ACCREDITATION AGRÉMENT CANADA
Qmentum

# Accreditation Report

## Carleton Place & District Memorial Hospital

Carleton Place, ON

On-site survey dates: May 11, 2023 - May 12, 2023

Report issued: June 8, 2023

# About the Accreditation Report

Carleton Place & District Memorial 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 2023. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

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

# Confidentiality

This report is confidential and will be treated in confidence by Accreditation Canada in accordance with the terms and conditions as agreed between your organization and Accreditation Canada for the Assessment Program.

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

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

# A Message from Accreditation Canada

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

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

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

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

We look forward to our continued partnership.

Sincerely,

Leslee Thompson
Chief Executive Officer

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# Executive Summary

Carleton Place & District Memorial 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

Carleton Place & District Memorial Hospital's accreditation decision is:

**Accredited with Commendation (Report)**

The organization has surpassed the fundamental requirements of the accreditation program.

# About the On-site Survey

- **On-site survey dates: May 11, 2023 to May 12, 2023**

- **Location**

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

  1. Carleton Place and District Memorial Hospital

- **Standards**

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

  ***System-Wide Standards***

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

  ***Service Excellence Standards***

  4. Diagnostic Imaging Services - Service Excellence Standards
  5. Emergency Department - Service Excellence Standards
  6. Inpatient Services - Service Excellence Standards
  7. Medication Management (For Surveys in 2021) - Service Excellence Standards
  8. Perioperative Services and Invasive Procedures - Service Excellence Standards
  9. Reprocessing of Reusable Medical Devices - Service Excellence Standards

- **Instruments**

  The organization administered:

  1. Canadian Patient Safety Culture Survey Tool
  2. 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) | 31 | 1 | 0 | 32 |
|  Accessibility (Give me timely and equitable services) | 39 | 4 | 0 | 43 |
|  Safety (Keep me safe) | 355 | 19 | 30 | 404 |
|  Worklife (Take care of those who take care of me) | 88 | 2 | 1 | 91 |
|  Client-centred Services (Partner with me and my family in our care) | 137 | 17 | 0 | 154 |
|  Continuity (Coordinate my care across the continuum) | 29 | 0 | 0 | 29 |
|  Appropriateness (Do the right thing to achieve the best results) | 454 | 46 | 10 | 510 |
|  Efficiency (Make the best use of resources) | 40 | 3 | 0 | 43 |
| **Total** | **1173** | **92** | **41** | **1306** |

# Overview by Standards

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

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

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

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

| Standards Set | High Priority Criteria * | | | Other Criteria | | | Total Criteria (High Priority + Other) | | |
|---|---|---|---|---|---|---|---|---|---|
| | Met | Unmet | N/A | Met | Unmet | N/A | Met | Unmet | N/A |
| | # (%) | # (%) | # | # (%) | # (%) | # | # (%) | # (%) | # |
| Governance | 50 (100.0%) | 0 (0.0%) | 0 | 36 (100.0%) | 0 (0.0%) | 0 | 86 (100.0%) | 0 (0.0%) | 0 |
| Leadership | 50 (100.0%) | 0 (0.0%) | 0 | 93 (96.9%) | 3 (3.1%) | 0 | 143 (97.9%) | 3 (2.1%) | 0 |
| Infection Prevention and Control Standards | 39 (100.0%) | 0 (0.0%) | 1 | 27 (93.1%) | 2 (6.9%) | 2 | 66 (97.1%) | 2 (2.9%) | 3 |
| Medication Management (For Surveys in 2021) | 88 (97.8%) | 2 (2.2%) | 10 | 47 (97.9%) | 1 (2.1%) | 2 | 135 (97.8%) | 3 (2.2%) | 12 |
| Diagnostic Imaging Services | 52 (91.2%) | 5 (8.8%) | 11 | 60 (90.9%) | 6 (9.1%) | 3 | 112 (91.1%) | 11 (8.9%) | 14 |
| Emergency Department | 59 (81.9%) | 13 (18.1%) | 0 | 92 (86.0%) | 15 (14.0%) | 0 | 151 (84.4%) | 28 (15.6%) | 0 |
| Inpatient Services | 47 (79.7%) | 12 (20.3%) | 1 | 70 (83.3%) | 14 (16.7%) | 1 | 117 (81.8%) | 26 (18.2%) | 2 |
| Perioperative Services and Invasive Procedures | 104 (92.9%) | 8 (7.1%) | 3 | 102 (93.6%) | 7 (6.4%) | 0 | 206 (93.2%) | 15 (6.8%) | 3 |

| 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 of Reusable Medical Devices | 78 (95.1%) | 4 (4.9%) | 6 | 40 (100.0%) | 0 (0.0%) | 0 | 118 (96.7%) | 4 (3.3%) | 6 |
| **Total** | **567 (92.8%)** | 44 (7.2%) | 32 | 567 (92.2%) | 48 (7.8%) | 8 | 1134 (92.5%) | 92 (7.5%) | 40 |

* Does not includes ROP (Required Organizational Practices)

## Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

| Required Organizational Practice | Overall rating | Test for Compliance Rating | |
|---|---|---|---|
| | | Major Met | Minor Met |
| **Patient Safety Goal Area: Safety Culture** | | | |
| Accountability for Quality (Governance) | Met | 4 of 4 | 2 of 2 |
| Patient safety incident disclosure (Leadership) | Met | 4 of 4 | 2 of 2 |
| Patient safety incident management (Leadership) | Met | 6 of 6 | 1 of 1 |
| Patient safety quarterly reports (Leadership) | Met | 1 of 1 | 2 of 2 |
| **Patient Safety Goal Area: Communication** | | | |
| Client Identification (Diagnostic Imaging Services) | Met | 1 of 1 | 0 of 0 |
| Client Identification (Emergency Department) | Met | 1 of 1 | 0 of 0 |
| Client Identification (Inpatient Services) | Met | 1 of 1 | 0 of 0 |
| Client Identification (Perioperative Services and Invasive Procedures) | Met | 1 of 1 | 0 of 0 |
| Information transfer at care transitions (Emergency Department) | 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 (Inpatient Services) | Met | 4 of 4 | 1 of 1 |
| Information transfer at care transitions (Perioperative Services and Invasive Procedures) | Met | 4 of 4 | 1 of 1 |
| Medication reconciliation as a strategic priority (Leadership) | Met | 3 of 3 | 2 of 2 |
| Medication reconciliation at care transitions (Emergency Department) | Met | 1 of 1 | 0 of 0 |
| Medication reconciliation at care transitions (Inpatient Services) | Met | 4 of 4 | 0 of 0 |
| Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures) | Met | 4 of 4 | 0 of 0 |
| Safe Surgery Checklist (Perioperative Services and Invasive Procedures) | Met | 3 of 3 | 2 of 2 |
| The “Do Not Use” list of abbreviations (Medication Management (For Surveys in 2021)) | Met | 4 of 4 | 3 of 3 |
| **Patient Safety Goal Area: Medication Use** | | | |
| Antimicrobial Stewardship (Medication Management (For Surveys in 2021)) | Met | 4 of 4 | 1 of 1 |

| Required Organizational Practice | Overall rating | Test for Compliance Rating | |
|---|---|---|---|
| | | Major Met | Minor Met |
| **Patient Safety Goal Area: Medication Use** | | | |
| Concentrated Electrolytes (Medication Management (For Surveys in 2021)) | Met | 3 of 3 | 0 of 0 |
| Heparin Safety (Medication Management (For Surveys in 2021)) | Met | 4 of 4 | 0 of 0 |
| High-Alert Medications (Medication Management (For Surveys in 2021)) | Met | 5 of 5 | 3 of 3 |
| Infusion Pumps Training (Emergency Department) | Met | 4 of 4 | 2 of 2 |
| Infusion Pumps Training (Inpatient Services) | Met | 4 of 4 | 2 of 2 |
| Infusion Pumps Training (Perioperative Services and Invasive Procedures) | Met | 4 of 4 | 2 of 2 |
| Narcotics Safety (Medication Management (For Surveys in 2021)) | Met | 3 of 3 | 0 of 0 |
| **Patient Safety Goal Area: Worklife/Workforce** | | | |
| Client Flow (Leadership) | Met | 7 of 7 | 1 of 1 |
| Patient safety plan (Leadership) | Met | 2 of 2 | 2 of 2 |
| Patient safety: education and training (Leadership) | Met | 1 of 1 | 0 of 0 |
| Preventive Maintenance Program (Leadership) | Met | 3 of 3 | 1 of 1 |

| Required Organizational Practice | Overall rating | Test for Compliance Rating | |
|---|---|---|---|
| | | Major Met | Minor Met |
| **Patient Safety Goal Area: Worklife/Workforce** | | | |
| Workplace Violence Prevention (Leadership) | Met | 5 of 5 | 3 of 3 |
| **Patient Safety Goal Area: Infection Control** | | | |
| Hand-Hygiene Compliance (Infection Prevention and Control Standards) | Met | 1 of 1 | 2 of 2 |
| Hand-Hygiene Education and Training (Infection Prevention and Control Standards) | Met | 1 of 1 | 0 of 0 |
| Infection Rates (Infection Prevention and Control Standards) | Met | 1 of 1 | 2 of 2 |
| **Patient Safety Goal Area: Risk Assessment** | | | |
| Falls Prevention Strategy (Inpatient Services) | Met | 2 of 2 | 1 of 1 |
| Falls Prevention Strategy (Perioperative Services and Invasive Procedures) | Met | 2 of 2 | 1 of 1 |
| Pressure Ulcer Prevention (Inpatient Services) | Met | 3 of 3 | 2 of 2 |
| Suicide Prevention (Emergency Department) | Met | 5 of 5 | 0 of 0 |
| Venous Thromboembolism Prophylaxis (Inpatient Services) | Met | 3 of 3 | 2 of 2 |
| Venous Thromboembolism Prophylaxis (Perioperative Services and Invasive Procedures) | Met | 3 of 3 | 2 of 2 |

## Summary of Surveyor Team Observations

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

The Carleton Place District Memorial Hospital (CPDMH) and the Almonte General Hospital (AGH) formed the Mississippi River Health Alliance (MRHA) in 2017 with the goal of providing the best possible care to their communities through their combined efforts. Together the hospitals serve a population of over 30,000 and provide a wide range of services including 24/7 emergency services, diagnostics (DI and Lab), medical/surgical beds, level one obstetrical beds, perioperative services, ambulatory care, complex continuing care and outpatient clinics. In addition, AGH operatives Almonte Fairview Manor, a 112 bed Long-Term Care home located on the AGH site, as well as Lanark County Paramedic Services. Over the last three years, the organizations have demonstrated their efforts on managing the COVID-19 pandemic. There is recognition for their proactive and flexible approaches to keeping patients, residents and team members safe and supporting where needed in other areas of their community.

