatives surrounding patient and family input and co-design, however, they agree "there is no limit to better." They are hopeful that a culture of openness to complaints, concerns, and suggestions will help the continuous quality improvement journey and that there will be accountability to ensure sustained improvement.

Detailed On-site Survey Results

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

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

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

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

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

See Appendix B for a list of priority processes.

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

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

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

Priority Process Results for System-wide Standards

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

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

Priority Process: Governance

Meeting the demands for excellence in governance practice.

Unmet Criteria		High Priority Criteria
Standards Set: Governance		
2.3	The governing body includes clients as members, where possible.	
13.6	The governing body regularly evaluates the performance of the board chair based on established criteria.	!

Surveyor comments on the priority process(es)

The board of St. Michael's Hospital is composed of dedicated, experienced, professional community leaders who are passionate about their role in serving the community and the province in providing the best and safest care, in the best way and the best place. In addition to having a strong history of responsibility for the hospital's financial viability and stakeholder accountabilities, they have taken on an increasingly greater role in improving quality of care and improving their own governance functioning. The board has worked hard in preparing for the accreditation on-site survey and must be commended not only for their efforts, but on the "excellence every day" demonstrated across all of St. Michael's services and programs.

The board reviews its size and composition and has established the following committees and sub-committees: Business Services Committee, Audit Sub-Committee, Pension Committee, Planning and Construction, Governance and Nominating, Quality Committee, Research and Education Committee, and Community Advisory Committee.

The board has worked through significant challenges over the past year and has used the organization's ethics framework and the experience and knowledge of board members, staff, and external legal counsel as needed. Great appreciation to the board was noted in managing a complex situation related to construction of the expanded SMH facilities.

Board members report undergoing a fulsome orientation to prepare them for their role and feel they receive information with adequate time to prepare for board meetings and decision making. The board is following many suggestions regarding best practices in board governance. For example, the board begins each meeting with a patient story to ground them in their deliberations and considerations. As well, CAPs have been in place for decades, contributing to engagement with the community, particularly for marginalized groups. More recently, the board has implemented an electronic (tablet) format for board materials, which not only reduces printing but also increases privacy and confidentiality of information.

The board sets the tone for its commitment to St. Michael's values and its vision of being a world leader in urban health. The "different kind of strategic plan, for a different St. Michael's" was described as taking a more patient-centred approach than ever before, and ensuring the nimbleness of the organization in light of constantly changing circumstances. The corporate goals and objectives have been streamlined and the board receives dashboard reporting to provide oversight for performance and accountability.

Newer board members are mentored to provide for succession and transition planning. The board described one of the enablers in their current strategic plan as "their people" and they are supporting the leadership of the hospital in development. Education and professional development is a significant strength across all levels of St. Michael's hospital as a result.

With oversight for physician credentialing and re-appointments, the board receives recommendations from the Medical Advisory Committee (MAC). The new electronic system used for physician files has been well received and adds additional rigour in ensuring the processes are complete and timely.

The board is knowledgeable about and committed to quality. A quality innovation fund was started with $1 million and matched by donation with another $1 million, helping the hospital achieve increased opportunities for quality improvement projects, such as the implementation of the new safety and learning system.

The board has participated in evaluating itself using the Accreditation Canada Governance Functioning Tool, along with other online surveys. There are plans to begin a process to evaluate the board chair during an in-camera session of the Governance and Nominating Committee of the board. The evaluation criteria that will be used are consistent with the Guide to Good Governance best practice model role description of the board chair.

Going forward it will be important to continue to assemble a board with diverse backgrounds and skills. While across the country most hospital and health boards are government appointed, the province of Ontario has maintained a voluntary governance model for hospitals. St. Michael's Hospital Board of Directors therefore has an opportunity to consider having a patient representative sit on the board in addition to the Community Advisory Committee acting as a proxy for that role.

Priority Process: Planning and Service Design

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

SMH is committed to meeting the needs of those they serve and work hard with their community and stakeholders to understand and identify health needs. St. Michael's has a proud history of hope and healing from the Sisters of St. Joseph and is now looked upon as the Urban Angel of compassionate care, academic research, teaching, and technology. The CAPs are seen as a vital partnership that are a bridge between the community and SMH. The four CAPs are a long-standing approach to community engagement, particularly for those perceived as most vulnerable. The CAPs focus on women and children, homeless and under-housed, mental health, and addictions and Aboriginal health.

Other community partners, from a range of local and broader services and programs, are very complimentary about the important role SMH plays. Community partners describe their relationship as strong, with key contacts and linkages at all levels of the organization. Examples of secondments and sharing education are important to the partners who may not have the fiscal or human resources that St. Michael's may be able to share. The approach the hospital has used in the past year include creating a strategic plan that is more nimble and appreciates that many changes need to be factored in over a three-year period, and that the plan "drives what they do."

The values, although reviewed regularly, have been a stronghold for the organization for decades. And while SMH has been through and will go through significant change with the 3.0 project, the organization is incorporating various change management strategies, such as Kotter's change and quality improvement theory and others to balance and support the best approaches to various situations. With patients as motivation, the organization is finding it is developing capacity and readiness in a new way. Examples were shared of how strategic and thoughtful changes were made including the provincial strategy to reduce the number of neurosurgery patients who had to travel to Buffalo, New York, for surgery. These types of examples demonstrate St. Michael's provincial role in addition to its key community and LHIN roles.

Resource and infrastructure needs are managed and leaders report that initiatives must be aligned with the strategic directions. Decisions are made by the senior leadership at the OPPC. Patient priorities such as a rapid referral to expedite transfers from the emergency department (ED) to the units and a new nurse call system are examples of responsiveness. Project charters are created to capture moves and transitions as part of the 3.0 project. These detailed documents help ensure communication and safety during decanting and changes in workspaces.

There has been a conscious effort made to pare down the number of corporate objectives and create a strategic management system that allows for clearer information flow across levels and to the board. A monthly CEO town hall is videotaped and well attended. Staff hear about progress and get updates on budget and the achievements of the organization and its people.

Community partners look forward to the opportunities to expand on some of the successes to date, with potentially more secondments, more telemedicine and education supports, increasing mental health supports particularly for detox, and ensuring succession of talent for retiring personnel.

Priority Process: Resource Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

St. Michael's strategic priorities are integrated with financial planning using guiding principles and clinical service plans, and take provincial directions into consideration to build the best budgets possible. Historically, when asked to make budget cuts the organization would implement an across-the-board one to two percent cut which was not only challenging, but did not necessarily look at opportunities for efficiencies and changes. Senior staff have been responsive in implementing a new approach to operational budgets and are happy to report they are in a favourable financial position.

The relationship with the ministry is important to St. Michael's and there are important provincial programs in which St. Michael's is instrumental. There are a number of successes described, such as having a five-year capital plan in advance, demonstrating transparency in resource allocation, ensuring partnerships with other organizations, achieving synergy, business fluency, and increased cooperation among all levels, including physicians and other clinicians.

The co-chair model, including a clinical director for OPCC, is felt to be successful. OPCC reports to the Senior Leadership Committee. Having clinical leadership involved in helping with difficult decisions and monitoring choices has been perceived to be useful. An important aspect of budget planning and processes has included increasing staff's "performance fluency" and an understanding of how business cases can help inform decisions and changes.

Examples were shared indicating how values are aligned with the strategic plan in order to consider all aspects of financial decisions and the impact on patients. Advocacy at the ministry level and support from the St. Michael's Hospital Foundation has allowed the organization to retain important programs and fund services that support doing the right thing for the right patient at the right time.

Front-line managers receive financial data in a system aligned with human resource and supply chain information. This new financial system went live in 2015. Feedback was received from managers that the new system was time consuming. In response, business managers and program financial consultants have been brought together with managers in a monthly forum for reviews. It is felt that people are effectively using the reports to manage and are better embracing the budget philosophy.

St. Michael's has successfully dealt with funding challenges by looking at the bigger picture. IPMO works hard to ensure no negative impacts on patient care occur. Data are used as a strategic resource and there are strong examples of significant savings through efficiency projects such as with supply chain achieving $7.4 million. It is felt that leaders are grateful for data that make sense and that the support of financial consultants and decision support are helping everyone become more business savvy.

The Capital Resources and Emergency Management Council makes recommendations regarding capital equipment and renovation expenditures and corporate planning for effective emergency planning.

Priority Process: Human Capital

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

St. Michael's has a history of caring for those who care for the patients. The expanded care team not only includes direct care providers but also those who support the work of the organization in its entirety. Patients are aware that they are the centre of the team and that as a teaching hospital they may encounter many student trainees as part of their care. Patients understand that they play an important role in helping to train the next generation of care providers.

Staff report some of the strengths of SMH as its commitment to values, compassionate service provision, collaborative teams, and strong volunteer support. A positive worklife has been fostered through numerous strategies and expected behaviours in code of conduct policies and is modelled by leaders in the organization. New leaders and new physicians are welcomed with clear and helpful orientation to ensure all human resources aspects and paperwork such as payroll are completed and monitored for accuracy.

The relationship with unions is reported to be excellent. Examples were shared of how everyone came together during a recent flood to truly consider the best interests of staff and ensure a safe and as speedy as possible return to work. Staff retention is strong and it is interesting to note that even if staff leave, many return to St. Michael's after gaining additional academic credentials or experience elsewhere.

Recruitment factors in data and decision support are considered in order to look at all aspects of operations. There is a strong pool of new graduates annually, many of whom choose to stay at SMH. Hiring for values is a key part of St. Michael's success. While there is some variation in performance review completion, SMH has made a commitment to ensure clinical staff have a review completed every two years. Senior staff performance reviews are completed at 100 percent in light of pay for performance. The people strategy includes mandatory training and education records are tracked electronically using the online learning system.

Some units are very large, with significant span of control, and in response some additional positions have been created to manage workload and provide stronger clinical and professional support. Studer principles of creating a culture of coaching and cultural transformation have been used to garner ideas and engage all levels of staff. An example of the CEO handing out apples to staff to connect and recognize their efforts was shared and staff report "liking having management visible and available."

Volunteers play a significant role at SMH and their dedication improves the experience for patients and visitors. The same level of rigour is applied in terms of human resource management for volunteers, ensuring a meaningful experience for them because they truly make a difference every day.

Credentialing and re-appointments for physicians are streamlined using an electronic approach. This ensures that all corporate policies are reviewed and mandatory online training and in-person testing and surveillance for communicable diseases is complete.

St. Michael's is committed to workplace safety and ensures incidents related to workplace violence are thoroughly reviewed and analyzed. The occupational health nurse is involved in the incident intake to ensure complete documentation. The Joint Health and Safety Committee includes a subcommittee that reviews the four most common staff safety incidents: client mobility, slips and falls, needlestick injuries, and workplace violence. At six-month intervals, the workplace violence sub-group completes a root cause analysis of each incident of workplace violence and, based on the findings, makes recommendations to the Joint Health and Safety Committee. The recommendations are reported to the Senior Leadership Committee for action as applicable. In addition, the Senior Leadership Committee receives a quarterly report that includes the number of reported workplace violence incidents.

Priority Process: Integrated Quality Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Quality is embedded in the strategic plan and SOAPEE (safety, outcomes, access, patient-centredness, efficiency, and equity) is embraced by all levels of staff. These Institute of Medicine quality dimensions have ensured clear messaging and a clear focus on quality for years. The quality improvement plan aligns with St. Michael's efforts to pursue achieving excellence in care, research, and education.

Quality is a notable driver in the organization, with "intentional weaving" and "cross-cutting" in services. The quality and safety priorities for SMH are approved by the board and publicly posted. There is an openness and understanding of the utmost care and attention to people, including patients, staff, physicians, and volunteers. The quality and safety priorities are written in a patient-focused manner and include patient input to focus on the things that matter most to patients. Key patient-focused language includes "keep me safe, keep me involved, and make my transition from hospital seamless."

The structure of quality at SMH ensures input from the physician quality leaders group as well as input from staff, patients, and families is ultimately shared with the board. There is organization support for quality. Quality and performance, enterprise risk, decision support, information management, professional practice, physician quality roles, education, and research all feed into strategies and services.

Some achievements St. Michael's is particularly proud of include the launch of the patient and family advisor program, the active involvement of physicians in quality, the enterprise risk framework, staff development, and the collaborative practice that ensures the best quality of patient care. Staff feel recognized for their quality efforts through the Values in Action annual recognition, internal and external poster and oral presentations, and donors who give back via the St. Michael's Hospital Foundation.

SMH is often a leader in seeking out and participating in external safety initiatives and is called on to provide expertise and advice to others regarding quality and safety in health care. The accreditation journey has been described by staff as something to embrace as "excellence every day." The maturity of the organization regarding safety and the integrity of the quality work was described as something physicians and staff "don't shy away from." St. Michael's has achieved the Registered Nurses Association of Ontario (RNAO) Best Practice Spotlight Organization designation. Numerous best practice guidelines have been implemented to continue to advance the quality and safety agenda at St. Michael's. At the unit level a number of key safety initiatives such as intentional rounding have made a profound difference to patients' perceptions of nursing care and to reducing falls and increasing comfort measures.

According to St. Michael's, the cornerstone of ensuring a patient safety culture is the just culture they create. The strategies used include updating the safety and learning system to be more user friendly and more responsive for follow up to reported incidents/adverse events. As well, safety culture cafes are held and patient relations plays a key role in ensuring follow up with patients and families who have concerns.

Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The ethics services at SMH are rooted in the tradition established by the Sisters of St. Joseph and the Health Ethics Guide published by the Catholic Health Alliance of Canada, which provide direction for the organization. The values are not only visible, but are lived and palpable to staff, students, patients, and visitors. The Centre for Clinical Ethics is a joint venture of Providence Healthcare, St. Joseph's Health Centre, and St. Michael's Hospital. The clinical service has grown over the years to include 10 hospitals. Education, consultations, policy development, and research are included. The ethics consultation service is available 24 hours per day, seven days per week to patients, families, staff, volunteers, and students.

There is a commitment to building capacity in ethics awareness and knowledge through regular attendance at clinical rounds, publications, and case study reviews. There are regular unit-based rounds, education at general hospital orientation, education of medical residents, nursing, and allied health, and ethics grand rounds. Grand rounds are held monthly with a variety of internal and external speakers, with topics ranging from "Gimme Shelter: Discharge Planning and Homelessness" to "Physician-Assisted Death: What is it? What are the issues? The questions?"

In 2014 there were 125 clinical consults/debriefs and eight administrative consults. In 2015, there were 138 clinical consults/debriefs and 28 administrative consults. As well there is a Fellowship Program in Clinical Ethics and an annual ethics conference.

Ethics issues are identified and addressed in many ways. An ethicist participates in rounds on many clinical units and is like an "antenna out there, available directly if issues are bubbling up." As well, the ethics service is called on by service providers, patients, students, and the public. The ethics information is available on the website. The information regarding the Centre for Clinical Ethics ensures clarity on what they are and what they are not (i.e., they are not arbiters of right and wrong, the moral police, the decision maker, legal experts, or the only people who "do" ethics).

The intent is to build capacity within the organization. A memorable acronym – the YODA ethics framework – is used, where Y = You, O = Observe, D = Deliberate, and A = Act. There are various considerations and steps under each component such as identifying the problem, considering alternatives, and articulating the decision.

The Research Ethics Board reports to the board of directors through the president. They review over 400 studies per year and 100 full board reviews annually. The committee, including dedicated community members, interfaces with researchers and ensures updated training and research compliance is met. They have implemented a new research quality audit to support junior investigators and support

corrective action plans as needed. There is tremendous pride in the work the review board has been able to achieve and the calibre of studies and research is commendable.

The ethics team appreciates that there will be tremendous work going forward regarding physician-assisted death and moral issues, and the tension of staying true to the traditions of St. Michael's. The team feels that more and better conversations about the end of life are required.

Priority Process: Communication

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

In comparison to the last accreditation on-site survey, the communication team established a communication plan overarching across the organization and focusing on four key areas: transparency, responsiveness, people-izing, and engagement.

Significant efforts have been made to create adaptive communication tools to meet various stakeholder needs in terms of communication strategies and streams. In the last fiscal year, the communications and public affairs team has made great strides in how they handled and faced negative publicity. In fact, this was so well managed that external stakeholders from similar industries reached out to seek input from them and share their successes, strategies, and lessons learned.

The organization has made significant strides as well in terms of implementing information technology (IT) and its information management (IM) plan. The use of social media as a feedback loop to support health promotion is a key success for the organization. Significant improvements were also noted in abstracting and coding health information management department permitting accurate (using a proxy with a 95 percent confidence interval) and timely reporting to the board and leadership teams on quality indicators.

Priority Process: Physical Environment

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

SMH was built in various stages between 1920 and 2000. There have been many retrofits and upgrades. In 2003, planning was started for St. Michael's 3.0, including a massive 17-story new addition and upgrades to patient areas to meet current standards. The majority of the new facilities will be in place by 2019. Planning for new facilities included input from staff and patient advisory groups who were engaged from the design phase.

Many areas of the hospital are old, worn down, cluttered, and lacking visual appeal. In areas like critical care or the ED, the units are open concept, making privacy an important issue for the teams working in those locations and for the patients. Staff must recognize this deficiency and be educated on ways to mitigate this concern until they move to new facilities.

During construction there is close communication between the contractor and the team. Best practices are followed to minimize the impact of construction related to noise, infection hazards, and general disruptions to way-finding.

The surgical suite is built to the standards of the 1990s with some upgrades. There is a sub-sterile corridor and restricted access. Patient flow is remarkably good, despite the limitations. There is remote and local monitoring for temperature and humidity in the operating room (OR).

The helipad is located on the roof and is equipped with fire safety features. Access to the ED is by an elevator that goes directly to the ED or the operating room. The power plant is new, clean, and contains adequate redundancy including six power generators. The HVAC system is also well maintained and monitored. The refuse handling areas are clean and orderly. Refuse handling includes sharps management, recycling, and general garbage.

Priority Process: Emergency Preparedness

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The emergency preparedness team is interdisciplinary and includes expertise from a wide range of clinical and non-clinical departments. The operational framework for disasters, including pandemic planning, is a command centre model known as the incident management system (IMS). This allows for a focused direction of activities during a disaster. The framework is role driven. IMS operates in close liaison with fire, police, emergency medical services (EMS), and other relevant partners.

St. Michael's has had recent experience with a major flood in the ED. IMS was activated and within two hours the team was functioning. The steps taken to mitigate the disaster, including patient transfer, rapid response, and staged reopening of the ED, was cited by the Healthcare Insurance Reciprocal of Canada (HIROC) as an exemplary practice. The team also planned for the G20 summit and the Pan-American Games. More recently, the team led preparations for a possible Ebola outbreak.

All disasters and drills are followed by a debriefing session and the analysis is used to improve planning or operations for the future.

Priority Process: Patient Flow

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The Patient Flow Committee has representatives from senior management, clinical leaders, and support services. The team meets twice each month to discuss emerging issues and action plans. The operational team meets daily to plan for discharges, transfers, repatriations, and any other factors that might be used to mitigate overcrowding.

The major bottlenecks are the patients admitted to the emergency department, ward beds, and the critical care units. The emergency department was designed to accommodate 40,000 visits each year. Current volume is 75,000. The ED is a main point of admission to the hospital. At present 39 percent of inpatient admissions are from the ED.

Indicators are used on a daily, monthly, and quarterly basis to inform the planning process to improve patient flow. The organization has put in place strategies to accommodate surge capacity in both anticipated circumstances like the influenza outbreak and uncontrolled conditions like a recent flooding of the ED. Indicators are also used to identify quality improvement activities. Best practice guidelines are used extensively throughout the organization, many of which are designed to improve both the effectiveness of an intervention and to improve efficiency.

The time from decision to admit to transfer to a bed remains unacceptably high at 18.4 hours (90 percent). The organization is encouraged to continue to look for opportunities to improve this metric including repatriation agreements, effective discharge planning, and admission avoidance. As a new initiative that shows early promise, the organization is encouraged to assess the impact of the rapid assessment clinic, and to include patient-reported outcomes in the assessment.

Priority Process: Medical Devices and Equipment

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

Unmet Criteria		High Priority Criteria
Standards Set: Diagnostic Imaging Services		
8.5	The team ensures the staff involved in cleaning and reprocessing diagnostic devices and equipment are qualified and competent.	
Standards Set: Perioperative Services and Invasive Procedures		
4.9	Contaminated items are transported separately from clean or sterilized items, and away from client service and high-traffic areas.	!
4.14	The education, certification, and competency of team members involved in reprocessing in the operating/procedure room are verified.	!
Standards Set: Reprocessing and Sterilization of Reusable Medical Devices		
3.2	The organization limits access to the medical device reprocessing department to appropriate team members, and posts clear signage limiting access to all entry points.	!
3.5	The organization regulates the air quality, ventilation, temperature, and relative humidity, and lighting in decontamination, reprocessing, and storage areas.	
3.6	The organization selects materials for the floors, walls, ceilings, fixtures, pipes, and work surfaces that limit contamination, promote ease of washing and decontamination, and will not shed particles or fibres.	
5.7	The team follows a detailed dress code while in the clean reprocessing area that addresses clothing, hair, jewelry, artificial fingernails of any form, and covered footwear.	!
11.3	All endoscopic reprocessing areas are equipped with separate cleaning and decontamination work areas as well as storage, dedicated plumbing and drains, and proper air ventilation.	!
11.10	The record of endoscopic device reprocessing includes the identification number and the type of endoscope, the identification number of the automated endoscope reprocessor (if applicable), the date and time of the clinical procedure, the name or unique identifier of the client, the results of the individual inspection and leak test, and the name of the person reprocessing the endoscope.	

12.6	The team follows an established procedure to recall sterilized items that may have been compromised.	!

Surveyor comments on the priority process(es)

The medical device and reprocessing department (MDRD) will be undergoing significant change in the weeks to come. MDRD will be operating in a satellite mobile unit for approximately three weeks during the 18-month construction project that is planned for MDRD. MDRD has a decentralized model, with reprocessing activities in the following areas: the main MDRD department, a clinic/program with high-level disinfection and reprocessing, and the endoscopy therapeutic unit on 16CC (4CC, Cardiology 7th floor, Cystoscopy 5CC, Diagnostic Imaging 3CCN, ENT 8CC, OBGYN, Ophthalmology, OR 5th floor, Women's clinic on Queen's).

Staff interviewed were highly engaged, experienced, qualified, and had been with the organization for many years. There is a variety of skill mixes working in reprocessing such as certified MDRAO staff, respiratory technicians, and environmental services staff. Not all staff have received the necessary training and a review of competencies and yearly re-certification is required. Understanding that the MDRD director is not accountable for all staff performing activities within the MDRD unit and report to other management teams, the organization is encouraged to take a coordinated approach to ensure all staff meet the competency requirements. Staff in the main MDRD are energized with the new equipment and environment in which they will soon be working. Leaders in this area have worked hard to improve the culture and daily huddles promote active communication and a focus on quality. Increased communication and staff input with regard to the new construction is advisable as staff shared concerns and are slightly apprehensive due to a lack of understanding and concerns about the impact it will have on future work flow.

SMH has a formal process for prioritizing capital procurement of medical devices and equipment, and for engaging distributors and suppliers. Capital planning has broad representation and established an electronic ballot for voting on priority and needs. With new procedures, products, and technologies, there are mechanisms to allow for multidisciplinary collaboration and appropriate input from various stakeholders. The preventive maintenance (PM) program uses a risk-based approach for PM prioritization and rationalization. Biomedical is able to monitor performance and preventive maintenance is completed as planned on an annual basis. The newly named clinical engineering department is responsible for the "self-insurance" model. Its dynamic model created the opportunity to evaluate over time the need to adjust the frequency of preventive maintenance according to needs. This unique system has allowed significant savings and in certain cases extended equipment life.

With regard to inventory control, in the operating room case preparation, significant resources and time are being dedicated to address return products from the operating room. A comprehensive review of preference cards is suggested for cost saving opportunities. Par adjustments, bin location, and labelling are other areas of focus that were mentioned by staff to address workload and inefficiencies for supply management in MDRD.

Contaminated instruments from the operating room and units are transported via open case carts in client service elevators in high-traffic areas. Open case carts are covered with an opaque plastic bagging, although staff stated it is difficult to contain residue fluid and visible excess blood stains through the bag during transportation.

Product recall processes are developed but inconsistent across the organization. The therapeutic endoscopy unit received the Unit of Excellence Award for two consecutive years by the OMED and have exceptional processes in place for recall and instrument tracking. The organization is encouraged to consider standardizing the practice to all MDRD settings to improve patient safety.

Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Competency - Primary Care

- Developing a highly competent interdisciplinary team with the knowledge, skills and abilities to develop, manage, and deliver effective and efficient programs, services, and care.

Living Organ Donation

- Living organ donation services provided by supporting potential living donors in making informed decisions, to donor suitability testing, and carrying out living organ donation procedures.

Organ and Tissue Transplant

- Providing organ and/or tissue transplant service from initial assessment to follow-up.

Point-of-care Testing Services

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

Clinical Leadership

- Providing leadership and direction to teams providing services.

Competency

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

Episode of Care

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

Decision Support

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

Impact on Outcomes

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

Medication Management

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

Organ and Tissue Donation

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

Infection Prevention and Control

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

Diagnostic Services: Imaging

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

Diagnostic Services: Laboratory

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

Blood Services

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

Transfusion Services

- Transfusion Services

Standards Set: Acquired Brain Injury Services - Direct Service Provision

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Neuro-trauma services at SMH is one of 11 adult neurosurgical centres in Ontario.

In alignment with the corporate strategic goals of innovation and minimally invasive procedures, the unit's focus has been on offering highly specialized services to which there is limited access, such as subarachnoid with coiling procedures. They distinguish themselves by offering specialty services in neurovascular disease, complex skull base lesions, brain tumours, and neurosurgery/orthopedic spinal care.