The Almonte General Hospital and Carleton Place District Memorial Hospital are separate corporations which formed the Mississippi River Alliance in 2017. Each hospital has a Board which is composed of seven elected members and seven ex-officio voting members from the other corporation. Over the past six years the members of the respective boards have worked closely together to identify and support the best possible integrated care close to home for all the communities served by the two hospitals. Through working together members of the boards recognized common goals and have now moved to have Allied Boards. The Allied Boards hold a single set of meetings and review data and make decisions for both corporations. Members of the Allied Boards are very knowledgeable and strongly committed to the integration of the organizations with the goal of being better together. The Allied Boards are commended for leadership they have demonstrated to their communities in working together to ensure that quality care is available to those living in smaller, rural communities.

The MRHA enjoys the support of a number of partners within their community and regionally. Working relationships were described as very collaborative, with an ability to readily communicate with hospital leadership. Partners described MRHA and their relationship with MRHA as supportive, like family, respectful, unwavering, innovative, interested in the community and progressive. Partners also commented that the hospitals enjoy a long history of providing good care and are held with affection by many.

The leadership team of MRHA is very engaged and committed. All the senior leaders as well as directors for several other services including finance, pharmacy, and human resources. are integrated across the two hospitals. The integrated leaders divide their time across the two sites and work to maintain visibility at both. Leadership at MHRA has adopted the Studer model of management to support increased alignment and accountability as well as improving employee engagement and patient experience. The organization is commended for the efforts that have been taken through use of the Studer model to ensure alignment of managers' goals and objectives with the corporate plan. The organization is encouraged to ensure that staff, physicians, patient and family members are included in the development and monitoring of program or

department specific goals and objectives.

The health human resource challenges facing MRHA are not different than found in other hospitals or in small rural healthcare environments. The market is highly competitive for all classifications including the support service area and ongoing efforts are in place related to recruitment and retention. To support these efforts, the organizations have developed a three-year Human Resources Plan (2023 – 2026) focused on encouraging existing staff to stay and grow within the organizations as well as on being more competitive to attract new staff and physicians.

To support retention of staff, a number of actions to promote a positive work life culture have been implemented including engaging staff in the review of schedules and implementing job sharing opportunities.

Staff and physicians are highly committed to the organizations and to their communities. They appear genuine, caring and compassionate and work well together as a team to support patients and their families.

Over the past several years, a significant focus has been on the development of an integrated clinical services plan (MRHA 2030) which was approved in 2021. This plan was developed through the work of six advisory panels (the composition of which included staff, physicians, and patient and family advisors) which focused on key areas of service delivery across the two organizations. For each of the existing areas of service (emergency, inpatient, surgical, obstetrics, outpatient, diagnostic, and long-term care) future growth and change were identified as well as the enablers to make these a reality. The enablers identified included the move to a common electronic medical record platform across the two sites, further integration of human resources, and facility renewal at both sites starting with the redevelopment of the Carleton Place emergency department which is currently underway.

The organizations support a culture of quality and patient safety with standardized practices and have a keen desire to provide quality care to their communities. The MRHA is encouraged to build upon this culture and enhance the structures and processes to support the identification, and implementation of quality improvement initiatives at the department level with the inclusion of staff, physicians, patients and families.

Fairview Manor provides a village approach to living. Connecting and involving community partners they support residents in a homelike environment that meets their unique needs while providing a sense of purpose and community connection daily. A focused restorative care approach defines living goals unique to each resident that will help them achieve the greatest independence possible. The physical space is incredibly clean and welcoming, providing an atmosphere of 'We have pride in our home'. This, along with the robust recreational therapy offerings, makes the manor a delightful place to live and work.

Patients interviewed were very appreciative of the care they had received. The ability to receive quality care close to home was deeply valued. The MRHA has had a long history of engaging patients and family in their care and using the voice of patient advisors to provide input on various operational documents and draft plans within the hospitals. The organizations are encouraged to build upon the good work that has been done to date by the PFAC and consider embedding advisors into the various programs and departments across the organizations.

# Detailed On-site Survey Results

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

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

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

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

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

See Appendix B for a list of priority processes.

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

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

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

# Priority Process Results for System-wide Standards

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

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

## Priority Process: Governance

Meeting the demands for excellence in governance practice.

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

The Almonte General Hospital and Carleton Place District Memorial Hospital are separate corporations which formed the Mississippi River Health Alliance (MRHA) in 2017. Over the past six years the members of the respective boards have worked closely together to identify and support the best possible integrated care close to home for all the communities served by the two hospitals. Through working together members of the boards recognized common goals and have now moved to have Allied Boards. Each hospital has a Board which is composed of seven elected members and seven ex-officio voting members from the other corporation. The Allied Boards hold a single set of meetings and review data and make decisions for both corporations. One nominating committee reviews and recommends candidates when an opening occurs on either of the Allied Boards. Members to each board are elected through an open and transparent process and are selected in keeping with a skills matrix as well as the goal of maintaining diversity in culture, gender, ethnicity and geographical locations within the areas served by the organizations. One Chair, Vice Chair and Treasurer are elected and serve both Allied Boards. New members to the Allied Boards received a thorough orientation and all members receive ongoing education on a regular basis.

Members of the Allied Boards are very knowledgeable and strongly committed to the integration of the organizations with the goal of being better together. The Allied Boards are commended for leadership they have demonstrated to their communities in working together to ensure that quality care is available to those living in smaller, rural communities.

The Allied Boards maintain five standing committees, each of which has a comprehensive workplan directing activities throughout the year. A patient and family advisor is a member of the Board Quality Committee and written patient stories/comments/concerns are brought forward to the committee on a regular basis. The organization is encouraged to explore the potential of, where possible, having patient stories presented directly by the patient or family member.

Monitoring patient safety, quality indicators and potential risks to the organizations are seen as critical

work by the members of the Allied Boards. Members are knowledgeable about patient safety and quality improvement and spoke to the rigor with which reports are reviewed and enquiries made of senior staff.

Members of the Allied Boards are highly committed to reviewing their own functioning, as an evaluation of committee functioning is completed after each committee meeting, a full board evaluation is completed on an annual basis, and member peer evaluations are conducted every two years.

## Priority Process: Planning and Service Design

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

| Unmet Criteria | High Priority Criteria |
|---|---|
| **Standards Set: Leadership** | |
| 4.12 Policies and procedures for all of the organization's primary functions, operations, and systems are documented, authorized, implemented, and up to date. | |

**Surveyor comments on the priority process(es)**

The two organizations developed a common strategic plan in 2017 and this plan has been under review in the past year. At the time of this survey, a new five-year plan (2023-2028) had been approved by the Allied Boards but had not yet been rolled out to the organizations. In addition to the review of the strategic plan, the organizations reviewed their respective missions and visions and created one mission and vision for the MRHA. Internal and external stakeholders have been engaged in the work of developing the new strategic plan, mission and vision. Work is to be done in the coming months to gather input from staff and physicians on the current values.

Corporate goals for the current year have been developed and are grouped under five key pillars: care, access, people, alliance, and resources. Implementation of the corporate goals and objectives across the organizations is supported with a leaders' effectiveness measures tool or LEM. Each leader has their own LEM which includes the goals and objectives they have set in keeping with the overall corporate goals. Leaders are expected to develop a 90-day action plan describing work to be done to achieve their goals. The organization is commended for the efforts that have been taken to ensure alignment of goals and objectives with the corporate plan. As well, the organization is encouraged to ensure that staff, physicians, patients, and family members are included in the development and monitoring of program or department specific goals and objectives.

Over the past several years, a significant focus has been on the development of an integrated clinical services plan (MRHA 2030) which was approved in 2021. This plan was developed through the work of six advisory panels (the composition of which included staff, physicians, and patient and family advisors) which focused on key areas of service delivery across the two organizations. The MRHA 2030 plan recommends furthering the service profile and priorities, clinical service enablers, partnerships and infrastructure required to best meet the needs of areas served. The MRHA has also joined the local Ontario Health Team with the goal of being an active participant in the provision of acute and long-term care services in the area.

A key focus within the clinical services plan is to redesign care delivery models to create true

interprofessional care teams with the introduction of new roles and ensuring staff can work to their full scope of practice. Enablers were also identified and include the move to a common electronic medical record platform across the two sites, further integration of human resources, and facility renewal at both sites starting with the redevelopment of the Carleton Place emergency department which is currently underway.