Refusing no one, they have the highest market share of highly acutely ill patients. Being a partner for CritiCall, the unit continuously plans to assure a "priority bed or life-or-limb bed" at all times for urgent needs. As leaders in the industry, the interdisciplinary team actively contributes to the Neurosurgical Education Outreach Network (NEON), Provincial Neurosurgery Ontario, and Critical Care Services Ontario. They have taken a proactive role in collaborating with external partners to ensure seamless, timely access to at patients at all transitions of care.

This team is recognized for being experts in their field and for having long-standing staff, engaged and committed leadership, and strong medical direction and oversight. Striving to be world leaders in critical care, they invest heavily in education (George Brown), training, mentorship, and workshops and are committed to quality and patient safety. It was evident that this is a high performing team. Leadership's visibility, transparency, supportive, and approachable nature demonstrate how the team lives the organization's mission, vision, and values.

Priority Process: Competency

There is a sense of uniqueness on entering this service. Staff are deeply committed to providing the best possible quality care with the best possible outcomes.

The organization is truly committed to and encourages, promotes, and supports staff to pursue education. If they choose to do so, staff are offered opportunities to pursue higher education or specialty courses in a variety of settings. Care is provided in a multidisciplinary model where learning and leveraging from each specialty resource is welcomed and encouraged.

Client- and family-centred care is a unit priority. They have patients and families listen in and actively participate in rounds by making sure time is allocated for questions or concerns. Families are provided with a quiet space in the crisis room adjacent to the unit where blankets, dim lighting, cots, couch, and unlimited access to their loved one is permitted. The unit has no visitation restrictions and encourages families to participate in care 24/7 if they wish.

Chaplain and social worker support is provided on a full-time basis and they attend all codes to assist and support the family. To obtain information about each patient, staff ask that families populate “My Story” so they can personalize the care they provide. Ethicists are also available and serve as an active member of the team to support staff, families, and medical staff in difficult ethical decisions such as end of life.

Priority Process: Episode of Care

Since the last on-site survey, many strategies have been developed to address safety issues and promote a culture of safety. The unit is currently piloting a new symbol that is posted as a visual indicator to all health care providers about potential violent behaviours. This tool has had positive feedback from all disciplines and results are being evaluated.

More work is required to increase hand-hygiene compliance throughout the unit. Falls assessments are documented in the charts and the team is encouraged to continue progress tracking.

Staff are recognized monthly with the Extra Mile Award and yearly with the Award of Distinction.

Engagement surveys are actively being done and the leadership team and staff make improvements collectively. Given that the patients often are not capable or are unable to participate in care, families and caregivers are highly involved in the care planning process.

Priority Process: Decision Support

The team collaborates with decision support to accurately review and obtain information with regard to volumes and quality indicators on which they are required to report.

Staff use electronic charting and physicians are charting on paper. Integration to have all disciplines document in the electronic medical record (EMR) would reduce the risk of errors and omissions.

Priority Process: Impact on Outcomes

Safety and quality improvement initiatives are evident on the unit. The team uses evidence to support best practice pathways for specialized patient populations such as those with subarachnoid hemorrhages and acquired brain injuries.

Standards Set: Ambulatory Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.3	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.	
2.6	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
Priority Process: Competency		
3.11	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
13.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
13.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The use of client and family advisory groups is at different stages across the ambulatory clinics visited. With input from clients and families the diabetes/endocrinology clinic has redesigned the waiting room to have a greater focus on health and well being. Based on feedback from their clients the dialysis clinic has implemented a system of rotating the order in which clients are placed onto the machines throughout the week so as allow each one the opportunity to be first to begin their treatment. The heart health unit has recently established their Patient and Family Advisory Council and as an initial project has requested input from this group on a draft discharge summary document.

It was not apparent from the information shared that clients and families have been engaged in discussions regarding improving the design and functioning of the services. Nor was it evident from the information gathered that clients and families had been asked to assist in determining the appropriate mix of skill level and experience within the team nor to assist in evaluating resources and/or staffing levels. The ambulatory care areas are encouraged to continue to build on the current processes and gather further input from clients and families who use their services.

All of the ambulatory clinics described partnerships that support the continuity of care for clients and families. The association with the six family practice clinics associated with the hospital is very beneficial to the continuity of care for clients and families associated with the ambulatory care clinics.

Priority Process: Competency

The interdisciplinary teams in the areas visited are all very engaged, competent, and committed to patient-centred care. Members respect each other's input, dialogue is collegial, and physician engagement is strong. All teams demonstrated a very high degree of collaboration and a strong focus of caring about the clients and families they serve.

The heart health team is commended for their work to cross-train staff thereby improving utilization and consolidating a large group of specialists into one area, which has facilitated greater access for clients.

The client and family roles with the interdisciplinary teams are growing. However, it was not evident from the information gathered that client and family feedback has been gathered regarding their roles and responsibilities, role design, and role satisfaction.

There is evidence of ongoing educational activities and opportunities for professional growth. As well, all areas have a strong orientation program which varies in length depending upon the need for additional skills (e.g., dialysis).

Priority Process: Episode of Care

The ambulatory care clinics are commended for their efforts to reduce wait times. In all three areas visited, wait times are monitored and steps have been taken to provide timely access. Urgent referrals from the emergency department and inpatient units are triaged and appointments are provided as quickly as within 24 hours.

Clients and families are encouraged to be engaged in their care to the degree they wish to be. Clients spoken to expressed their appreciation for the level of information they were given and the open and transparent communication. They have felt a part of the team.

Given the diverse population served, language barriers are common and all of the areas have done excellent work to provide translation and interpretation services either through telemedicine or in person.

The transfer of standardized information at transitions is evident and requires further development to ensure consistency across ambulatory care areas.

Priority Process: Decision Support

Although an electronic medical record is now found in most areas of the hospital, this work has not yet been expanded to the ambulatory care areas. It was identified in two of the areas visited that implementation of an electronic medical record (EMR) would greatly enhance client care and data collection for quality initiatives. The organization is encouraged to quickly implement an electronic medical record in the ambulatory care areas.

The dialysis unit is commended for the work that has been recently completed to implement a software program specifically designed for use in dialysis units. This new program (NephroCare) streamlines documentation of the care of the patient during dialysis.

Priority Process: Impact on Outcomes

All of the ambulatory care areas surveyed actively gather client and family feedback through formal and informal satisfaction surveys and use this information to guide quality improvement activities.

Each of the areas surveyed has developed quality improvement activities with metrics and timelines. Several of the quality improvement activities include reducing turnaround times for new referrals and monitoring the number of clients who do not arrive for a scheduled appointment.

In addition to the use of an independent third-party client satisfaction survey (NRC Picker), several of the areas have begun to implement real-time surveys to respond in a timely manner to concerns raised by clients and families.

The ambulatory care areas are encouraged to expand the current work of gathering client and family input to include getting feedback on the work processes and the selection of evidence-informed guidelines.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.3	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.	
8.2	Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from clients and families where appropriate.	
Priority Process: Competency		
6.15	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		
Priority Process: Medication Management		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The medical day care unit is part of the cancer program and closely affiliated with the inpatient cancer unit. The physical area is quite congested during peak times of service; however, flow is maintained with support from staff and volunteers in the area. The unit is commended for implementing the "buzzer" program by which clients and their families are able to leave the immediate area but be notified when their appointment time has arrived. The medical day care unit will be relocated to a larger space once the new tower is complete and the inpatient unit is also able to move.

The cancer program is commended for responding to feedback from client and families by implementing a patient navigation specialist role to help clients and their families manage the challenges faced during their journey to recovery. Clients commented that this has been very helpful, and they greatly appreciate having someone to answer their questions and coordinate access to services offered by other health professionals.

From the information shared, it was not apparent that clients and families have been engaged in discussions regarding the appropriate mix of skill level and experience within the team nor to assist in the work and job design of staff. The program is encouraged to continue to build upon the current processes and gather further input from clients and families who use their services.

Priority Process: Competency

The interdisciplinary team is very engaged, competent, and committed to patient-centred care. Members respect each other's input, dialogue is collegial, and physician engagement is strong. All teams demonstrated a very high degree of collaboration and a strong focus of caring about the clients and families they serve.

The orientation program for registered nurses is extensive to support the learning needs surrounding administration of systemic cancer therapy medications. The majority of the registered nurses work between the inpatient unit and the medical day care. As well, a number of the allied health professionals also work between the inpatient cancer unit, the palliative unit, or the medical day care. This overlap across the program facilitates continuity of care for clients and families.

Priority Process: Episode of Care

Clients and family members expressed feeling very engaged in their care. They appreciate of the vast amount of information that is made available to them in a manner they can understand.

Clients are made aware of potential transitions. The fact that many of the staff work in several areas of the cancer program aids continuity.

Direct flow between the medical day care clinic and the inpatient unit allows for the accommodation of clients who may not be well at the time of their clinic visit and require admission for ongoing care.

The interdisciplinary team available to clients and families supports very comprehensive physical and psychosocial care.

Clear processes are followed for preparing, using, and administering cytotoxic drug products. The presence of a clinical pharmacist supports questions and consultations from the team regarding drugs and drug processes.

Priority Process: Decision Support

Records are both electronic and paper charts. Information is accessible; however, effort is needed to acquire a comprehensive understanding of the care the client is receiving or has received during their stay in the unit. The organization is moving to a full electronic medical record and is encouraged to expedite this process.

The interactive symptom assessment and collection (ISAAC) system, by which clients are able to electronically enter information regarding their key symptoms, has proven to be a valued tool by clients and has aided the assessment interview with the health care provider.

Priority Process: Impact on Outcomes

The cancer care program adheres to the standards developed by CCO, a provincial agency overseeing cancer care in Ontario. CCO has been a leader in engaging clients and families in the development of standards and guidelines for cancer care in the province.

The hospital's cancer program also reports to CCO on a number of quality indicators including systemic therapy volumes, breast cancer screening, diagnostic volumes, and wait times.

Safety has been a significant focus for the entire organization and this is evident within the cancer care program. Best practices implemented by the nursing team in the program include pain assessment and management, therapeutic relationships, managing fears and anxieties, and transfer of accountability. In addition, the program has implemented a new chemotherapy class and orientation booklet, and pre-printed orders for oral chemotherapy are now being completed in an electronic ordering tool called E-prescription.

Priority Process: Medication Management

The guidelines for safe handling and administration of systemic cancer therapy medications are well established, available to staff, and closely followed. Staff were observed performing the required double checks and taking other necessary precautions including wearing appropriate personal protective equipment.

The variety of infusion pumps is limited across the organization. The pumps are several years old and the organization is about to purchase new pumps but plan to again limit the variety.

The presence of a dedicated pharmacist in the medical day care unit is very helpful in managing the administration of systemic cancer therapies and in providing support to staff and physicians regarding these therapies.

Standards Set: Biomedical Laboratory Services - Direct Service Provision

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

The organization has met all criteria for this priority process.

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

Much of the laboratory services program was recently assessed by the Institute for Quality Management in Healthcare (IQMH) process; therefore, this assessment is limited to items not included in the IQMH assessment.

The main laboratory supports the needs of the hospital as well as the work generated in two community collection centres. The laboratory leadership team also oversees three outpatient laboratory facilities associated with the hospital. The main laboratory is well equipped with significant automation that facilitates turnaround time for results.

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

The laboratory appears to have a well-developed quality management program and frequently gathers feedback from clients regarding satisfaction with service levels. Recent quality improvement activities identified opportunities to improve the appropriateness of testing, leading the team to identify the need to focus on utilization as a key strategic direction for the laboratory.

The laboratory leadership team is commended for their efforts in gathering input about their services and their recent strategic planning session. Through this planning session the team identified three main areas of focus: diagnostic innovation, utilization, and engagement. All three areas are in keeping with the broader corporate goals and objectives of the hospital.

The strategic focus on engagement is aimed at increasing dialogue with clinical colleagues regarding reducing unnecessary testing. The team is looking to dedicate more time to being available for clinical consultation and supporting the clinical teams in planning diagnostic testing needs.

The laboratory team has actively sought external partnerships. The medical laboratory director role is shared with another organization and discussions are ongoing as to the potential to create centres excellence in diagnostic laboratory testing.

Standards Set: Cancer Care and Oncology Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.3	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.	
5.2	Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from clients and families where appropriate.	
Priority Process: Competency		
3.12	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The organization is actively involved in the Toronto Central Regional Cancer Program and with Cancer Care Ontario (CCO), a provincial agency overseeing cancer care in Ontario. Working with these agencies and other cancer care providers, the organization has identified and implemented new programs to fill the gaps in cancer care. One such program provides an expedited pathway for clients who are suspected of having colorectal cancer.

The cancer program is commended for responding to feedback from client and families by implementing a patient navigation specialist role to help clients and their families manage the challenges faced during their journey to recovery. Clients commented that this has been very helpful and they greatly appreciate having someone to answer their questions and coordinate access to services offered by other health professionals.

From the information shared, it was not apparent that clients and families have been engaged in discussions regarding the appropriate mix of skill level and experience within the team nor to assist in the work and job design of staff. The program is encouraged to continue to build upon the current processes and gather further input from clients and families who use their services.

Priority Process: Competency

There is an extensive interdisciplinary team that supports this program. Members appear to be very collaborative and, while recognizing their different scopes of practice, support each other to best meet the needs of the client. Daily huddles are held to discuss the plan of care for the clients on the unit as well as potential discharges or admissions.

The orientation program for registered nurses is extensive to support the learning needs regarding administration of systemic cancer therapy medications. The majority of the registered nurses work between the inpatient unit and the medical day care. As well, a number of the allied health professionals also work between the inpatient cancer unit and palliative unit or medical day care. This overlap across the program facilitates continuity of care for clients and families.

Staff report receiving performance feedback on a regular basis. Allied health team members receive feedback from their respective professional practice leaders as well from the administrative lead for the unit.

The co-location of the diagnostic imaging services within the breast cancer screening clinic creates the opportunity for the team to also include mammography technologists, ultrasound technologists, and radiologists.

Staff report having opportunities for ongoing learning and professional development.

The program is encouraged to continue on its journey of gathering input from clients and families and to include opportunities for input related to their roles and responsibilities.

Priority Process: Episode of Care

Clients and family members expressed feeling very engaged in their care. They appreciate of the vast amount of information that is available to them in a manner they can understand.

Clients are made aware of potential transitions. The fact that many of the staff work in several areas of the cancer program aids continuity.

Direct flow between the medical day care clinic and the inpatient unit allows for the accommodation of clients who may not be well at the time of their clinic visit and require admission for ongoing care.

The interdisciplinary team available to clients and families supports very comprehensive physical and psychosocial care.

Clear processes are followed for preparing, using, and administering cytotoxic drug products. The presence of a clinical pharmacist supports questions and consultations from the team regarding drugs and drug processes.

Priority Process: Decision Support

Records are both electronic and paper charts. Information is accessible; however, effort is needed to acquire a comprehensive understanding of the care the client is receiving or has received during their stay in the unit. The organization is moving to a full electronic medical record and is encouraged to expedite this process.

The flow of client information is aided by the physical proximity of the various entities within the program. This is particularly true in the breast cancer screening clinic where diagnostic services are located in the clinic.

Priority Process: Impact on Outcomes

The cancer care program adheres to CCO standards. CCO has been a leader in engaging clients and families in the development of standards and guidelines for cancer care in the province.

The hospital's cancer program reports to CCO on a number of quality indicators including systemic therapy volumes, breast cancer screening, diagnostic volumes, and wait times.

Safety has been a significant focus for the entire organization and this is evident within the cancer care program. Best practices implemented by the nursing team in the program include pain assessment and management, therapeutic relationships, managing fears and anxieties, and transfer of accountability. In addition, the program has implemented a new chemotherapy class and orientation booklet, and pre-printed orders for oral chemotherapy are now being completed in an electronic ordering tool called E-prescription.

Standards Set: Critical Care - Direct Service Provision

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

Critical care services is composed of four units—cardiovascular, medical/surgical, neuro/trauma, and coronary care—under one leadership. The leadership encourages input from patients and families. Patient surveys are administered on a continuous basis and are reviewed by the team on a quarterly basis. The results are used for quality improvement.

Current locations are crowded and raise concerns about privacy and infection control. The critical care units will move to new facilities in 2018. The new facility has had significant input from staff and patients in the design. The new critical care units will meet code for both space and infection control. In the interim, the team is encouraged to use creative methods to ensure privacy and confidentiality.

The outreach team may be called by nurses, physicians, allied health, and other personnel. Patients and families have easy access to the team.

A physician lead is identified for a block of time. The physician is responsible for clinical care, education of medical students and other staff, and research.

Priority Process: Competency

SMH has a well-developed system for verifying professional staff and physician credentials. All new hires undergo an organizational orientation. Nursing staff who are hired have completed or are enrolled in a critical care program. The orientation consists of didactic and practical work and excellent mentoring.

Performance appraisals are done annually and are used to identify educational opportunities. SMH provides access to educational opportunities for staff. An educational plan is in place for when the new information technology system is rolled out through the organization. Many educational opportunities have been developed with input from the patient advisory council.

The interdisciplinary team works effectively and cohesively. The team includes good access to ethical support and spiritual care. Patient engagement is understood and practiced by all members of the team.

Priority Process: Episode of Care

Admission and discharge from the critical care units are based on criteria developed in association with other services in the hospital. On admission to the units, patient and family engagement is encouraged. This includes orientation to the unit, introducing staff to patients and families, and clarifying roles and responsibilities of patients.

A comprehensive assessment is undertaken by the team members and appropriate diagnostic and laboratory testing is done. Access to diagnostics and laboratories is available at all times.

A treatment plan is developed in collaboration with the patient and family. The patient is re-evaluated on a daily basis during team rounds. In the cardiovascular intensive care unit, a checklist is used to ensure that all aspects of the patient's condition and management are considered. The checklist includes elements of the ventilator-associated pneumonia bundle.

There is extensive support for families. Team members are forthright with the families, particularly if the patient is unstable. Ethical support and spiritual care are available as needed. Difficult decisions about end-of-life care, transition to palliative care, and organ donation are based on the SMH ethical framework.

Priority Process: Decision Support

Critical care services use a hybrid paper and electronic system for charting. A comprehensive record is maintained for each patient and includes assessments, interdisciplinary notes, progress notes, orders, and medications. The teams have developed good processes to ensure all relevant information is available.

Patients have access to their records on request, under the supervision of a physician.

Priority Process: Impact on Outcomes

The critical care units use evidence-based guidelines for the most common problems encountered in each division. Best practice guidelines are researched and adapted for use and provide the basis for care in the units. They also allow the staff to educate patients on the expected course of management.

Patient safety, and in many instances patient involvement, are important in the critical care units. Hand hygiene, falls, and skin breakdown assessment are most effective with patient participation.

All serious adverse events are analyzed and lessons learned are shared with all staff. Disclosure is an organizational requirement and staff are supported to provide effective but compassionate disclosure.

The critical care units have strong cultures of quality improvement. The teams participate in organization-wide improvements including hand hygiene and patient engagement. They also develop initiatives specific to their units. All staff are aware of quality improvement and many local initiatives are staff driven.

The critical care program is indicator driven. Efficiency data, cost effectiveness, and outcome data are collected on a regular basis and shared with the team.

The critical care teams are encouraged to investigate ways in which patient-reported outcome data could be gathered and tracked.

Priority Process: Organ and Tissue Donation

Critical care services at SMH are leaders in tissue and organ donation. The first policy for donation after cardiac death (DCD) in Canada was developed at SMH. The donation program is active, works in close association with the Trillium Gift of Life Network, and identifies a large volume of potential donors with a high conversion rate.

Standards Set: Diagnostic Imaging Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Competency

Priority Process: Diagnostic Services: Imaging

The medical imaging department provides a wide array of services within the Greater Toronto Area (GTA).

There is a great sense of pride and commitment within the team to provide quality services in all modalities in a timely fashion, at minimal level of risk to clients they serve. The team uses an interdisciplinary approach which includes radiologists, technologists, nurses, aides, educators, clerical staff, and porters servicing over 260,000 exams each year.

Unit and medical leadership cohesiveness and partnership are strong, and clear lines of accountability and collaboration exist. This demonstrates how the unit aligns and supports the mission, vision, and values of the organization. Staff and patient satisfaction surveys are a key tool used on a regular basis to evaluate level of service and continually strive to improve patient experience.

The unit exceeded expectations with regard to the falls prevention program, and uses two patient identifiers by leveraging IT solutions and integration to improve safety within the unit. Technology has truly enabled the department to address wait time issues and inefficiencies.

Equipment is currently being updated with a provision for future replacement included in the five-year capital plan. The organization is strongly encouraged to review the current location for ultrasound probe cleaning and disinfection due to the distance from the actual ultrasound unit and resource allocation based on volumes and skill set. The unit has made great strides with regard to building strong relationships with other medical disciplines and should be commended for its openness and willingness to collaborate collectively. Staff also should be recognized for their family-centred care and caring approach.

Standards Set: Emergency Department - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
5.5	Standardized communication tools are used to share information about a client's care within and between teams.	!
6.6	Education and training on occupational health and safety regulations and organizational policies on workplace safety are provided to team members.	!
6.8	Education and training are provided to team members on how to prevent and manage workplace violence, including abuse, aggression, threats, and assaults.	!
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		
Priority Process: Organ and Tissue Donation		
The organization has met all criteria for this priority process.		
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

The emergency department (ED) is currently in a transitional phase. The current space was designed over 40 years ago for 40,000 annual visits. Planning for a redevelopment began in 2009 and the first phase is complete. The first transition to the new ED took place in May 2016. The total development will occur over several years and will be complete in 2019. The space is designed to accommodate 80,000 visits annually and can be expanded to accommodate 100,000 visits annually. The new space was designed with significant input from staff and patients.

The ED is integrally involved in the emergency preparedness plans. The team was central in planning for Ebola and the Pan American games. The responses were severely tested over the past year when a flood occurred in the ED, necessitating closure, evacuation, and a gradual resumption of services. The ED response has been cited by HIROC for planning by other organizations for similar events.

The ED works closely with other hospitals and community partners to optimize emergency services in Toronto.

Privacy is difficult to achieve at present, but was a major consideration in the design of the new unit. Despite that, seclusion areas are available for patients with mental health admissions and to isolate those with known or suspected infectious diseases.

Priority Process: Competency

SMH has an effective orientation program for all new staff. The program includes organizational orientation and orientation specific to the emergency department. The ED participates in the new grad program for nursing personnel and this has been an effective tool for recruitment. The ED also participates in the education of nurses, nurse practitioners, and allied health personnel. Training includes an introduction to ethics. As a faith-based organization, SMH has developed a strong and comprehensive ethics framework which is integral to the practice in the ED.

The approach in the ED is family centred. A patient advisory committee advises the ED on goals and objectives in alignment with the strategic plan.

The team works closely with consultants. Response times are monitored and appropriate reminders sent as necessary. The consultants were observed to be integrally involved in the care of patients in the ED. After a decision to admit, the responsibility for patients is shared between the ED physician and the consultant staff.

The team is in the process of implementing a standardized process for transfer of accountability between shift changes and on transfer to other parts of the hospital. This is only partially implemented. The team is encouraged to adopt a system for transfer of accountability and to develop a tool or process to ensure it is complete and documented.

Support service staff were unaware of potential dangers to their personal health of some of the chemicals that are used. They also reported incidents where they were inadequately advised of infectious hazards in areas they were asked to clean. The organization is encouraged to provide specific instruction in the handling of cleaning chemicals, and to identify potential serious infection hazards (e.g., scabies, bedbugs) to the housekeeping staff before they clean the area.

Security staff are available to assist staff in the event of a violent activity. The organization instituted training in de-escalation techniques several years ago, but the process was discontinued. SMH is encouraged to re-implement ED staff training in de-escalation techniques to mitigate the effects of workplace violence.

Priority Process: Episode of Care

SMH is a downtown ED in a large city. It is on the border of one of the less advantaged areas of the city. An overarching commitment of the organization is to provide care and comfort to some of the most disadvantaged people in the city.

All patients who present asking for service are admitted to care in a fair, comprehensive, and non-judgemental way. There are no barriers to care based on background, religion, ethnicity, or lifestyle.

The average time to triage is well within Canadian Triage and Acuity Scale (CTAS) guidelines. Experienced staff undertake the triage. Following triage, a secondary system is in place to verify the results of the initial triage. All staff including clerical staff, security, and others are trained to observe waiting patients for signs of deteriorating status. As a result, there have been very few incidents and no sentinel events over the past few years.

Patients and families are encouraged to participate in the care of patients in the ED. There are no restrictions on visiting hours. When needed, families are encouraged to participate, particularly if there is a language barrier. It is noted that up to 100 languages and dialects are included in the SMH catchment area.

The ED uses the ethical framework of the organization. It is rooted in the faith-based origins of the hospital and extends to all patients and families. There is a robust system for complaints and they are used by the organization and by the team for quality improvement.

Medication reconciliation is in place for admitted patients and selected patients who will not be admitted. A clinical pharmacist has recently been added to the team to assist in the process. A robust falls risk assessment is done in the ED and is well documented on the chart. The team has a system for suicide prevention.

Diagnostic services are available on a priority basis. An effective system has been developed to follow up on results of testing procedures or missed diagnoses based on incorrect interpretations. Nurse practitioners are used for this follow-up service. Also, SMH in association with other Toronto hospitals has developed a process to obtain information about patients who present at other organizations for re-admissions that have not been captured in the past.

SMH has developed a program in association with the Rotary Club of Toronto for the care of disadvantaged, often homeless, people who do not require admission. Four beds are allocated to allow social workers to identify appropriate follow-up care for these individuals. The result is that a great system has been implemented, but is not used by all staff. Recent evaluation showed that the system is used in only 50 percent of cases. The organization is encouraged to ensure that a uniform, well-documented system is used at all transition points, including shift handovers.

All staff are knowledgeable about the transfer of accountability. The challenge for the organization is to make the process more robust especially with compliance in this very difficult group of patients.

Priority Process: Decision Support

ED records are primarily paper-based. Much of SMH has transitioned to an electronic medical record, while the ED will transition in a few months. Champions, super users, and educational plans are in place to ensure a smooth transition.

Records meet applicable standards and are comprehensive. Patients may access their records on request.