The organizations are in the process of reviewing and revising policies and procedures to create consistency across MRHA. There are several policies that have not yet been reviewed and are out of date. The organizations are commended for working toward this consistency and are encouraged to move forward and complete the work to update all policies and procedures.

The MRHA enjoys the support of a number of partners within their community and regionally. Working relationships were described as very collaborative, with an ability to readily communicate with leadership. Partners described MRHA and their relationship with MRHA as supportive, like family, respectful, unwavering, innovative, interested in the community and progressive. Partners also commented that the hospitals enjoy a long history of providing good care and are held with affection by many.

## 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)**

The MRHA has recently integrated the finance department staff across the two hospitals. This has resulted in improved workflow and efficiency. However, the two organizations do continue to have separate budgets and financial reporting. There is a consistent and comprehensive process in place to create annual operating and capital budgets in the two organizations. Managers are engaged in zero based budgeting with the support of the finance team. Monthly variance reports are available to the managers who in turn provide an analysis of potential variances to their director/vice president. Capital budgeting is a very open and collaborative process, including managers, physicians and the foundation staff in the review of what is required to support patient care and the prioritization of these needs in terms of funds available.

The Allied Boards approve both the annual operating and capital budgets and receive regular reports throughout the year on how spending is tracking to budget. Annual audits are conducted on the two organizations by external audit firms and the finding are presented to the Finance Committee of the Allied Boards as well as the full membership of the Allied Boards.

The Almonte General Hospital has recently been successful in having the Ministry of Health recognize the organization's long standing structural deficit and with this funding has been able to move out of a deficit position.

The MRHA is commended for the focus on cost reduction and the engagement of staff, physicians and managers in identifying potential cost saving opportunities in their areas of work. The organizations are encouraged to explore the implementation of a formal impact analysis prior to onboarding new physician specialties and/or programs.

The Carleton Place and District Memorial Hospital (CPDMH)is currently undergoing a major expansion for a new emergency department. CPDMH is commended for the work that has been done with the Foundation and the community to raise significant funding in support of this redevelopment.

## Priority Process: Human Capital

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

**The organization has met all criteria for this priority process.**

**Surveyor comments on the priority process(es)**

The MRHA has implemented a number of actions to promote a positive work life culture including engaging staff in the review of schedules and implementing job sharing opportunities. As well, staff are encouraged to take their vacation and to disconnect from work and not feel the need to respond to emails when not at work. A peer support program has been implemented to assist staff who may be experiencing a challenging situation in their home life or post an unusual event at MRHA.

The organizations have drafted a three-year Human Resources Plan (2023 – 2026) focused on recruitment and retention of health human resources. The challenges facing MRHA are not different those found in other hospitals or in small rural healthcare environments. The market is highly competitive for all classifications including support service areas. The three-year plan is focused on becoming more competitive and attractive to candidates; to support the health and well-being of staff, as well as build leadership capacity with the goal of retaining current staff, and to also create a culture of inclusivity and respect for the populations served. The organizations are encouraged to move forward with implementing this plan and to also enhance the talent management plan to include steps to support staff growth and development such that the organization is growing their own leaders.

Currently both hospitals have a significant number of novice staff, many with less than two years of experience. The MRHA is encouraged to ensure that adequate resources are made available to support both novice staff and leaders.

The organization is commended for the consistent approach to the completion of performance reviews and staff rounding which provides an opportunity for the manager to provide positive and constructive feedback as well as career goals.

The formal role descriptions define reporting relationships are available for all roles; however, the hospitals are encouraged to review the various different titles of leaders and bring further clarity to the organizational reporting structures.

A key goal for the organization is to implement an inter-professional model of care and to maximize the scopes of practices for all regulated health professionals. To date work has been done to support registered practical nurses (RPN) to practice to their full scope of practice.

The organizations are encouraged to move forward with their plan to implement an Equity, Diversity and Inclusion (EDI) Committee and to also address some relatively quick changes such as non-gender washrooms.

## Priority Process: Integrated Quality Management

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

**The organization has met all criteria for this priority process.**

**Surveyor comments on the priority process(es)**

The organizations support a culture of quality and patient safety with standardized practices and a keen desire to provide quality care to their communities. Opportunities for quality improvement are identified through several formal and informal methods including incident reports, inspection reports, patient and staff satisfaction reports, post discharge phone calls, and performance indicators. Committees throughout the organization have a responsibility for quality improvement within their particular mandate. Overall quality of patient care and services is monitored by organization-wide committees that in turn report quality results to the Quality Committee of the Allied Boards.

In some of the departments visited, corporate goals were posted along with a Stoplight document which described the work being done in that department to achieve actions which align with the corporate goals. However, in a number of the areas staff were not able to identify quality initiatives being worked on in their department and quality boards were not consistently found across the organizations. The MRHA is encouraged to review and enhance the structures and processes in keeping with the identification, implementation, and monitoring of quality improvement initiatives at the department level. As well, it is recommended that the organizations include patient and family advisors in the identification, implementation, and monitoring of department or unit quality improvement work and that education be provided to staff, and patient and family advisors, to increase their knowledge on quality improvement.

Both hospitals hold the same quality indicators for the current year with a focus on discharge information to patients, medication reconciliation, and ensuring alignment with the Choosing Wisely best practice guidelines for blood transfusions and inpatient blood draws. The Long-Term Care home, Fairview Manor, is focused on reducing falls and implementing individualized palliative care plans for patients when needed.

Incident reporting is facilitated through a paper form in Carleton Place and electronic forms in Almonte. There is a plan to move to electronic reporting at CPDMH as well. Every incident is reviewed by the appropriate manager and cumulative reports are reviewed at the monthly patient care and quality committees. Reports are also summitted to the Allied Boards Quality Committee. The organizations review near misses and have recently re-branded this work as Good Catch" to provide opportunities for education regarding best practices and ensure an actual event does not occur.

The organizations are commended for the work on ensuring the consistent use of bedside shift reporting and on the post-discharge follow-up phone calls being made to the patients. As well the organizations have welcomed family members or close friends of the patients or residents to act as an essential care

partner and to provide consistent support for the patient/resident throughout their care journey.

There is no dedicated individual who supports quality improvement activities. This responsibility is carried by several leaders. The organization is encouraged to review the potential of having a dedicated resource for quality.

## 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 Mississippi River Health Alliance (MRHA) has an active Ethics Committee engaged in elevating the practice of ethical decision making. They are actively involved in educating the organization through online education, lunch and learns, and promotional material, to ensure staff understand practice expectations and resources available to support decision making. The committee has representation from all sites made up of frontline, leadership, a board member, clergy, physicians, PFAC, and an ethicist from Champlain Center for Health Care Ethics. The partnership with Champlain provides a regional approach to the provision of health care ethics services. There is the ability to access an ethicist for challenging clinical and organizational issues as well as to partner for education. The PFAC member of this committee also sits on the regional Ethics Committee and is very engaged in providing input to the team.

MRHA is committed to an ethical framework to guide and support ethical behaviour and decision making by all staff, medical staff, volunteers and students. They have implemented two decision making tools. The IDEA framework and the Accountability for Reasonableness Framework (A4R). The IDEA framework provides a fair, step-by step process to help guide healthcare providers and administrators in working through clinical ethical issues encountered in the delivery of healthcare. The A4R is used for more organizational ethical issues or at a governance level. The team uses these frameworks to guide decision-making and actions about ethical issues that arise from the bedside to the boardroom.

The team reviews any research proposals to understand the impact and risk to the organization is discussed and has a policy to guide decision making. As the organization roles out the new strategic plan and mission, vision and values it is encouraged to ensure that any research undertaken at MRHA is aligned with the mission, vision and values. Another opportunity to continue to maintain awareness of Principal Based Care and Ethical Decision Making is to continue with the ongoing educational opportunities using different modalities as well as, at a minimum, ensure appropriate education is delivered during the orientation process.

## Priority Process: Communication

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

| Unmet Criteria | High Priority Criteria |
|---|---|
| **Standards Set: Leadership** | |
| 11.1 Information management systems selected for the organization meet the organization's current needs and take into consideration its future needs. | |

**Surveyor comments on the priority process(es)**

The MRHA currently has two communication plans; one that speaks to general communication activities to internal and external audiences, and a second plan that has focused on building awareness of the alliance between the Almonte General Hospital and the Carleton Place District Memorial Hospital. The goal in the near future is to blend these two plans into one, with actions that speak to both areas of focus. The two corporations have separate websites and work is also underway to implement a new, common website. Several different social media platforms are used to communicate externally, and this usage is monitored and evaluated.

Communication with the community and external stakeholders is supported through various actions including the publishing of board meeting minutes, media releases, semi-annual publication of a newsletter, and periodic town halls and open forums. Patient and resident information handbooks are available to all new admissions and this booklet provides information such as patient's rights and responsibilities and how to raise concerns or complements. Digital communication monitors are also used internally to support sharing of information with staff, physicians, patients and visitors.

The two corporations currently have different electronic information systems and although these systems are supporting some of the organizations' needs, there is a significant need to enhance the degree of electronic documentation, including the implementation of Computer Physician Order Entry (CPOE) in both organizations. As well, to support patient care between the two hospitals, the organizations are urged to move to a common system which will support the flow of clinical and administrative information and enhance patient care and operating efficiencies.