An area for improvement would be to develop an annotated record for communication at transitions of care. Currently, most transitions are done by telephone. There is general knowledge of a transfer format, but it is by no means universal.

Priority Process: Impact on Outcomes

Evidence-based guidelines are at the heart of ED care, and indeed of patient management at SMH. SMH is a spotlight organization of the RNAO for the use of BPG and have implemented 26 over time. Others are in the process of being evaluated.

Best practice guidelines are selected and implemented with input from patient advisory committees, and are regularly evaluated for effectiveness and modified as appropriate. A major focus for the advisory committees is risk management and patient safety.

Incidents are reported effectively and are reviewed at all levels of the organization including senior leadership and the board. Disclosure of incidents to patients and families is an integral part of the ethical framework of SMH.

SMH has used NRC Picker as a patient-experience reporting tool. They have determined that it is not as effective as they wish and are developing their patient satisfaction survey. The organization is encouraged to include patient-reported outcomes in this redevelopment. PROMS have been shown to be an effective method for patient- and family-centred care and as a change driver for continuous quality improvement and improved outcomes.

EMS offload times are comparable to other EDs in downtown Toronto. Bypass is rarely used, and never in situations of "life and limb."

Data are used to track times to transfer after a decision to admit; these are above organization targets. The organization has adopted a number of methods including flow management, surge procedures, opening of closed areas, and most recently a rapid assessment clinic. This clinic is in its early days, but preliminary data shows it may be an effective technique to reduce the pressure on hospital services, thereby improving bed management.

Quality improvement activities are embedded in ED practice at SMH. All staff at all levels are familiar with these activities. Most have participated and are aware of the effectiveness of the interventions. The staff are willing to participate in any activity that may improve patient care.

Priority Process: Organ and Tissue Donation

Organ and tissue donation is an important program at SMH. One of the first policies on donation after cardiac death (DCD) was developed at the hospital. The ED is in many cases the starting point for organ donation and the staff are well aware of the policies and procedures.

Standards Set: Hospice, Palliative, End-of-Life Services - Direct Service Provision

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

The palliative care unit is a warm and welcoming unit. It includes an open kitchen/lounge, quiet rooms, and hardwood laminate floor that creates a homey space for patients and their families. The care team includes all health disciplines, support and service workers, as well as dedicated volunteers and students in academic health programs. The average length of stay is 14-17 days, with a median of eight days, and with 90 percent of patients admitted remaining until death. In addition to the 10-bed palliative care unit, consultation services are available for inpatients and a new palliative care clinic was established in 2015 to help support symptom management, advance care planning, and community-based palliative care coordination one afternoon per week.

Significant donations from the St. Michael's Hospital Foundation provide for patient televisions, artwork, stained glass windows, fresh flowers delivered to patients, and a new lovely spa-like washroom for family members and visitors.

The team works hard to maintain a culture of high-quality and high-compassion care. The tone on the unit is palpably values driven and commendable, with daily palliative care bullet rounds, all day workshops, and clinical fellowships to help foster a culture of client/family and staff engagement.

Priority Process: Competency

The team is collaborative in their approach. Daily bullet rounds include a diverse team of care providers. The team reports an increase in their communication and teamwork since implementing daily rounds that were previously conducted weekly. All staff work to their full scope, which is rewarding to the individual and most efficient in managing workload. Patient and staff preferences are accommodated as much as possible for assignments.

There is a strong focus on education with hospital-based and unit-specific orientation for all disciplines. There are online educational resources as well as in-person options. Managers and individuals can see education records using the electronic learning system.

Support for education and training and the dedication of the team to students and trainees is well received and appreciated. Staff value the opportunity to pursue additional education and certifications and examples of conference presentations and journal submissions were shared.

Priority Process: Episode of Care

Access to care has improved with the clinic operating one day per week and increased uptake of consultation services offered. An intake approach has improved with ongoing partnerships with other palliative care providers. The nurse coordinator arranges tours of the unit so patients and families have an opportunity to see the unit, speak to staff, and increase their comfort with the process. The team reviews goals with the patient and family daily during bullet rounds. Handouts such as “Dealing With Pain” and “Breathing Noises” help prepare patients and families with information about end-of-life considerations. As well, online resources are provided to families. Care planning includes the family and patients report a high level of satisfaction with the services they receive, particularly in comparison to other facilities they have experienced. Patients indicate that there is an openness and compassion among the staff that they appreciate tremendously, particularly at such a difficult time of loss.

Volunteers play a vital role on this team. Many of them have dedicated decades to the service. Thanks to the volunteers, the smell of fresh baked cookies fills the lounge to capacity where family members can access reading material, look at previous families’ experiences in a scrapbook, and have a chance to chat with others.

Priority Process: Decision Support

There is a hybrid health record, including an electronic medical record with lab information, transcribed notes, and interprofessional notes, and a paper-based record with progress notes, best possible medication history, face sheet, and ambulance records. Electronic records are password protected, with access level based on credentials. There is an e-sign out, e-discharge template and e-referral form used, maximizing communication at transitions and ensuring the patient is fully informed.

The team feels the e-referral form helps in the matching process for patient access to palliative care for the Toronto Central LHIN (Local Health Integrated Network). This leads to a more patient-centred approach. The team described success in the built palliative electronic tools such as order sets and CADD (computerized ambulatory drug delivery) infusion pumps that pharmacy, information technology, and nursing informatics were a key part of.

Information for research purposes is reviewed by the Research Ethics Board. The palliative team ensures that patients and families are aware of the opportunities for research and thoroughly explains the process to them.

Priority Process: Impact on Outcomes

The work of the team is evidence based. Standardized, specialized tools and research in the field are used to provide excellent care currently and into the future

As soon as possible after a patient is admitted a family meeting is held.

There are built-in supports for the marginalized populations served and every effort to “grant wishes” is made. One gesture that was made possible through generous donations are fresh flowers at the bedside and a card for each patient. There are regular memorials and celebrations of life that family members and staff attend.

Measures and indicators are tracked and trended, and the team is proud to share that typically their results for hand hygiene surpass other areas in the hospital. As a teaching and academic organization, a large number of students and trainees have an opportunity to experience working on this unit. They along with others know how privileged and humbled they are to have experienced the warmth and caring of the palliative care unit.

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

Unmet Criteria	High Priority Criteria
Priority Process: Infection Prevention and Control	
14.1 The organization has a quality improvement plan for the IPC program.	!
Surveyor comments on the priority process(es)	
Priority Process: Infection Prevention and Control	

The infection prevention and control (IPAC) program is highly embedded in clinical practice and quality councils. The IPAC team consists of seven experienced infection control practitioners (ICPs) and a medical lead. Each ICP is assigned a cluster of units to which they provide regular oversight for a certain period of time, but will occasionally rotate to ensure competency and skill sets are maintained. Having exposure to different environments and specialties and being embedded in the day-to-day operations of the units gives the ICPs visibility and this involvement has created great cohesive relationships with front-line staff and interdisciplinary teams.

Regular collaboration with external partners such as public health occurs weekly and policies and procedures are regularly reviewed. Providing safe and quality patient care is evident within this team. Staff recruitment and retention are not an issue and they have been very successful in recruiting through the summer student exposure training program. Linkages with a number of external bodies are developed and strong. Meetings and active collaboration with MDRD, endoscopy, public health, PICNET, environmental services, quality and patient safety, occupational health and safety leadership and staff occur monthly.

Although there is a vaccination program and influenza campaign, the organization continues to have low influenza vaccination rates and is encouraged to continue to focus on increasing influenza vaccination rates.

Key strategies for advancing safe care in the prevention of infections have been implemented as a result of transparent and aggressive measures taken by the IPAC team with regard to outbreaks and outbreak measures. The team shared multiple examples that demonstrated continuous monitoring, education, physical environmental decluttering, and training for extended periods of time until issues are resolved or improved. Training and orientation for all staff including environmental services and volunteers are also conducted in collaboration with ICPs.

In conjunction with the quality and performance team, hand hygiene appears to be an organization-wide initiative. Having set corporate hand-hygiene goals at 67 percent for moment 1 and 75 percent for moment 4, units created their own targets depending on their starting point. Peer-to-peer support is in

full effect with initiatives such as code aqua in the endoscopy therapeutic unit. Spread of this initiative is highly recommended. Progress is tracked and evaluated on a monthly basis. Unit staff provide feedback on dispenser placement and ways to improve compliance.

Medical device reprocessing has been identified as an area of concern, particularity in the satellite areas where cleaning, disinfection, and reprocessing occurs. The organization is encouraged to pay particular attention to infection control practices in decentralized MDRD areas, especially during the new construction and temporary location in the external mobile unit

Standards Set: Medication Management Standards - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Medication Management		
11.4	The organization regularly tests the limits set for soft and hard doses to make sure they are working in the smart infusion pump.	!
11.5	The organization regularly reviews the limits set for soft and hard doses and makes changes as required.	
Surveyor comments on the priority process(es)		
Priority Process: Medication Management		

The organization is commended for the progress it has made with regard to medication management since the last on-site survey. A comprehensive plan has been implemented for high-alert medication and the availability of certain medications. The restricted availability of concentrated electrolytes and certain concentrations of heparin and narcotics (opioids) was evident. The use of concentrated electrolytes in some areas is documented and has been approved by the Pharmacy and Therapeutics Committee.

To support comprehensive medication management, a number of interdisciplinary committees have been established including antimicrobial stewardship, hazardous drugs, diabetes, order sets, and medication system safety. All of these committees report to the Pharmacy and Therapeutics Committee.

The organization is commended for its work in implementing a large number of standard order sets. These order sets are electronic and readily available to clinical staff.

A robust incident management process is in place with the process beginning at the department level and then moving to the organizational level to identify potential trends. A number of improvements have been made based on the findings of incident reviews.

The organization has a large research department and participates in many drug trials. The study medications and relevant client information related to these trials are segregated from the main pharmacy and well labelled.

The types of infusion pumps are standardized across the organization. Work is underway to replace the current pumps with newer technology to enable greater capability.

The majority of multi-dose vials have been removed with the exception of insulin and lidocaine. Single patient use options continue to be explored for these drugs.

Pharmacy is a strong team and works very collaboratively within the department and with the clinical departments. With the recent addition of the emergency department, clinical pharmacists are now deployed in all clinical areas. They were observed providing education and consultation to both patients and staff and are seen as valuable members of the team.

Standards Set: Medicine Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Team members describe the team as an “energetic dynamic team” that address past performance, and patients as a priority in order to develop goals and objectives that align with the strategic plan for St. Michael’s.

The team has worked hard to develop a culture that embraces the interdisciplinary approach and it is noted that “students love to come here.” Every two to three months “ice cream rounds” are conducted that help with team building and sharing. The 14CC general internal medicine unit is comprised of 70 inpatient beds, including 50 acute care, four step up, six acute care of the elderly (ACE), and ten stroke beds. There are high volumes and high complexity of patients. There is excitement about the space that the St. Michael’s 3.0 state-of-the-art tower design will provide.

The CAPs are asked for feedback and make St. Michael’s a leader in community-hospital collaboration for health equity and access. Leadership has been provided to monitor resources and use data and the big picture to leverage business case development with other units (e.g., the use of “sitters” for patients requiring observation).

Numerous partnerships have been established so as to be responsive to patients. Internally there are plans to move the ACE beds to the eighth floor of the hospital. The rapid referral clinic was developed to streamline the admission of patients from the emergency department to the medicine unit.

Priority Process: Competency

A collaborative approach is evident with the team. Medical resident feedback is consistently positive and they say they "love working at St. Michael's." The management structure includes two clinical leader and managers (CLMs) and one administrative manager. The addition of a CLM since February is perceived as important and positive. Physicians describe the unit as a "deep well of good will" and this was evident in observation of physicians, staff, students, and volunteers on the unit.

A great deal of training and continuing education is supported. Learning plans and specific orientations for disciplines are in place. In addition to a comprehensive unit orientation, significant improvements have been made in having a "one stop shop" for the student centre process for onboarding with information technology registration and badge access. The learning system is an impressive online tool that staff access for education materials and for tracking completed courses and certifications.

Priority Process: Episode of Care

The unit has established strong and positive relationships with community partners. A number of agencies that serve the marginal and homeless population are nearby and often require the services of internal medicine. Every effort to improve access and decrease wait times, such as the rapid referral clinic, are implemented. Patients and families are involved as appropriate.

Care planning is comprehensive and interdisciplinary, including daily rounds, and ongoing communication is evident. Patients report care and compassion in the services they receive. Patients who have had experience in other facilities share that there is more attention and caring at St. Michael's than at other organizations. Patients state that they "see the nurses and they check on us regularly." The unit has implemented intentional rounding on night shift, checking if the patient has any pain, requires positioning, or needs to use the bathroom, and a decrease in patient falls has resulted.

Patients and families are involved in their care. In some instances patients are admitted without adequate clothing. As a result of donations and dedicated volunteers, there is a room of new clothing to support patients in need prior to discharge. Transition planning is supported by case managers and the staff appreciates having the Community Care Access Centre (CCAC) staff on-site on the unit.

Priority Process: Decision Support

Patient information is kept confidential and clinical information is in electronic and paper format. A physician-designed secure email Blackberry system has been implemented that supports timely communication among nurse and physicians. The e-admit and sign out components are electronic and the discharge summary is an important support in ensuring the prescription, letter to patient, and letter for the family physician are completed. Tools such as transfer of accountability, shift-to-shift report at the bedside, and white boards in patient rooms have been helpful in supporting client information and information transfer.

There is a mandatory orientation each year regarding policies for the use of electronic communications and privacy. A clinical teaching unit guide has been developed for trainees and will be posted on the St. Michael's website.

Priority Process: Impact on Outcomes

Indicators related to the NRC Picker patient experience surveys, falls data, pressure ulcer prevention, hand hygiene, and others are monitored and tracked on the Q-dashboard.

Policies and guidelines are available on the St. Michael's website and choosing wisely is being increasingly used. Quality improvement and standardized processes are holding staff accountable. RNAO (Registered Nurses Association of Ontario) best practice guidelines also support evidence-informed care. Creative and innovative approaches are used to increase safety such as PIMP the Resident, whereby a nurse is able to text-page the resident doctor. The P = patient name and number, I = information up to 240 characters, M = my name and number, and P = priorities as high, medium, or low. The information is sent from the WOW (workstation on wheels) and the physician is able to respond directly to the nurse. It is reported that this has increased communication and trust between the physicians and nurses. Another creative phrase used by the team is "holy moly, it's a foley," in an effort to decrease the use of in-dwelling catheters to reduce infections.

Safety huddles are held regularly and the new safety and learning system is on every desktop. Trend reports are available and better closure and understanding of safety events/incidents is the result. Safety for staff is also paramount with the use of the walk safe program for staff to be escorted by security to parking.

Standards Set: Mental Health Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Mental health and addiction services support some of the city's most disadvantaged populations who have serious mental illness, addictions, and complex needs. SMH serves the largest homeless, marginalized population of the GTA. The team provides a wide array of services, partnering with other community agencies for services that they are unable to provide, to fill service gaps.

The leadership team regularly reviews the Ontario Mental Health Reporting System (OMHRS) and CIHI data to determine service gaps and opportunities. The service reviews wait times and length of stay quarterly. Regular service planning has resulted in an increase in bed allocation for acute care in psychiatry, increasing it to ten. The team is continuously participating in quality initiatives and research with internal and external partners and stakeholders to identify opportunities for improvement.

Priority Process: Competency

Crisis intervention training is conducted through the psychiatry unit educator at all staff orientations and a refresher course is offered and tracked yearly.

The team uses an interdisciplinary approach to care and was fortunate to see team rounding on the unit, which occurs daily. Decisions are made in collaboration with the patients where possible and staff have

the liberty to make changes to care plans based on safety concerns. Team huddles occur twice daily and, based on patient/staff needs, changes to workload assignments are made. Continuous education is promoted and supported. Highly skilled and talented staff are recruited through student placement programs in community and acute care.

Priority Process: Episode of Care

The primary focus for mental health and addictions revolves around equity, patient experience, and access to services. It is through community partnerships and collaborations like the STAR Peer Support Centre that people are helped to transition from homelessness to housing. Other services such as the withdrawal management services integration between the University Health Network and SMH means that enhanced community supports including a new aftercare program and day and case management services can be offered.

Care planning may include psychiatric assessment, crisis intervention, short-term treatment and stabilization, or treatment and nursing care in a safe environment. The average length of stay is intentionally short. The addictions strategy is focused on patient and family needs, and depends on the interdisciplinary and collaborative team.

One challenge in falls prevention is the balance of ensuring patients are taking their medications, which can create conditions that may make them unsteady on their feet, while encouraging them to be mobile and also avoiding the use of restraints.

Transition planning is supported by the skills of knowledgeable staff, who are connected with resources in the community. Strategic meetings and ongoing conversations, particularly through community engagement, are helping to raise awareness of mental health and addictions issues.

Priority Process: Decision Support

Patient documentation involves a hybrid approach of paper-based and electronic records. Records are secure and patients are aware of their addictions service client rights.

Team members are involved in research and evaluation, and interprofessional implementation evaluation on peer support integration in acute mental health is one of the priorities for 2016-17.

Priority Process: Impact on Outcomes

The team is committed to meeting its priorities such as ensuring all clinicians are educated on trauma-informed care and offering cross-training for mental health and addiction clinicians.

Care and attention is given to obtaining consent for research projects.

Indicators are tracked corporately and at the team level. The team monitors its progress against established priorities, with a view to advance health equity.

The team is involved in publications and advancing addictions care and research. As well, there is a desire to continue to build capacity by offering training sessions to community providers.

Standards Set: Obstetrics Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The obstetrics, gynecology, neonatal intensive care unit (NICU) teams have implemented a number of services to best support the needs of their population, which is complex and growing. There are approximately 3,000 births per year from all spectrums of society. The MORE OB Program has been adopted and interdisciplinary education days take place in the Simulation Centre. These are well attended and the staff report these sessions help build team work and trust across disciplines. The team has achieved the significant goal of attaining the stage 3 level of the Baby Friendly Initiative. Client input is sought, for example with management of the P3 population (patient with HIV). Patients and families are involved in service design and every effort is made to support the management of high-risk patients, including those with substance abuse issues, to be able to stay with their infants. The level 2 neonatal intensive care unit has worked on a primary care nursing model and a family-integrated care model.

There are a number of partnerships, including the obstetrics GTA initiative for shoulder dystocia and postpartum hemorrhage and the bleeding disorders clinic. A pilot was conducted in 2014 with a midwife birthing centre which was very successful. Patients must be pre-determined and have a midwife assigned to use the facility. As well there are discussions underway with Toronto Public Health regarding breast feeding and postpartum support on weekends.

Increased space is required as a result of increased volumes of new immigrants settling in downtown Toronto and having babies. There are plans to expand the area and senior executive support has been confirmed. The new spaces will help improve family-integrated care.

Priority Process: Competency

The obstetrics, gynecology, and NICU areas are adjacent, meaning that labour, delivery, postpartum, and NICU care teams collaborate with one another. Teamwork and communication are enhanced by daily rounds. Creative solutions have been implemented to ensure privacy of patient and family information by having other neonate's family members wear headphones while rounds are being conducted, but permitting families to actively participate in the discussions when their baby is being discussed.

Everyone is compliant with this approach, and confidentiality is respected.

At morbidity and mortality rounds, sentinel events and deaths are used as opportunities for learning to discuss codes and simulations using SIMs.

The team includes midwives, nurse practitioners, registered nurses, family practice physicians, ob/gyn physicians, as well as anaesthesiologists, a chaplain, volunteers, and social workers. Team members have input into their work, with a strong emphasis on continuity of care.

Priority Process: Episode of Care

Access to obstetrical services is particularly important for marginalized populations. Approximately 20 to 25 percent of the patients are in a high-risk category, often without health insurance and as new refugees to the country. Removing barriers to access and care is important to the staff at St. Michael's, as staff always want to live the values of the organization and provide compassionate and timely care. Efforts in the community to increase information about obstetrical services are important, particularly as an increase in volume is expected.

Care planning takes into consideration the culture and preferences of the family. The interdisciplinary team tries to accommodate unique and special requests. Language challenges are managed with the use of interpreter services and creative means of communicating are sometimes required. White boards informing families of their nurse's name and care goals and questions are used as a means of communication in all areas except the NICU. As of November 2015, the NICU has undertaken a research program referred to as the Cuddler Program to demonstrate an impact of babies in withdrawal. This program offers seven day a week am/pm volunteer coverage to come and cuddle the newborns during parental absence or respite. Although this program has been in effect for less than a year, parents and staff in the NICU have expressed significant advantages to having this service and the positive outcome of care for these fragile babies.

Standardized assessment tools are used and outcomes from MORE OB data indicate compliance with guidelines. Information transfer is improved with the labour summary tool. Social work and community providers are actively involved in discharge planning, especially when women may not have a home to be discharged to.

A challenge the teams face is when there is a death of an infant. If an autopsy is required, it is conducted at The Hospital for Sick Children and it could take up to five or six months to receive the results. Families struggle with this as they search for answers and closure.

Priority Process: Decision Support

Patient records are a hybrid of paper-based and electronic charting. The electronic records are particularly helpful when transitions from one area, for example from labour and delivery to the operating room or postpartum area, are needed. Records are stored confidentially and no patient identifiers are used in open spaces to optimize privacy for patients. The MORE OB tools have proven helpful in quality improvement initiatives, as audits and measures ensure continuous monitoring and accountability.

Research is an important aspect of development in these areas. The goal is to always bring research closer to the patient/neonate and the team keeps up to date with relevant best practices and guidelines.

Priority Process: Impact on Outcomes

A number of corporate initiatives are highly successful in obstetrics, gynecology, and the NICU. For example, hand-hygiene compliance in the NICU consistently ranks number 1 in the hospital, with a rate of 95 percent. The other areas of labour and delivery and postpartum consistently meet or exceed the target for moment 1 of hand hygiene. Guidelines for best practice are implemented through MORE OB and indicators are tracked and trended and shared with physicians and staff.

Safety incidents are reported using the new learning system that staff suggest is more user friendly. Managers ensure they close the loop on incidents and report back to staff any trends to maximize learning and reduce the likelihood of the same incident being repeated.

Research and best practices are used across obstetrics, gynecology, and the NICU. As an academic teaching facility, numerous students and trainees have their clinical placements on the units and bring their freshness and willingness to learn from experienced and skillful staff.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
5.7	A comprehensive orientation is provided to new team members and client and family representatives.	
5.16	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		
Priority Process: Organ and Tissue Donation		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

SMH has one of the most successful organ donation programs in Canada. SMH participates in both donation after neurological death (DND) and donation after cardiac death (DCD).

The first policy in Canada for DCD was developed at SMH and has been widely used as a template in many other organizations. The donor programs result in 30 to 50 donors identified annually with a conversion rate of 75 to 85 percent. Trillium Gift of Life Network (TGLN) personnel work closely with the team to support the donation and patients, families, and staff.

The Organ Donation Committee meets quarterly to review progress and improve service. The standard operating procedures are reviewed and updated as needed or as the practice evolves. Although there has been much input from families of deceased donors, the team could consider adding a family representative to provide additional insight from the patient and family perspective.

Priority Process: Competency

The medical director of the organ donation program is a highly qualified physician who is a leader in organ donation in Canada. The team is also highly qualified and broadly representative of the personnel needed in a successful program. All new staff are oriented to the service by an experienced nurse educator. Ongoing education is supported extensively in the organization. There is strong ethical support and spiritual care is readily available. The team supports the cultural differences that are prevalent in the patient population.

Although there is extensive input into the organ donation program, there is no family representative on the committee.

Priority Process: Episode of Care

Potential donors are identified when possible neurological death is imminent or when patients transition from therapy to comfort care.

Priority Process: Decision Support

SMH follows all applicable rules, regulations, and operating procedures for tissue donation. The team works closely with Trillium Gift of Life Network, the provincial organ procurement organization to ensure all policies and procedures are followed. Identification of organs and tissues is done carefully and accurate records are maintained.

Priority Process: Impact on Outcomes

Organ donation is conducted under the auspices of a regulatory framework and medical and ethical guidelines. Guidelines are modified as needed to ensure equity and transparency and to respect cultural differences. The team works with families to ensure they are informed and their wishes or those of the patient are respected.

Patient safety incidents are recorded, reported both internally and to the relevant authorities, and carefully analyzed. Disclosure is undertaken when incidents that affect the patient or family are detected.

Quality improvement is an ongoing process and includes organization-wide initiatives and those that are developed on the units. The units each have a quality board to keep staff and families informed. An ongoing patient survey is reported at the Organ Donation Committee.

There is an increased interest in the effects of major illness on family members. The team is encouraged to develop a program of family-reported outcomes to assess the effects of organ donation on survivors.

Priority Process: Organ and Tissue Donation

Families are provided with information about organ donation after they have requested withdrawal of treatment, for patients who are candidates for DCD. Families are offered support including counselling and spiritual and ethical support. Personnel from the Trillium Gift of Life Network are present to help the team provide support.

Potential donors are screened for suitability using a combination of laboratory and diagnostic tests and physical assessment.

Organ procurement is coordinated after recipient organizations have identified appropriate recipients. The procurement team is assembled in the operating room. Procurement is done by qualified surgeons and assistants. Organs are flushed with preserving solutions after identification by the recipient surgeons. Transportation to the recipient site is pre-arranged.

Standards Set: Organ and Tissue Transplant Standards - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Organ and Tissue Transplant

On entry into the renal transplant program, patients undergo a complete history and physical and psychosocial assessment and results are recorded on the patient record. Patients are placed on a wait list that is managed by the Trillium Gift of Life Network (TGLN) and available to the transplant team. Donor organs are allocated based on an algorithm. The issue of organ allocation has undergone a complete review by the TGLN in association with transplant programs. SMH held an information session for patients and for dialysis centres. The allocation system is now provincial and is based on a point system. These and other changes were made to increase fairness and transparency in the system.

Exceptional distribution of organs occurs occasionally and is well documented.

Immediately prior to transplant, recipients are reassessed by the team including the anaesthesiologist to ensure they are medically fit for the procedure.