## Priority Process: Physical Environment

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

| Unmet Criteria | High Priority Criteria |
|---|---|
| **Standards Set: Perioperative Services and Invasive Procedures** | |
| 3.1 The physical layout of the operating and/or procedure room(s) and equipment are designed to consider client flow, traffic patterns, the types of procedures performed, ergonomics, and equipment movement logistics. | |

**Surveyor comments on the priority process(es)**

The Carleton Place and District Memorial Hospital is an old facility which has undergone very few renovations. It was built in 1955 as a one-story building and in 1965 a second floor was added to accommodate growing needs. There is only one entrance into the facility which is used for emergency patients (other than those arriving by ambulance), ambulatory care patients, staff and all visitors. The current building is said to meet Code standards for hospitals. There is no sprinkler system in the patient care areas, although there are plans for this to to be rectified shortly. The stairwells are narrow and steep with well-worn steps, some of which have cracks in the cement. There is only one elevator. The hallways throughout the facility are narrow and it is difficult to keep them clear of equipment. Patient washrooms are not wheelchair accessible and not all patient rooms have washrooms. The physical space constraints do not allow for good patient flow. For example, the OR is in the back of the emergency department in a very crowded small space and patients must first go through the emergency department to arrive at the OR.

CPDMH had been requesting full redevelopment on a green field site. However, since this did not look to be attainable several years ago, it was agreed to rebuild the emergency department. This work is underway and due to be completed next year. There is good hoarding between the areas of the facility currently operating and the construction for the new emergency department. The MRHA is encouraged to continue to pursue a total hospital redevelopment as many of the areas within the facility do not have sufficient space and are not designed to continue to support the care needs of a growing community.

The team providing care and services at CPDMH are to be commended for continuing to provide excellent care in very constrained spaces and for their creativity in finding solutions and work-arounds due to the limited space available within the physical building.

## 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 development of a Joint Emergency Preparedness Committee across Almonte/Carlton Place Hospitals and Fairview LTC has been successful in ensuring consistent processes, while at the same time looking at unique ways of meeting emergency preparedness standards for the LTC site.

There is evidence of a passionate and genuine commitment to emergency preparedness planning, and they are encouraged to continue defining their annual workplan to reflect the proactive work they want to achieve. It is clear they use information from actual and mock code situations to make improvements to their processes.

Working in collaboration with external stakeholders (EMS, OPP, Municipalities and others) is important to them and they are encouraged to continue with those efforts. The organizations are encouraged to continue to look at table-top code exercises as a simplified way of doing mock codes.

Over the last three years, the organizations have demonstrated their efforts on managing the COVID-19 pandemic. There is recognition for their proactive and flexible approaches to keeping patients, residents and team members safe. They are also recognized for supporting where needed in other areas of their community.

Emergency preparedness plans have been tested throughout the pandemic. As well, the team has had the opportunity to action their plans during a complete loss of power following a windstorm. As incidents happen the team debriefs and adjusts plans and processes as needed.

The team works across the MRHA to standardize policies and processes ensuring they capture the individual nuances where appropriate to ensure all plans and processes meet the individual needs of the environment/space.

## Priority Process: People-Centred Care

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

| Unmet Criteria | | High Priority Criteria |
|---|---|---|
| **Standards Set: Emergency Department** | | |
| 4.3 | A comprehensive orientation is provided to new team members and client and family representatives. | |
| 4.15 | Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable. | |
| 17.7 | Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families. | ! |
| 18.3 | Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families. | ! |
| **Standards Set: Inpatient Services** | | |
| 1.1 | Services are co-designed with clients and families, partners, and the community. | ! |
| 1.9 | Barriers that may limit clients, families, service providers, and referring organizations from accessing services are identified and removed where possible, with input from clients and families. | |
| 3.3 | A comprehensive orientation is provided to new team members and client and family representatives. | |
| 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. | |
| 15.9 | Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families. | ! |
| 16.3 | Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families. | ! |

| | | |
|---|---|---|
| **Standards Set: Leadership** | | |
| 3.3 | Teams, clients, and families are supported to develop the knowledge and skills necessary to be involved in quality improvement activities. | |
| **Standards Set: Perioperative Services and Invasive Procedures** | | |
| 1.1 | Services are co-designed with clients and families, partners, and the community. | ! |
| 1.7 | Barriers that may limit clients, families, service providers, and referring organizations from accessing services are identified and removed where possible, with input from clients and families. | |
| 2.4 | Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families. | |
| 6.3 | A comprehensive orientation is provided to new team members and client and family representatives. | |
| 6.12 | 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. | |
| 24.7 | Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families. | ! |
| 25.3 | Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families. | ! |

**Surveyor comments on the priority process(es)**

The organizations have had a long history of engaging patients and families in their care. Relationships with patients and families appeared to be very respectful, and patients and residents spoke highly of the care they were receiving.

Patient and Family Advisors and the Patient and Family Advisory Committees (PFAC) have been in place for several years. Each of the corporations has had their own PFAC until last year when the two committees agreed to form a joint Patient and Family Advisory Committee for MRHA. The Joint Patient and Family Advisory Committee consists of Patient and Family Advisors as well as staff that provide coordination and leadership as needed. Throughout the past few years PFAC has been engaged in activities including wayfinding, providing input on various operational documents, initiating a presentation about PFAC at General Orientation, pet therapy, and providing input to the plan for a new ER in Carleton Place. As well a member of PFAC now sits on several of the MRHA wide committees including the Board Quality Committee, the Ethics Committee and the Records Management Committee.

The Fairview Manor has an engaged Resident and Family Council which meets monthly and has been involved the residents' feedback form, falls prevention, and a walking program that has been initiated to further residents' mobility.

There has however been an ongoing challenge with recruitment of additional members to the PFAC and this was further hindered during the pandemic. The MRHA is encouraged to renew their efforts to bring on more members and consider embedding the advisors into the various programs and department across the organizations. Members of the PFAC interviewed during the survey supported the suggestion of being associated with a particular department and becoming more engaged in the work of that area. Patient advisors as part of programs or departments also provides the opportunity to engage these voices in the co-design of services, the identification and monitoring of quality initiatives and in many of the service planning activities which at this point do not have patient and family input.

The MRHA is encouraged to review the criteria for becoming a patient advisor and the length of term to be served by the advisor. Currently volunteers can also serve as advisors and this has the potential to create difficulty in separating the roles as a volunteer and acting as a patient advocate, versus a patient advisor who is to provide input to the organization through a patient's eyes.

## 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 ED team and leadership are innovative and collaborative in finding opportunities to improve patient flow, including working across all three sites of the MRHA.

The team tracks the time to inpatient bed following admission and this continues to benchmark favourably. One of the greatest challenges is the lack of isolation beds available to use on the inpatient unit. The team has interdisciplinary rounds to identify and remove barriers to discharge if possible. The team reports that physicians typically arrive on the unit to round on their patient early to optimize discharges. Consider formalizing this process into bullet rounds for consistency to remove barriers for discharge sooner.

The organization is encouraged to continue to work on efforts for meeting the 48-hour repatriation target.

## Priority Process: Medical Devices and Equipment

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

| Unmet Criteria | | High Priority Criteria |
|---|---|---|
| **Standards Set: Reprocessing of Reusable Medical Devices** | | |
| 3.2 | The MDR department is designed to prevent cross-contamination of medical devices, isolate incompatible activities, and clearly separate work areas. | ! |
| 3.3 | Access to the MDR department is controlled by restricting access to authorized team members only and being identified with clear signage. | ! |
| 12.1 | The MDR department has an appropriate storage area for sterilized medical devices and equipment. | ! |
| 12.2 | Access to the sterile storage area is limited to authorized team members. | ! |

**Surveyor comments on the priority process(es)**

The physical location of the reprocessing of medical devices is situated behind the current ED and next to the operating room. The area is appropriately marked but does not have controlled access. The team has optimized their workspace to ensure that they are able to deliver the service to support the organization using a one-way flow of clean to dirty for instruments and devices. However, there needs to be attention given to expanding this area to have appropriate flow of staff from clean to dirty given the fact that it is solo staffed. The staff there is knowledgeable and a great asset to the organization. On the clean side of the department there are clean supplies stored close to the sterilizer; they should be stored separately. A workstation to assemble and wrap trays is also found here as well as the sterilized packages. There is no automatic washer, instruments are manually cleaned which increases workload. A consideration could be to move to a hard container system to protect and organize the surgical instruments better, protecting them from damage to paper wraps stored on cramped shelving units. There is also a green alternative to the sterilization wrap reducing waste. The primary MDR technician reported working with occupational health and safety in the past to review the ergonomics of the workspace to meet her needs, however, there is not an adjustable worktable that would accommodate other employees that may work in the area.

Medical devices are cleaned and sterilized according to manufacturer recommended standards. A reference binder of procedures and processes is available to help guide the practice as well as pictures to aide in assembly. The team receives education and support from company representatives when introducing new technology or refreshing on existing technology which is the case for endoscopes. Endoscopes are cleaned, stored and transported according to standards and can by tracked to use on a patient as required.

Medical devices and equipment are maintained through a preventative maintenance program. This program is contracted out to the biomedical engineering services of Children's Hospital of Eastern Ontario. The biomedical team is proactive in ensuring a comprehensive preventative maintenance program is in place to support medical devices and equipment. The staff feel well supported by this team to help trouble shoot when necessary and have the equipment available in working order on demand.

## Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

**Clinical Leadership**

- Providing leadership and 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

## Standards Set: Diagnostic Imaging Services - Direct Service Provision

| Unmet Criteria | | High Priority Criteria |
|---|---|---|
| **Priority Process: Diagnostic Services: Imaging** | | |
| 4.12 | Access to spiritual space and care is provided to meet clients' needs. | |
| 12.1 | The team interprets elective, urgent and emergent diagnostic imaging results in a timely manner. | ! |
| 17.3 | The team identifies measurable objectives for its quality improvement initiatives and specifies the timeframe in which they will be reached. | ! |
| 17.4 | The team identifies the indicator(s) that will be used to monitor progress for each quality improvement objective. | |
| 17.9 | The team designs and tests quality improvement activities to meet its objectives. | ! |
| 17.10 | The team collects new or uses existing data to establish a baseline for each indicator. | |
| 17.11 | The team follows a process to regularly collect indicator data to track its progress. | |
| 17.12 | The team regularly analyzes and evaluates its indicator data to determine the effectiveness of its quality improvement activities. | ! |
| 17.13 | The team implements effective quality improvement activities broadly. | ! |
| 17.14 | The team shares information about its quality improvement activities, results, and learnings with clients, families, staff, service providers, organization leaders, and other organizations, as appropriate. | |
| 17.15 | The team regularly reviews and evaluates its quality improvement initiatives for feasibility, relevance and usefulness. | |
| **Surveyor comments on the priority process(es)** | | |
| **Priority Process: Diagnostic Services: Imaging** | | |

The diagnostic imaging department is located adjacent to the emergency department. Diagnostic services at Carleton Place and District Memorial Hospital (CPDMH) provide a range of exams including general X-ray, ultrasound, ECGs, Holter monitoring, and pacemaker checks. These services are provided by a small and very dedicated staff as well as a working manager. The department is open for 12 hours (7:30 – 19:30) and available on an on-call basis throughout the evening and night. The department enjoys high staff engagement and patient satisfaction.

The physical space allocated to diagnostic services is very limited. There is very little distance between the registration desk and the waiting area within the department. As such, to provide some privacy, the patient is only asked their name and date of birth at the registration desk and all further screening is conducted in the actual treatment areas. In addition, the actual treatment areas for ultrasound are small and access can be challenging for larger wheelchairs or mobility devices. The ECG areas is in an inner hallway with a curtain drawn around it, offering very little privacy. MRHA is encouraged to look at opportunities to expand the space that is allocated to diagnostic imaging and to also consider co-location to the new emergency department which is being built. If the department remains where it is located, there will be significant distance between it and the new emergency department. Long distance transport may create some inefficiencies in treatment as well as safety and quality issues for the patients who are required to travel between these departments.

There is currently a three week wait for ECG tests to be read by a cardiologist or internal medicine specialist. MRHA is encouraged to move forward with a solution for this as soon as possible.

The two different electronic systems between the MRHA hospitals have created the need for each to have a relationship with different regional hospital partners for radiology support. As well, the hospitals have different PACS (picture archiving and communication system). The lack of a common electronic information system has created work-flow differences and the need for different protocols. This makes it more difficult for staff to work between the two organization and for there to be synergy between the two diagnostic imaging departments. The MRHA is encouraged to move forward in the very near future to address the fact that the hospitals are operating within different electronic information systems.

There is a need for great focus on quality improvement initiatives within the department. Several department goals have been identified in keeping with the corporate goals however, no measurable objectives, indicators, or targets have been identified. The department is encouraged to identify clear action steps and the indicators that will be measured to determine when or if the goals have been met. As well, they are encouraged to include the voice of staff and of the patient/family in this work.

## Standards Set: Emergency Department - Direct Service Provision

| Unmet Criteria | | High Priority Criteria |
|---|---|---|
| **Priority Process: Clinical Leadership** | | |
| 1.3 | Specific goals and objectives regarding wait times, length of stay (LOS) in the emergency department, client diversion to other facilities, and number of clients who leave without being seen are established, with input from clients and families. | |
| 1.4 | Services are reviewed and monitored for appropriateness, with input from clients and families. | |
| 2.4 | An appropriate mix of skill level and experience within the team is determined, with input from clients and families. | |
| 2.6 | Seclusion rooms and/or private and secure areas are available for clients. | ! |
| 6.2 | 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** | | |
| The organization has met all criteria for this priority process. | | |
| **Priority Process: Episode of Care** | | |
| 8.2 | The Pediatric-CTAS is used to conduct the triage assessment of pediatric clients. | |
| 8.4 | A triage assessment for each pediatric client is conducted within P-CTAS timelines, and in partnership with the client and family. | ! |
| 9.16 | A process to investigate and respond to claims that clients' rights have been violated is developed and implemented with input from clients and families. | ! |
| 10.2 | The assessment process is designed with input from clients and families. | |
| 13.9 | The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families. | |
| **Priority Process: Decision Support** | | |
| 14.8 | There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements. | ! |

| | | |
|---|---|---|
| 15.2 | Policies on the use of electronic communications and technologies are developed and followed, with input from clients and families. | |
| **Priority Process: Impact on Outcomes** | | |
| 16.2 | The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners. | |
| 16.3 | There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines. | ! |
| 16.4 | Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families. | ! |
| 16.5 | Guidelines and protocols are regularly reviewed, with input from clients and families. | ! |
| 17.1 | A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families. | ! |
| 17.2 | Strategies are developed and implemented to address identified safety risks, with input from clients and families. | ! |
| 17.3 | Verification processes are used to mitigate high-risk activities, with input from clients and families. | ! |
| 17.4 | Safety improvement strategies are evaluated with input from clients and families. | ! |
| 18.1 | Information and feedback is collected about the quality of services to guide quality improvement initiatives, with input from clients and families, team members, and partners. | |
| 18.2 | The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families. | |
| 18.4 | Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families. | |
| 18.13 | Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families. | |
| **Priority Process: Organ and Tissue Donation** | | |

The organization has met all criteria for this priority process.

## Surveyor comments on the priority process(es)

### Priority Process: Clinical Leadership

Work has begun on the new ED space. The team looks forward to moving into the new space that will support patient care. The current space consists of two trauma rooms and four bays to provide care for a rapidly growing community. Volumes have not returned to pre-pandemic levels but continue to grow. The new space will have an additional five bays to care for patients and they currently have bypass protocols and surge plans in place to support care. The team is working to ensure that they do not have to enact bypass or closure protocols without reviewing all possible solutions first as they are committed to providing care to the community they serve.

There is evidence that the ED clinical leadership uses information to inform service design and address the recruitment/retention of ED staff. The leadership team is encouraged to continue with skill mix opportunities. The ED physician team is acknowledged for revisiting their scheduling approach for vacant shifts as well as becoming cross credentialed with Almonte to provide consistent coverage.

There is not a seclusion room and/or private and secure area available for clients. The team uses one of the private rooms near the nursing station when the need presents. They have the ability to call a security guard to stay with the patient when needed for close observation to monitor safety. The team also uses the OPP for support. It is recommended that the team review security and safety processes across the site.

The team has engaged a wide variety of stakeholders including patients and families while designing the new ED. They are encouraged to imbed the voice of the patient in program design and functioning as they move forward and to include a patient partner on patient care teams to provide the proactive approach to program functioning rather than taking a reactive approach through feedback and incident reporting.

### Priority Process: Competency

The ED team and leadership is committed to ensuring all team members are provided with ongoing education and training. The opportunity to provide cross training between ED and other units is excellent for growth and development of staff in ED and other areas.

The team leader role is providing exceptional support for education, mentorship of new staff, and leading changes for the department.

There is a list of competencies required to work in the department that does not include PALS. Consider making this a mandatory requirement given the growing population and patients presenting to ED. There is one educator that works part time for the organization and team leads that support education at the elbow. MRHA is encouraged to review the roles of team leads and educators to ensure that they have adequate time for teaching, coaching and mentoring novice staff as a retention strategy for new staff.

**Priority Process: Episode of Care**

The ED team has well established processes and procedures to ensure the delivery of safe, quality care to their patients and families.

Through discussion with patients and families it was highlighted that the team members take time to explain and involve them in care and they feel safe and informed. There was also the recognition of the caring approach of the team members.

There are strong collaborative partnerships with EMS and OPP that have been beneficial to achieve safe care.

The team has implemented all Required Organizational Practices to support the delivery of safe patient care. They are challenged with the cramped space in the current ED but continue to meet all best practice patient care standards.

They care for paediatric patients and have appropriate medications and equipment. They do not use the PTAS scoring system but utilize CTAS scoring effectively for this population.

It is recommended that they engage a patient family advisor on their ED program team meetings to provide input on a regular basis.

**Priority Process: Decision Support**

The ED team provides good documentation given that they are using both electronic and paper-based systems. To ensure quality and safety, the organization needs to continue with their efforts towards a fully electronic medical record.

There is a need to audit documentation to ensure completeness and identify areas to improve documentation.

The team is encouraged to move towards a formal patient/family representative role at the ED program meetings.

**Priority Process: Impact on Outcomes**

The ED team is committed to using evidence based and best practice guidelines to develop policies/procedures, medical directives, patient information, and other tools to guide their practice.

Quality and safe care is a priority for all members of the team and the passion for quality improvement is clearly evident. A process to share quality key indicators that is tracked and monitored should be available for frontline to review and understand changes. It is the frontline staff that will be able to add valuable problem-solving strategies.

There is a paper-based incident reporting system that the team should review with a focus on improving this process and upgrading it to an electronic tool. An electronic tool can improve the efficiency and effectiveness of the reporting process and help to understand opportunities to develop processes to improve quality and safety of care.

The leadership team is strongly encouraged to evolve the Patient and Family Advisory role formally on the ED program meetings to ensure there is regular input into planning and evaluating of ED services.

**Priority Process: Organ and Tissue Donation**

The ED team is commended for their work on establishing the organization's organ and tissue donation process since the last survey!

They have created a relationship with Trillium Gift of Life Network to support processes through education and policies. The team monitors their reporting compliance and uses the information to make improvements. Consider including a hard stop in the documentation process following death to ensure 100 percent compliance always.