Pre- and post-operative teaching is provided to patients and families. The teams go to exceptional lengths to ensure the education is understood.

Priority Process: Clinical Leadership

SMH is one of the largest renal transplant centres in Canada. Over the past year, over 145 transplants were done. There are 200 to 300 patients on the waiting list and over 1400 patients followed in the post-transplant clinic.

The program is well organized and innovative. An extensive clinical database has been developed by the team to track patients, appointments, and blood work. The database is searchable and provides an excellent platform for longitudinal research. The team works closely with the Trillium Gift of Life Network and reaches out to and supports referral organizations. Standard operating procedures are developed in association with TGLN and are developed with input from transplant patients.

Staff are trained in patient selection, wait list management, operating procedures, and post-transplant care, both short and long term.

Priority Process: Competency

SMH has developed an expert team led by the medical director who has expertise in nephrology and renal transplant, research, and education. The transplant coordinator works with all team members, patients, and families. The transplant committee is broadly representative of the disciplines necessary to ensure a successful transplant program.

A transplant educator prepares orientation for new recruits to the program. All staff are encouraged to participate in an education day for staff, interested hospital employees, and this year for the first time, patients.

All team members undergo an annual performance appraisal. In addition to reviewing competence, educational opportunities for staff growth are identified.

The renal transplant program has been developed with input from patients and families.

Priority Process: Episode of Care

Patients who are referred to the SMH renal transplant program undergo a comprehensive assessment and an education program about transplant, risks and benefits, alternatives, and details about the process including wait times and procedures when a donor is identified.

Patients are reassessed when the transplant is imminent to determine if there have been changes in health prior to the actual procedure. Families are engaged throughout the process.

A care plan is developed for each individual patient in association with the patient and family. This allows them to understand the approximate time of surgery, when they can visit, expected course in hospital, possible complications, and expected length of stay. The plan is adjusted based on the progress of the patient.

Patients and families are given education. Close to discharge, they receive a teaching pamphlet that is explained to them in detail. It provides information about future visits, what to expect at the visits, their activity levels, diet, driving, vaccines, and medications.

Priority Process: Decision Support

Each patient record consists of a hospital record for the work-up of the recipient, the transplant episode, and all subsequent admissions. The team has developed a comprehensive database that includes follow-up data and allows patients to be followed closely both for clinical and epidemiological research. The chart and the follow-up database meet all applicable laws including privacy laws and regulations.

Priority Process: Impact on Outcomes

The SMH renal transplant program uses best practice guidelines to ensure care is uniform across the continuum. The program is research based and patients may be offered an opportunity to participate in studies that have ethical approval.

Safety is paramount in the program. Patients are assessed for falls and skin breakdown, and receive venous thromboembolism prophylaxis. Hand hygiene is important at SMH and the team works in partnership with patients and families so they understand the importance of their role in hand hygiene. The team uses the hospital incident management system. Incidents are reported, analyzed, and disclosed. If there are incidents related to a transplanted organ, they are reported to the Trillium Gift of Life Network.

There are many quality improvement activities, and many of them have been developed in collaboration with patients. A renal transplant day is held each year where scholarly work done by staff is showcased. Patients are invited to the event and this year, eight patients attended. The team is encouraged to include patients on the planning committee and to increase the participation of patients in the program.

The team has developed a database for follow up of patients that includes appointment dates, blood work, status of the transplant, medications, and intercurrent illness. The database provides longitudinal information about the kidney transplant program.

Standards Set: Organ Donation Standards for Living Donors - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Living Organ Donation

SMH has developed a large living donor program that includes a paired donation program conducted in association with University Health Network. The program is based on standard operating procedures that have been developed for the program.

The key to the success of the program is the comprehensive information and consent process that has been developed. The information and consent includes the right of potential donors to withdraw. The program receives strong support from the ethics department at the hospital.

All patients are assessed for suitability prior to entering into the program. The assessment includes screening for transmissible diseases, cancer, and other conditions that may negate a transplant. A

comprehensive psychosocial assessment is done. If a patient must be removed from the program, appropriate medical or psychological support is made available. All decisions are confidential.

Exceptional distribution is allowed based on individual case decision and is well documented. The program conforms with applicable CSA standards and Health Canada regulations.

Follow up after donation is appropriate for a major surgical procedure including pain control, wound management, and complications if any. Information is sent to the family physician for longer-term follow up.

Priority Process: Clinical Leadership

SMH has developed a large and effective living donor program for the renal transplant program. In association with University Health Network, a paired donation program has also been developed. The living donor program is one of the largest and most innovative in Canada.

SMH works closely with referring hospitals and dialysis programs to ensure patients are managed effectively.

The conduct of the transplant program is governed by standard operating procedures that are in compliance with the Canadian Standards Association.

Personnel working in the transplant program are experts trained in renal transplantation.

Priority Process: Competency

The living renal donor program is led by the medical director who leads an interdisciplinary team that includes ethicists and spiritual care. Allied health professionals have expertise in organ donation. A donor advocate is available for living donors. The living donor is aware that they may withdraw at any time.

There is a comprehensive training program for new employees and many educational opportunities throughout the year, at rounds, conferences, and lectures. Opportunities for educational activities are discussed at annual performance reviews.

The family advisory council has had an important impact on policies and procedures in the living donor program. Patients and/or families have attended renal transplant meetings based on research by staff. The patient advisory council provided input into the design of new space in the hospital.

Priority Process: Episode of Care

The decision to participate in a living donor program is based on a personal decision tree and may have ethical or psychosocial implications. A very careful assessment of all aspects of physical and psychosocial health is done. Once the decision to participate is undertaken, the surgery proceeds.

The care transitions are as for any other major surgery and are based on a care map for living donor surgery.

Priority Process: Decision Support

Medical records are developed in accordance with all applicable regulations. The medical record at SMH is a hybrid, both paper and electronic. Patients have access to the record under supervision by medical personnel.

In the case of living donors, other health professionals on the transplant team may need access to information about the donor. This is acceptable under existing regulations.

Priority Process: Impact on Outcomes

The living donor program uses best practice guidelines to ensure effective outcomes. Risks to patients are identified and mitigated. All safety procedures are followed including safe surgery checklist, sterile technique, availability of expert anaesthesia, proper recovery room follow up, and transfer of accountability at transitions. Incidents are recorded, reported as required to Health Canada, and analyzed. Incidents are used to improve service delivery.

In association with patients and families, the living donor program has developed a number of quality improvement initiatives. They also work with TGLN on quality initiatives. An annual living donor appreciation night is held in association with The Hospital for Sick Children and the University Health Network. The program also conducts a symposium for post-kidney transplant patients. The quality improvement agenda is driven by data which are collected on all patients.

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

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
7.4 Standardized communication tools are used to share information about a client's care within and between teams.	!
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	
Priority Process: Medication Management	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Perioperative services are in transition due to the redevelopment of the operating rooms and related spaces. As of May 2016, the preadmission facility had only been in operation for a week. It was designed with input from patients, particularly the elderly, who focused on colour and brightness. A patient survey and a staff survey were undertaken in the old facility two months prior to the move. A second survey will be undertaken in two months to assess the impact of the new facility.

There has been considerable input into the design of the new operating rooms that are under construction. Although there is considerable potential for problems, the leadership team has mitigated risks through designing space in transition to accommodate infection control standards and principles. Flow in the existing operating room is limited by the physical layout, but will be acceptable in the new unit.

One of the principles of the new preadmission facility is to offer patients "one stop shopping." The process begins with the clerical and booking staff who identify what services may be consulted and book based on service availability. For example, patients who require an endocrine consult in addition to anaesthesia are cohorted to ensure only one visit is needed.

At the unit level, links with the community are available for various types of surgery. Patients have access to information about convalescent and palliative care as needed. They also have access or are given information about physiotherapy and community care access social work.

Priority Process: Competency

SMH has a comprehensive process to verify the credentials of new additions to the professional staff. The reappointment process for physicians is based on continuing competence and ongoing education, and the ongoing education includes a focus on ethics and cultural sensitivity. Staff education includes ethical decision making, safe use of equipment, and responding to emergencies. The electronic medical record will be extended to the operating room and associated services over the next three to six months. A comprehensive education program used on other units will be used to educate staff on the new system.

SMH has a comprehensive performance appraisal system that is used to identify ongoing education needs of staff. The system is annual and is current in the surgical services.

The tools used to transfer information vary from one unit to the next. All units have a process for transfer of information, but there are distinct differences. The surgical service is encouraged to adopt a uniform approach to the information transfer and accountability to decrease the possibility of error based on communication.

There are four notable initiatives underway on the general surgery floor 16CC. One is the HUGS program, designed to build respect among team members. The organization is encouraged to roll this program out to other units. For patients with a colostomy or ileostomy, a stoma management program has been developed in partnership with patients. The falls management program is an example of a sustainable quality improvement program on the unit. The fourth notable program is the enhanced recovery after surgery (ERAS) program, based on a guide developed for patients. Since implementation, satisfaction has improved as has length of stay.

Priority Process: Episode of Care

Surgical and perioperative services includes a broad range of surgical services including cardiac surgery, plastic surgery, general surgery, orthopedics, urology, and gynecology. The organization supports and encourages minimally invasive surgery. The operating rooms are old and cramped but functional. Elements needed to ensure safe surgery are present. There is a substerile corridor and soiled equipment, linen, and devices are isolated from sterile areas. The sterile reprocessing area is soon to undergo renovation. New operating rooms have been designed and will be available for use in 2019.

Staff are engaged, motivated, and expert. They undergo an extensive orientation. Although staff are capable of working in many areas, they are usually assigned to a specific specialty. The operating rooms are designated for specific specialized services based on the equipment and the expertise.

Patient engagement was observed at all levels and verified by the patients who were interviewed. Staff in all areas understand the importance of the patient voice in the design and delivery of care. Staff have been educated in the concept and it has become engrained in the practice.

SMH has a unique population and its catchment area is extremely diverse. Translation is readily available and family and friends are engaged as needed. The staff group is also diverse and can offer services in many languages.

Patients are assessed by appropriate staff members. A broad interdisciplinary team is available to assess patients. A full range of diagnostic and laboratory services is available.

All patients undergoing major surgical procedures and those with significant risk factors and/or comorbidities are assessed by an anaesthesiologist. Consultation services are available in the pre-assessment facility for endocrinology and general internal medicine. In response to input from patients, the pre-assessment facility is designed to offer one stop shopping.

On all surgical units, patients are assessed for risk of falls and skin breakdown, and venous thromboembolism prophylaxis is used.

The options for treatment and the risks of surgery are discussed with the patient during the informed consent process. A plan of care is developed with the patient, which starts with the first encounter with the surgeon and continues through the assessment process. The basis of the care plan is usually a best practice guideline which offers guidance to the patient and family. The plan is modified as needed in consultation with the patient and family.

All services have a practice for transfer of information that is generally effective. The iPass model is used on many services. The surgical program is encouraged to adopt one system for use by all services and wards.

All important elements of safe operating room care are included in the standard operating procedures and are adhered to by staff. Effective sterile technique, proper gowning and gloving, and OR attire are used. Anaesthesia is administered by an expert staff member with effective monitoring of vital signs. Patients are transported to the post-anaesthesia care units under continuous monitoring. Of concern is the need to use an elevator for some high-risk patients who are being transported to the critical care units. The organization is encouraged to minimize the time and therefore the risk of transport of these patients by adopting an elevator call system. It is noted that this will be an interim measure that is addressed by the new operating room design.

Priority Process: Decision Support

Record keeping and decision support are in a transitional phase in the surgical service. The electronic medical record has been implemented on the wards, but not in other areas. Implementation of the electronic medical record will occur in three to six months in the operating room area. Plans for other perioperative service areas will follow. In the interim, charts are on paper until patients reach the ward.

On the wards, the chart is a hybrid; electronic for ward documentation and paper for the ED and the OR. Special vigilance is needed during this time until all perioperative services use the electronic medical record.

Priority Process: Impact on Outcomes

Surgical services use evidence-based guidelines for the provision of care. Guidelines are selected and modified to ensure patients receive appropriate care.The guidelines are used to inform patients and families of the care that they can expect. On admission, patients are informed about their role in safe care.

Safety incidents are mitigated, analyzed, and disclosed.

Incidents and complaints are used to identify quality improvement opportunities. Quality improvement is undertaken on a widespread basis by the surgical team. Initiatives reviewed include hand-hygeine audits, falls assessment, and skin breakdown.

Priority Process: Medication Management

Medications used in the operating room that are to be passed on to the surgical field are double checked by the operating room nurses and documented on the chart. Medications are passed to the surgical field using sterile technique.

The cardiac arrest carts are stocked exactly the same as the carts throughout the hospital. They are checked for outdated medications.

Anaesthesia carts contain an adequate supply of medications for anaesthesia, cardiac rescue analgesics, anti-emetics, and analgesics. Narcotics are stored under lock and key and are carefully controlled.

There is a satellite pharmacy in the operating room that is supported by the pharmacy department.

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

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

The organization has met all criteria for this priority process.

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

The organization provides a number of different point-of-care testing modalities across the organization, all of which are overseen by the medical laboratory director. There are interdisciplinary committees to review quality data and education needs of the providers.