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

| Unmet Criteria | | High Priority Criteria |
|---|---|---|
| **Priority Process: Infection Prevention and Control** | | |
| 5.2 | Team members, clients and families, and volunteers are engaged when developing the multi-faceted approach for IPC. | |
| 14.3 | Input is gathered from team members, volunteers, and clients and families on components of the IPC program. | |
| **Surveyor comments on the priority process(es)** | | |
| **Priority Process: Infection Prevention and Control** | | |

The Infection Prevention and Control (IPAC) program and approach is consistent across the two hospitals. The same leaders provide support at the two sites and work is being done to revise all policies and procedures so that they are consistent across the MRHA. The IPAC Committee serves both hospitals and meets every two months to review indicators.

A difference between the two hospitals is the increased challenges that are felt at CPDMH due the age of the facility and lack of space. That said, there is a great deal of energy and enthusiasm amongst staff and physician working at CPDMH to ensure that patients are kept safe from infections. The team is particularly proud that they have not had any hospital-acquired outbreaks for a very long time, including during the pandemic. Alcohol based rubs are readily available to support hand hygiene and are regularly used.

CPDMH maintains a kitchen and cooks and prepares all meals served within the hospital. Staff within the kitchen are all trained in safe food handling and refrigerators are alarmed to ensure that temperature changes are identified quickly.

Infection prevention and control policies and procedures are in keeping with provincial infection control standards. All staff receive education at their general orientation as well as on an ongoing basis through the mandatory learning modules.

Hand hygiene is audited regularly but is only posted on an annual basis. It is recommended that the results of the audits be reported more frequently, and that the information posted be more specific so that departments can determine how well they are doing relative to other departments. As well, IPAC is encouraged to develop some goals and measurable objectives in keeping with the corporate plan.

## Standards Set: Inpatient Services - Direct Service Provision

| Unmet Criteria | | High Priority Criteria |
|---|---|---|
| **Priority Process: Clinical Leadership** | | |
| 1.6 | Services are reviewed and monitored for appropriateness, with input from clients and families. | |
| 2.8 | A universally-accessible environment is created with input from clients and families. | |
| **Priority Process: Competency** | | |
| 3.1 | Required training and education are defined for all team members with input from clients and families. | ! |
| **Priority Process: Episode of Care** | | |
| 9.4 | The assessment process is designed with input from clients and families. | |
| 11.2 | For pediatric or youth clients, transition planning to adult care is completed in partnership with the client and family and is identified in the care plan. | |
| 11.9 | The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families. | |
| **Priority Process: Decision Support** | | |
| 13.2 | Policies on the use of electronic communications and technologies are developed and followed, with input from clients and families. | |
| **Priority Process: Impact on Outcomes** | | |
| 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. | ! |
| 14.4 | Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families. | ! |
| 14.5 | Guidelines and protocols are regularly reviewed, with input from clients and families. | ! |
| 15.1 | A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families. | ! |

| | | |
|---|---|---|
| 15.2 | Strategies are developed and implemented to address identified safety risks, with input from clients and families. | ! |
| 15.3 | Verification processes are used to mitigate high-risk activities, with input from clients and families. | ! |
| 15.4 | Safety improvement strategies are evaluated with input from clients and families. | ! |
| 16.1 | Information and feedback is collected about the quality of services to guide quality improvement initiatives, with input from clients and families, team members, and partners. | |
| 16.2 | The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families. | |
| 16.4 | Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families. | |
| 16.9 | Information and data on bed availability is collected and used for quality improvement initiatives in collaboration with organizational leaders, and with input from clients and families. | ! |
| 16.12 | Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families. | |

**Surveyor comments on the priority process(es)**

**Priority Process: Clinical Leadership**

The inpatient unit provides care for both surgical and medical patients and does not include care for the paediatric population. There are 22 acute medical/surgical beds which include two ward rooms and two private rooms, with one being equipped for negative pressure, acute medical/surgical beds on the unit with a multidisciplinary team providing care. They have a high occupancy rate and like many organizations have challenges placing ALC (alternate level of care) patients. Recent opening of additional community facilities in the area has eased some of the backlog of patients waiting for placement but the team recognizes this is only a short-term reprieve as these beds are filling up quickly. Another strategy was creating restorative care beds in Almonte to facilitate readiness for discharge home. ALC rates average 20 percent of their total bed spaces but can go above 50 percent at times. MRHA is encouraged to build relationships and strategies to address this.

The team solicits feedback from patients and families using a discharge survey tool completed prior to leaving either with staff or on their own. The questions allow an opportunity to validate patient safety initiatives currently practiced on the unit and address any concerns the patient may have had. Questions are altered according to the quality improvement projects underway on the unit. Additional open-ended questions allow for feedback to identify opportunities for improvement.

There is not a forum to receive input from patients and families. Leadership is encouraged to include patient and family advisors on the Patient Care Committee to be able to give input into program design, service delivery and monitoring.

**Priority Process: Competency**

There are challenges with recruitment and retention with a plan to continue efforts to ensure appropriate staffing can be achieved. The team has built relationships with local universities and colleges to provide clinical placements as a strategy to recruit new graduates. They have also created clinical extern positions to be able to hire students into these positions to facilitate future employment opportunities. The team has unfilled vacancies as well as 50 percent of their current staff with less than two years' experience creating challenges with skill mix. There is one educator that works part time for the organization and team leads that support education at the elbow. MRHA is encouraged to review the roles of team leads and educators to ensure that they have adequate time for teaching, coaching and mentoring novice staff as a retention strategy for new staff.

The interdisciplinary team works collaboratively to provide care working closely with clients and families. There are interdisciplinary rounds weekly and family meetings as needed to help coordinate care. Consideration could be given to understanding if a daily bullet round at a set time would benefit the team. The physicians are often on the unit first thing in the morning to ready patients for discharge so, by creating a bullet round time, others could be present to aide in removing barriers and delays to discharge. Presenting data regularly on Length of Stay and Conservable Bed Days may be a step in identifying issues and looking for opportunities to improve. The team would then be able to assess if changes in practice make a difference in these important indicators of patient care.

The team uses hourly rounding to improve delivery of safe patient care. They have attempted to initiate bedside shift reports but have not been successful. The team is encouraged to look to their partners in Almonte to understand opportunities to move this initiative forward. White boards in patient rooms were noted to be filled out with all relevant information and consistently used as a communication tool. The team has adopted the use of an SBAR (situation, background, assessment, recommendation) tool for transferring patients from ED to inpatient to ensure that all relevant information is communicated to the receiving unit.

**Priority Process: Episode of Care**

The team uses the Morse Fall Scale scoring which provides an indication of the likelihood that a patient will fall. Universal fall precautions are then implemented where appropriate to ensure a safe environment that prevents falls and reduces the risk of injuries from falling. Information and education are given to the patient as to how they can help prevent a fall. If a fall occurs the incident is recorded in the safety management system allowing the team to review processes to make improvements when needed. The unit leader reviews the fall with the team caring for the patient however, there was no information posted that would allow staff to understand how many falls are occurring and any improvements underway.

Consider posting the number of falls and falls with injuries to engage staff in problem solving.

Upon admission a Best Possible Medication History (BPMH) is generated and documented by a member of the team using and indicating at least two, whenever possible, other sources and involving the patient/family in the process. The admitting physician reviews each medication and orders the appropriate therapy for the patient by circling C (continue) DC (discontinue) or see new order. The BPMH in the medication reconciliation report for admission is then reviewed within 24 hours by the physician and appropriate changes are made to the patient's medication treatment. The team has been working with pharmacy towards improving the accuracy and quality of the BPMH on admission through auditing and education.

The Braden scale for predicting pressure sore risk is completed upon admission and every week. Documented protocols and procedures based on best practice guidelines are then implemented to prevent the development of pressure ulcers. This is another quality metric that could be regularly shared with staff to assess the effectiveness of the interventions in place and look for opportunities.

VTE prophylaxis is included in admission order sets, and patient information is included in the Patient Care Handbooks that each patient receives on admission. There is a VTE policy in place to guide practice and pharmacy plays an important role in ensuring patients are on the appropriate thromboprophylaxis.

The team uses an SBAR transfer tool to ensure that information shared at care transitions between units is defined and standardized. At shift change the team is encouraged to implement a bedside shift report into the practice on the unit making the patient a part of the process in the delivery of their care. This important initiative allows the nurse to visualize and assess the patient and environment, as well as communicate with and involve the patient in the plan of care.

In addition to a bedside shift report the team uses hourly rounding to proactively address a patient’s needs. Some of the benefits of hourly rounding include increased patient satisfaction and decreased call bells for assistance. Consider tracking and sharing these metrics to understand the impact hourly rounding is having.

**Priority Process: Decision Support**

The team has hybrid documentation using both paper and electronic tools to complete documentation. Use of a hybrid documentation system can be inefficient and lead to miscommunication among caregivers. The electronic platform is Meditech which is not standardized across the MRHA which presents additional challenges for care delivery. To maintain an accurate, up-to-date, and complete record for each patient, standardizing within MRHA or with regional partners will enhance communication and coordination of care.

The organization has policies and procedures for securely storing, retaining, and destroying client records that are in accordance with legislation.

**Priority Process: Impact on Outcomes**

There is no patient representation on the Patient Care Committee. The purpose of this committee is to improve quality and safety of patient care and services through the effective use of clinical and operational information, supported by available scientific evidence and best practice information. By including patients on this committee, the voice of the patient could be imbedded in the program more effectively.

The team collects quality indicators but does not share openly with staff and patients. There are opportunities to expand unit specific indicators to reflect the quality improvement initiatives that are undertaken. Linking data to show the improvement made or the need to improve would help staff understand the magnitude of the problem and further engage frontline staff in problem solving. Initiatives underway such as falls prevention has data collected but not shared with frontline staff in a meaningful way. Consider implementation of a unit quality board with huddles to help staff understand current quality improvement initiatives and how they link to the overall strategic goals and objectives of the organization.

## Standards Set: Medication Management (For Surveys in 2021) - Direct Service Provision

| Unmet Criteria | | High Priority Criteria |
|---|---|---|
| **Priority Process: Medication Management** | | |
| 13.2 | Medication storage areas are clean and organized. | ! |
| 13.11 | Medication storage areas are regularly inspected, and improvements are made if needed. | |
| 15.10 | Medication orders are accurately transcribed into clinical documents such as medication administration records. | ! |
| **Surveyor comments on the priority process(es)** | | |
| **Priority Process: Medication Management** | | |

At CPDMH the pharmacy has membership on the Patient Care Committee to co-ordinate medication practice and policy. There is a need to have a presence on the Medical Advisory Committee at this site as well. All patient safety incidents and near misses for medication management are reported, reviewed and analyzed to look for opportunities to prevent the same or similar incidents or near misses from recurring. The team is using a paper-based reporting system and there is an opportunity to complete reporting electronically to provide easier access for staff, ensure all the information is captured and allow additional tracking and trending to look for improvement opportunities. Through incident reporting the team has identified a need to improve transcription practices to reduce errors.

The pharmacy team provides support within MRHA working collaboratively to provide expertise to the frontline to ensure the safe delivery of medication. They participate in patient care rounds with an interdisciplinary team to review and advise on medication for patient care. Pharmacists are available to provide resources for physicians and staff on call after-hours using internal and an external resource. Pharmacy technicians work collaboratively with nursing to complete the best possible medication history (BPMH) for admitted patients.

There is an antimicrobial stewardship program to optimize and monitor the use of antimicrobials. The program includes interventions such as auditing and feedback, a formulary of targeted antimicrobials and approved indications, education, antimicrobial guidelines and clinical pathways for antimicrobial utilization. The team has a good relationship with the physician group and finds that they are used as a valuable resource in guiding practice.

There is a need to move forward with closed loop medication administration through integration and upgrading of the current health information system (HIS). The use of technology through automated dispensing units and barcoding of medications is a step towards closed loop medication administration

but is not consistently set up across the units. With the implementation of a new health information system (HIS), the whole medication cycle (prescribing, processing, dispensing and administration) will ensure correct medication serving, reducing risks of medication errors and adverse drug events. Computerized physician order entry will also be part of the upgrade to the new IHS. The team is encouraged to engage all stakeholders to ensure a successful implementation.

Work has been completed on issues noted during the last survey with unit dose packaging, up dated policies, and the storage and handling of look-alike, sound-alike medications and high alert medications. Additionally, the team has been involved in the roll out of a new fleet of smart infusion pumps across MRHA helping to improve patient safety through automation.

The teams would benefit from regular audits of medication rooms/areas and carts to provide better standardization, organization of areas, and compliance with best practice. The space limitations in the current ED are recognized. MRHA is encouraged to ensure that pharmacy has a voice in the design of the new build to ensure appropriate space is available to support safe medication practices.

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

| Unmet Criteria | | High Priority Criteria |
|---|---|---|
| **Priority Process: Clinical Leadership** | | |
| 1.3 | Service-specific goals and objectives are developed, with input from clients and families. | |
| **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** | | |
| 23.2 | The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners. | |
| 23.3 | There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines. | ! |
| 23.4 | Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families. | ! |
| 23.5 | Guidelines and protocols are regularly reviewed, with input from clients and families. | ! |
| 24.1 | A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families. | ! |
| 24.3 | Verification processes are used to mitigate high-risk activities, with input from clients and families. | ! |
| **Priority Process: Medication Management** | | |
| The organization has met all criteria for this priority process. | | |

## Surveyor comments on the priority process(es)

### Priority Process: Clinical Leadership

The team completes approximately 1274 procedures each year. Services provided are for minor general surgery (hernia, cholecystectomy), orthopaedics (knee arthroscopies), ENT (tonsils), ophthalmology (strabismus) and plastic surgery, both OHIP and self-pay cases. The team has partnered with CHEO and The Ottawa Hospital to coordinate care for patients closer to home. Surgeons operate at Carleton Place and District Memorial Hospital (CPDMH) from area hospitals to decrease wait times and provide easier access for patients. Both surgeons and patients report a high satisfaction with this new arrangement.

The operating room and recovery room is located behind the ED. It is clearly marked as a restricted area but does not have a controlled access. The team has all the necessary equipment to be able to deliver safe high-quality care.

### Priority Process: Competency

The team receives the appropriate education to be able to deliver consistent, evidence-based care using ORNAC (Operating Room Nurses Association of Canada) standards. There is a documented and coordinated approach for infusion pump safety that includes training, evaluation of competence and a process to report problems with infusion pump use, which is implemented. The organization recently purchased the Plum 360 smart infusion pump to help reduce the risk of medication errors and ease of set up.

Prior to COVID-19 patients came into the organization for a preoperative visit but to meet requirements during COVID-19 the team developed a new process to prepare patients for their upcoming procedures. The team considers Choosing Wisely Canada Guidelines Drop the Pre-Op to reduce unnecessary visits and investigations in pre-operative clinics. Preoperatively, patients are optimized for surgery by their surgeons and through preoperative assessment phone calls with referral for an anaesthesia consult as required. Patients are transferred to the recovery area by the surgical team where a full report is verbally given.

### Priority Process: Episode of Care

The perioperative services team works collaboratively to provide seamless care for the patients coming for their procedure. Many of the team members can work across the program from the preoperative clinic to the post anaesthetic care unit which provides continuity of care to enhance safety. The team follows the Operating Room Nurses Association of Canada (ORNAC) standards, guidelines and position statements. These standards serve as a guide and reference for perioperative nurses and health care facilities providing care to surgical patients and reflect current best practice. Mandatory education including ACLS, PALS, and a recognized perioperative course, are required by staff working in the operating room.

The team demonstrated the surgical safety checklist (SSC) during surgical procedures observed using a standard three phase approach. The entire team went to the bedside for the first phase of the SSC enabling the participation of the family in the first phase. A policy can be found on the common drive to

standardize this process and the team audits the compliance. Compliance slipped with documentation of the SSC but during a review it was evident that the SSC had been completed, just not appropriately signed off. Education was delivered to correct the problem to ensure that this process is completed for every case.

Patient families interviewed and followed through the OR were very satisfied with their care throughout their surgical journey. They felt staff were extremely knowledgeable, caring and attentive to their individual needs. Surgeons and anaesthesia expressed high satisfaction with team dynamics and the fact that they had the instruments and resources to deliver safe care to their patients. Family physicians trained in anaesthesiology provide all delivery of anaesthetic in the operating room. They have very collegial relationships with ED physicians and regional care providers to provide and receive support as needed.

**Priority Process: Decision Support**

The documentation remains paper based which poses a risk to the organization as there remains a hybrid of paper and electronic documentation. An electronic Health Information System (HIS) makes charting easy by making information easily accessible to nurses to help return their time to focus more on care delivery. It also encourages increased standardization of information collected for completeness of data. Ideally a standardized HIS across MRHA would support flow of patient care information to inform patient care decisions.

**Priority Process: Impact on Outcomes**

The team has limited involvement with research activities however there is a process for approval of all research through the Ethics Committee. The team has been tracking OR utilization as a quality indicator to ensure that they are meeting the provincial target. There are several other quality indicators with provincial targets and benchmarking that could be used to drive continuous quality improvement within the department. The team is encouraged to review reportable indicators to look for the relevance to their department to initiate quality improvement projects.

Incident reporting is currently paper based and then uploaded into the incident management system used within MRHA. It is recommended to review this process to improve incident reporting. Incidents are reviewed with the Patient Care Committee to look for trends and opportunities for improvement. It is important to provide feedback to staff to close the loop after a report has been submitted.

**Priority Process: Medication Management**

The team follows the ORNAC standards for the safe delivery and handling of medications used within the operating room. Medications on the sterile field were observed to be appropriately labelled and documented according to policy.

Emergency equipment and life support systems are available for the team. There is a Code Blue cart, Code Pink cart and a Broselow paediatric cart available to support delivery of emergency care.