Staff have online access to a wealth of information regarding standard operating procedures. Competency is reviewed regularly and documented. Adverse events and recalls are handled appropriately.

Results are documented electronically and go directly to the lab system as well as the patient record. This is a well-established program that is integrated into clinical practice.

Standards Set: Primary Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Competency - Primary Care		
The organization has met all criteria for this priority process.		
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
3.11	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
14.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
14.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!

Surveyor comments on the priority process(es)

Priority Process: Competency - Primary Care

Physicians associated with the family practice clinics are credentialled through the hospital's processes. As part of these processes, evidence is gathered to ensure each physician has legal liability coverage.

All members of the interdisciplinary team interviewed are practicing to their full scope and feel supported by other team members to practice in this manner.

Priority Process: Clinical Leadership

There are six family practice clinics associated with the hospital. All of the physicians involved in these clinics belong to one family health team and also have an academic association with the local university

faculty of medicine. Together the clinics service approximately 40,000 residents, most of whom live in the areas surrounding the hospital. Services provided by the allied health professionals and specialty services at the various sites are accessible to clients associated with any of the family practice clinics.

Through innovative partnerships the clinics have been able to provide additional services including psychological counselling, dentistry, chiropody, and legal services. The family practice clinics have a strong partnership with the hospital that supports rapid access to primary care for unattached patients seen at the hospital, as well as the opportunity for improved access for referrals from the clinics to specialty services in the hospital.

The family practice clinics are commended for the work they have done to engage clients and families. Through a full-day event last year, where several hundred clients attended, the clinics have identified individuals who were prepared to become advisors on various committees and projects. Currently these advisors provide input to programming, roles within the clinic setting, and a number of other initiatives.

Priority Process: Competency

There are extensive interdisciplinary teams that support the family practice clinics. Members appear to be very collaborative and, while recognizing their different scopes of practice, support each other to best meet the needs of the clients. Daily huddles are held to discuss activities and to problem solve. A whiteboard is used to facilitate communication.

The physicians associated with the family practice clinics are credentialled through the hospital's processes. The allied health staff attend the hospital orientation program in addition to receiving an orientation to the clinic setting. The staff and physicians are able to access many of the hospital-wide education programs.

A great deal of work has been done to gather feedback from client and family representatives. However, since the program is relatively new, it was not evident at the time of the on-site survey that these representatives have been asked to provide feedback on their roles and responsibilities or on role satisfaction.

Priority Process: Episode of Care

Access to service is monitored on a regular basis. Wait times for primary care visits are relatively short; however, several of the specialty services such as psychology and legal have longer wait lists. All six clinics are able to accommodate same-day access for clients who need to be seen quickly. After-hours urgent care is provided by at least one of the clinics each evening throughout the week and weekend access is also available at one of the six sites.

The family practice clinics are commended for their actions aimed at impacting the social determinants of health for disadvantaged clients. These initiatives include a "reach out to read" program which promotes reading in young children and the "health justice initiative" which provides free legal counselling for

clients who may need this service. In addition, the clinics have implemented interventions aimed at increasing cancer screening for disadvantaged clients who may not initiate the screening on their own.

Clients are encouraged to be engaged in their care and self-manage their health where possible. Clients interviewed were extremely positive about the care at the clinics, commenting that they feel they are a part of the team, they are listened to and not rushed through an appointment, and they are provided with sufficient health information in a format that they can understand.

To support continuity of care, the family practice clinic is notified by the hospital if a client of the clinic is hospitalized and again when the client is discharged. As a follow-up to discharge, a team member from the clinic contacts the client to determine when they may need to be seen in the clinic.

Priority Process: Decision Support

A common, comprehensive, electronic medical record has been in place for the past five years across all six family practice clinics.

The clinics also have connectivity to several areas of the hospital which has positively impacted the flow of information. Physicians covering after-hours clinics at the various sites can access client records. As well, emergency department physicians are able to access (as read only) client medical records within the family practice clinics, thereby obtaining current information about the client's health status and facilitating the emergency department visit and continuity of care.

Priority Process: Impact on Outcomes

In keeping with the hospital's corporate strategic directions, the family practice clinics have established a strategic plan with a number of goals and objectives aimed at improving the quality of care for the clients. Five key strategies have been identified with several initiatives flowing from each of these strategies, some of which have been mentioned earlier.

The clinics have a designated quality lead and the staff and physicians interviewed were aware and up to date on the main quality initiatives that are underway.

In addition to the quality initiatives flowing from the strategic plan, client satisfaction surveys are done monthly and feedback is used to make changes as needed.

Standards Set: Transfusion Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Transfusion Services	

The organization has met all criteria for this priority process.

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

The transfusion service actively seeks feedback from the clinical programs across the hospital and adjusts services accordingly. The department has an active Transfusion Committee and transfusion oversight is appropriate.

The transfusion service is commended for their quality improvement activity aimed at reducing the number of inappropriate transfusions. This activity has proven to be very successful.

Staff have the required training and expertise to conduct their roles and are also supported by several medical experts.

The autologous donor program continues to be available; however, the number of participants is decreasing.

Instrument Results

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

Governance Functioning Tool (2011 - 2015)

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

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

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

- **Data collection period: September 9, 2015 to October 5, 2015**
- **Number of responses: 14**

Governance Functioning Tool Results

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1 We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations.	0	7	93	93
2 Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	0	0	100	95
3 We have sub-committees that have clearly-defined roles and responsibilities.	0	0	100	97
4 Our roles and responsibilities are clearly identified and distinguished from those delegated to the CEO and/or senior management. We do not become overly involved in management issues.	0	0	100	95

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
5 We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decisionmaking.	0	0	100	92
6 Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	95
7 Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	98
8 Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	0	0	100	96
9 Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	0	0	100	94
10 Our governance processes make sure that everyone participates in decision-making.	0	0	100	94
11 Individual members are actively involved in policy-making and strategic planning.	0	0	100	89
12 The composition of our governing body contributes to high governance and leadership performance.	0	0	100	93
13 Our governing body’s dynamics enable group dialogue and discussion. Individual members ask for and listen to one another’s ideas and input.	0	0	100	96
14 Our ongoing education and professional development is encouraged.	0	0	100	88
15 Working relationships among individual members and committees are positive.	0	0	100	97
16 We have a process to set bylaws and corporate policies.	0	0	100	95
17 Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	97
18 We formally evaluate our own performance on a regular basis.	0	14	86	82
19 We benchmark our performance against other similar organizations and/or national standards.	0	21	79	72

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
20 Contributions of individual members are reviewed regularly.	8	23	69	64
21 As a team, we regularly review how we function together and how our governance processes could be improved.	0	21	79	81
22 There is a process for improving individual effectiveness when non-performance is an issue.	8	23	69	64
23 We regularly identify areas for improvement and engage in our own quality improvement activities.	0	0	100	80
24 As a governing body, we annually release a formal statement of our achievements that is shared with the organization's staff as well as external partners and the community.	0	21	79	84
25 As individual members, we receive adequate feedback about our contribution to the governing body.	7	21	71	69
26 Our chair has clear roles and responsibilities and runs the governing body effectively.	0	0	100	96
27 We receive ongoing education on how to interpret information on quality and patient safety performance.	0	0	100	84
28 As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	95
29 As a governing body, we hear stories about clients that experienced harm during care.	0	0	100	85
30 The performance measures we track as a governing body give us a good understanding of organizational performance.	0	0	100	92
31 We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	0	0	100	87
32 We have explicit criteria to recruit and select new members.	0	0	100	84
33 Our renewal cycle is appropriately managed to ensure continuity on the governing body.	0	0	100	90

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
34 The composition of our governing body allows us to meet stakeholder and community needs.	0	0	100	94
35 Clear written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	94
36 We review our own structure, including size and subcommittee structure.	0	7	93	89
37 We have a process to elect or appoint our chair.	0	0	100	95

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2014 and agreed with the instrument items.

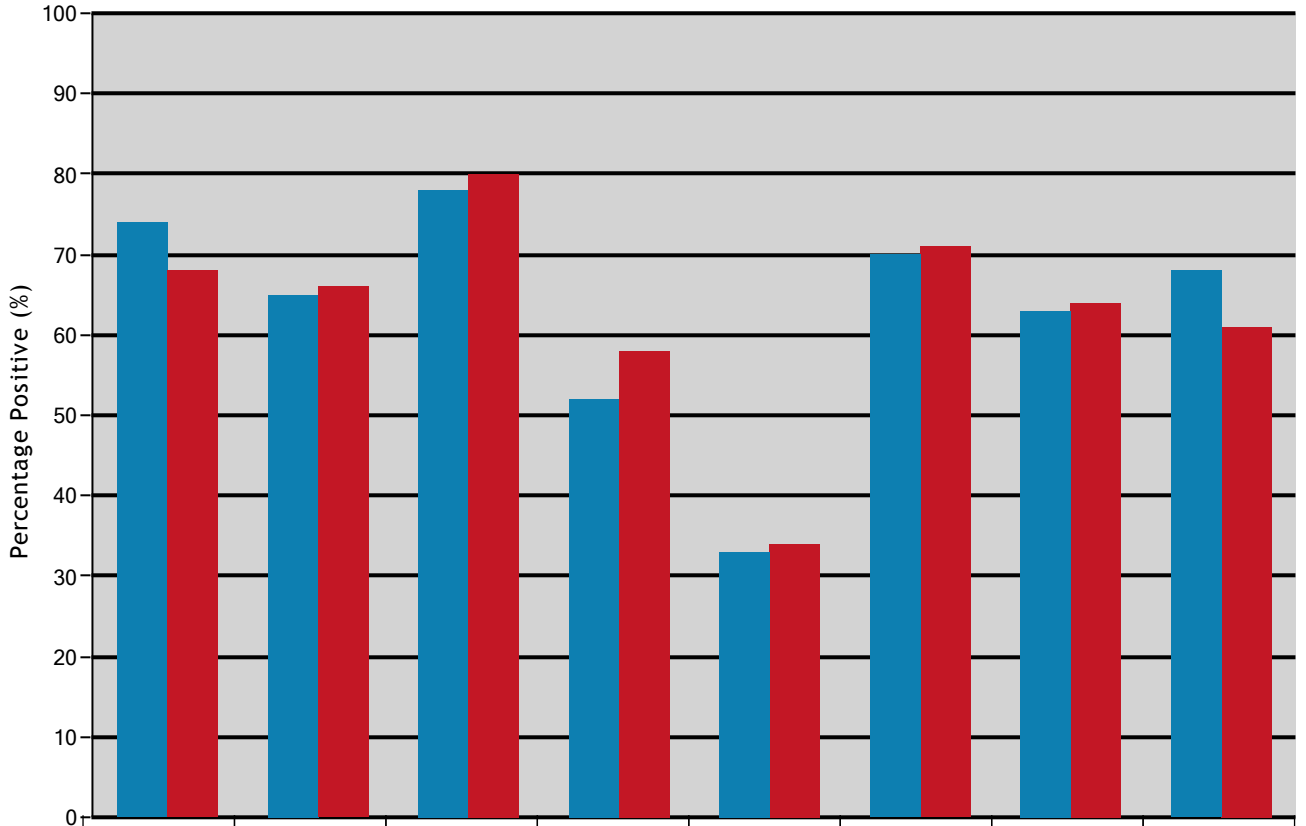
Canadian Patient Safety Culture Survey Tool

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

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

- **Data collection period: January 6, 2015 to February 6, 2015**
- **Minimum responses rate (based on the number of eligible employees): 346**
- **Number of responses: 535**

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



	Organizational (senior) leadership support for safety	Supervisory leadership for safety	Unit learning culture	Enabling Open Communication I: judgment-free environment	Enabling Open Communication II: job repercussions of error	Incident follow up	Stand-alone items	Overall Perceptions of Client Safety
	74%	65%	78%	52%	33%	70%	63%	68%
	68%	66%	80%	58%	34%	71%	64%	61%

Legend

St. Michael's Hospital

* Canadian Average

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

Worklife Pulse

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

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

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

Client Experience Tool

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

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

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

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

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

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

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

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

Organization's Commentary

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

At St. Michael's, our commitment is to provide the best possible experience to our patients, their caregivers and families. Whether someone comes to us in an emergency, to treat a chronic health issue or to receive care in our community and primary health programs, we want to ensure health-care needs are met and that patients have a positive experience throughout their care journey.

St. Michael's sees accreditation not as an isolated activity, but as an opportunity to continually monitor and showcase the hospital's rigorous quality and safety standards and activities. This perspective is nicely illustrated by our 2016 accreditation slogan: Excellence Every Day and our belief there is "no limit to better".

We would like to thank our staff, physicians and leaders for the care they provide each and every day to our patients and families and their commitment to continuously improving the quality of care. Through the expertise of our staff, physicians and leaders and their engagement and involvement in our quality journey, we will provide the best possible experience to our patients and families. Without them, our goal of continuous improvement would not be achievable.

Appendix A - Qmentum

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

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

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

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

Action Planning

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

Evidence Review and Ongoing Improvement

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

Appendix B - Priority Processes

Priority processes associated with system-wide standards

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

Priority processes associated with population-specific standards

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

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

Priority processes associated with service excellence standards

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

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