# 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.

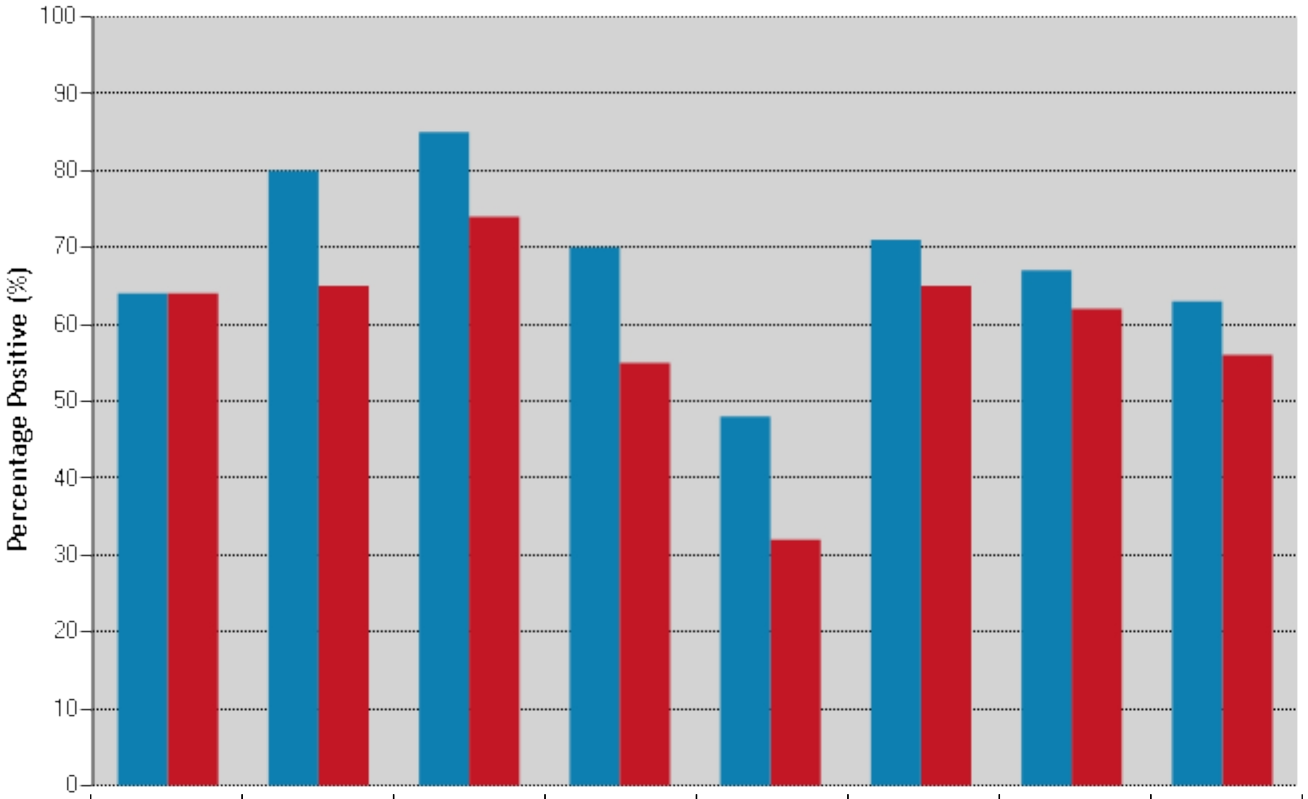
## Canadian Patient Safety Culture Survey Tool

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: November 23, 2022 to December 14, 2022**
- **Minimum responses rate (based on the number of eligible employees): 64**
- **Number of responses: 79**

**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 |
|---|---|---|---|---|---|---|---|---|
| | 64% | 80% | 85% | 70% | 48% | 71% | 67% | 63% |
| | 64% | 65% | 74% | 55% | 32% | 65% | 62% | 56% |

**Legend**

Carleton Place & District Memorial Hospital

* Canadian Average

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

## Worklife Pulse

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

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

The organization used an approved substitute tool for measuring the quality of worklife.

# 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.**

Physical Environment Correction: There is one entrance into the hospital, which is used for emergency patients (other than those arriving by ambulance) ambulatory care patients, and visitors (staff do not use this door they have a staff entrance that they use that takes them almost immediately to change room). Sprinkler system is in patient care areas was completed in April 2023.

People Centred Care: PFAC, Community Members, Community Partners: In May 2021 our MRHA Integrated Clinical Service Plan was released. Input was obtained from the community via open community forums. The advisory panel membership included PFAC members, board members, MD's, community partners (Home and Community care, Ottawa Valley Midwives, CMNRP, Lanark County Mental health and sexual assault services, staff, and managers. This plan involves Inpatient care (Acute, CCC and LTC), Outpatient services, Surgical Services, OBS, ER and clinical support services. Together the Advisory Panel membership reviewed future planning, future programming, future role and service profiles. PFAC also had the opportunity to review and provide feedback about the Staff Satisfaction Survey and Patient Safety Survey.

Client/Family Feedback: Are engaged and provide feedback through various venues such as:

- Post discharge phone calls (RR)
- Post discharge from (in pt unit)
- Patient DI Survey
- MD DI Survey
- Complements,concerns,complaint process
- Patient Rounding (ER,Inpt unit)
- Leaders sitting on various local and regional committees

Orientation:All employees of CPDMH receive a very comprehensive orientation both corporately and department specific. The orientation process/checklist are modified following input from patients/health care partners such as MD, other facilities.  Input can be received via surveys (NRC Picker), discharge follow up, patient rounding, trends in the patient incidents, feedback around complaints and concerns.
Newly hired staff have a 90 day standardized check in with their Manager. Access to a full-time educator coordinator who flexes their time between AGH/FVM and CPDMH. On hire all staff are consistently assigned certain learning modules in:

- Surge Learning WHMIS
- IPAC Core Competencies
- AODA
- Workplace Violence and Harassment
- Public Health Just Clean your hands
- MOL Worker Health and Safety Awareness
- Emergency Codes
- AIDET
- Cyber Security
- General Lifting,IV Pump Training, Pharmacy ADU Training, Kangaroo, CADD, Accu Check, Blood Easy.

There are also yearly recertification/education that is assigned to all staff with a set completion date. If at anytime staff or their manager feel that there is a need for additional education there are numerous learning modules that can be assigned to staff, or they themselves have the opportunity to assign themselves courses.

Patient Safety Incident/Concerns: Are analyzed and improvements are implemented. They are reviewed at Patient Care then MAC and then Board Quality. If necessary, a critical incident review is completed and/or a unit/facility debrief is conducted with all members involved.

Quality Improvement Initiatives: All leaders have Quality Improvement Initiatives that are built into their yearly departmental goals. These are developed by looking at the Integrated Clinical Service plan that had involved of PFAC, community, and health care partners, QIP, Trends in complaints/concerns. A lot of time they also relate to the Corporate Goals for the facility. These QA/goals are recorded on the leaders individual LEM, involve time specific targets, outcomes, steps to be taken. They are based on a quarterly workplan. Individual department (QA initiatives/goals) are reviewed with staff when developing new processes (such as starting Bedside Shift report where staff not only received education about what it was but the reasons why it needed to happen), location of outpatient blood transfusion etc) memos to staff, rounding with staff.

Barriers in health care: Besides being looked at with our Mississippi River Healthcare Alliance Integrated Clinical Service Plan to identify what the barriers our community was having accessing certain services. All patients/staff have access to contracted Translation service. All staff are assigned mandatory AODA education. Medical Devices and Equipment - clear signage on all doors leading into the area.

Diagnostic Services: Imaging Screening of client occurs in individual examination rooms. There is booking requirements on reqs that the MD complete. Routine results are reported with 24 to 48 hours.

Stat protocol: radiologist is notified of stat exam by phone call, results done within 4 hours. Audit has showed that the results are typically reported within 1 hour. Exams (x-ray/ultrasound that are ordered for ER patient, once complete they return to unit for the ER MD to do a preliminary review of test. Patient Safety Incident/ Concerns Are analyzed and improvements are implemented. They are reviewed at Patient Care then MAC and then Board Quality. If necessary, a critical incident review is completed and/or a unit/facility debrief is conducted with all members involved. Quality Improvement Initiatives: All leaders have Quality Improvement Initiatives that are built into their yearly goals. These are developed by looking at the Integrated Clinical Service plan that had involved of PFAC, community, and health care partners, QIP, Trends in complaints/ concerns. They also involved the Corporate Goals for the facility. These QA/goals are recorded on the leaders individual LEM, involve time specific targets, outcomes, steps to be taken. They are based on a quarterly workplan. QA initiatives/goals are reviewed with staff when developing new processes (ie Bedside Shift report), location of outpatient blood transfusion etc) memos to staff, rounding with staff. Quality Improvement a reporting calendar, Staff meetings, Wait time monitored weekly,Report time monitored daily, Rounding with staff/huddles.

Emergency Department: Was part of the Integrated Clinical Service Plan as outlined above. 2.6 In the ER department room 104 has been set up as a “safe” room. This room allows visualization from various areas around the unit, the cabinet doors can be locked, items on the walls can easily be removed, Standardized process to investigate and respond to concerns is in effect. The PFAC group had input into the turn around time and avenues in which the facility should respond. As well as the wording on the website.

Documentation/Communication/Technologies: Process in place to run reports in Meditech to audit certain types of documentation. Polices on electronic communication/technologies developed in partnership with Meditech partners and PIDAC

Narrative note: PALS: Is a requirement in the ER department, if staff do not have it at start date they have 6 months to obtain it.

Correction in note: The Educator works as a full time integrated educator

Inpatient Services:
- Part of the Integrated Clinical Service Plan as outlined above. 11.2 Should be not applicable as we do not admit children or youth to our facility.
- Process in place to run reports in Meditech to audit. Corporate policies in place around electronic communication. Policies around technologies were developed in partnership with Meditech partners and PIDAC
- Client and family feedback is through various venues such as past discharge form, patient rounding, compliments, concerns and complaint process, leaders sitting on various local and regional committees.When a policy/process or procedure is being reviewed or it has been identified that process needs to be reviewed following input from a patient/family.

Medication Management: The manager of pharmacy does a audit every 6 months for all units in the hospital Policy on Medication Storage, disposal, dispensing clearly states that medication entered onto a MAR Periop Procedures at CPDMH follow input from our health care partners. Peri op identifies risk and safety measure put in place

# Appendix A - Qmentum

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

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

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

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

## Action Planning

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

# Appendix B - Priority Processes

## Priority processes associated with system-wide standards

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

## Priority processes associated with population-specific standards

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

## Priority processes associated with service excellence standards

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

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