Accreditation Report

Georgian Bay General Hospital

Midland, ON

On-site survey dates: November 19, 2023 - November 23, 2023

Report issued: December 18, 2023

About the Accreditation Report

Georgian Bay General 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 November 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.

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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

Georgian Bay General 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

Georgian Bay General Hospital's accreditation decision is:

Accredited with Exemplary Standing

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

About the On-site Survey

- **On-site survey dates: November 19, 2023 to November 23, 2023**

- **Location**

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

  1. Georgian Bay General Hospital

- **Standards**

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

  System-Wide Standards

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

  Service Excellence Standards

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

- **Instruments**

The organization administered:

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

Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
Population Focus (Work with my community to anticipate and meet our needs)	43	0	0	43
Accessibility (Give me timely and equitable services)	76	1	0	77
Safety (Keep me safe)	579	0	18	597
Worklife (Take care of those who take care of me)	123	0	1	124
Client-centred Services (Partner with me and my family in our care)	320	2	0	322
Continuity (Coordinate my care across the continuum)	61	0	2	63
Appropriateness (Do the right thing to achieve the best results)	841	3	12	856
Efficiency (Make the best use of resources)	56	0	0	56
Total	**2099**	**6**	**33**	**2138**

Overview by Standards

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

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

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

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

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	50 (100.0%)	0 (0.0%)	0	35 (97.2%)	1 (2.8%)	0	85 (98.8%)	1 (1.2%)	0
Leadership	50 (100.0%)	0 (0.0%)	0	95 (99.0%)	1 (1.0%)	0	145 (99.3%)	1 (0.7%)	0
Infection Prevention and Control Standards	40 (100.0%)	0 (0.0%)	0	31 (100.0%)	0 (0.0%)	0	71 (100.0%)	0 (0.0%)	0
Medication Management (For Surveys in 2021)	95 (100.0%)	0 (0.0%)	5	49 (100.0%)	0 (0.0%)	1	144 (100.0%)	0 (0.0%)	6
Ambulatory Care Services	45 (100.0%)	0 (0.0%)	2	78 (100.0%)	0 (0.0%)	0	123 (100.0%)	0 (0.0%)	2
Critical Care Services	60 (100.0%)	0 (0.0%)	0	102 (98.1%)	2 (1.9%)	1	162 (98.8%)	2 (1.2%)	1
Diagnostic Imaging Services	61 (96.8%)	2 (3.2%)	5	68 (100.0%)	0 (0.0%)	1	129 (98.5%)	2 (1.5%)	6
Emergency Department	72 (100.0%)	0 (0.0%)	0	106 (100.0%)	0 (0.0%)	1	178 (100.0%)	0 (0.0%)	1

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Inpatient Services	60 (100.0%)	0 (0.0%)	0	84 (100.0%)	0 (0.0%)	1	144 (100.0%)	0 (0.0%)	1
Obstetrics Services	71 (100.0%)	0 (0.0%)	2	88 (100.0%)	0 (0.0%)	0	159 (100.0%)	0 (0.0%)	2
Perioperative Services and Invasive Procedures	113 (100.0%)	0 (0.0%)	2	109 (100.0%)	0 (0.0%)	0	222 (100.0%)	0 (0.0%)	2
Point-of-Care Testing **	38 (100.0%)	0 (0.0%)	0	46 (100.0%)	0 (0.0%)	2	84 (100.0%)	0 (0.0%)	2
Rehabilitation Services	44 (100.0%)	0 (0.0%)	1	80 (100.0%)	0 (0.0%)	0	124 (100.0%)	0 (0.0%)	1
Reprocessing of Reusable Medical Devices	85 (100.0%)	0 (0.0%)	3	40 (100.0%)	0 (0.0%)	0	125 (100.0%)	0 (0.0%)	3
Transfusion Services **	71 (100.0%)	0 (0.0%)	5	68 (100.0%)	0 (0.0%)	1	139 (100.0%)	0 (0.0%)	6
Total	**955 (99.8%)**	2 (0.2%)	25	1079 (99.6%)	4 (0.4%)	8	2034 (99.7%)	6 (0.3%)	33

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

Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

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

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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation as a strategic priority (Leadership)	Met	3 of 3	2 of 2
Medication reconciliation at care transitions (Ambulatory Care Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Critical Care Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Emergency Department)	Met	1 of 1	0 of 0
Medication reconciliation at care transitions (Inpatient Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Rehabilitation Services)	Met	4 of 4	0 of 0
Safe Surgery Checklist (Obstetrics Services)	Met	3 of 3	2 of 2
Safe Surgery Checklist (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
The “Do Not Use” list of abbreviations (Medication Management (For Surveys in 2021))	Met	4 of 4	3 of 3
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management (For Surveys in 2021))	Met	4 of 4	1 of 1
Concentrated Electrolytes (Medication Management (For Surveys in 2021))	Met	3 of 3	0 of 0
Heparin Safety (Medication Management (For Surveys in 2021))	Met	4 of 4	0 of 0
High-Alert Medications (Medication Management (For Surveys in 2021))	Met	5 of 5	3 of 3
Infusion Pumps Training (Ambulatory Care Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Critical Care Services)	Met	4 of 4	2 of 2
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 (Obstetrics Services)	Met	4 of 4	2 of 2

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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Infection Control			
Infection Rates (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Critical Care Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Inpatient Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Obstetrics Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Perioperative Services and Invasive Procedures)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Rehabilitation Services)	Met	2 of 2	1 of 1
Pressure Ulcer Prevention (Critical Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Inpatient Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Rehabilitation Services)	Met	3 of 3	2 of 2
Suicide Prevention (Emergency Department)	Met	5 of 5	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Venous Thromboembolism Prophylaxis (Critical Care Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Inpatient Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2

Summary of Surveyor Team Observations

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

L'hôpital général de la Baie Georgienne GEORGIAN BAY GENERAL HOSPITAL (GBGH) is commended on its commitment to quality improvement and patient safety through its active participation in the accreditation program.

GBGH is a 113-bed community hospital, serving the communities of Midland, Penetanguishene, and Christian Island, as well as Tiny, Tay, Georgian Bay and Springwater Townships. The population base of this area is 55,000 and swells to more than 200,000 for six months of the year. In addition to a large seasonal population, throughout the year GBGH also serves a significant Francophone and Indigenous community, which is an important role for the organization. In 2017, GBGH received its Partial French Language Services Designation, confirming its commitment to providing designated services in French for francophone patients.

The Board of Directors (board) understands its role as a governing body and is aware that oversight for patient safety, risk management and quality improvement is a fundamental focus of governance. In 2023 the board embarked on an internal and external engagement process as the organization developed a seven year (2023-2030) strategic plan emphasizing a commitment to We Make Excellent Care Personal. The strategic plan is comprised of four key pillars that are spread throughout the organization and departmental goals are well aligned with these initiatives. Family-centered care is a noticeable thread throughout the plan.

There is tremendous dedication from the leadership team at GBGH that is highly engaged in supporting the provision of excellent care to patients and families. Teams expressed the value and importance of collaborative work and appreciate the open-door policy that allows them to bring any matter to the attention of the leadership team, always.

From a community perspective, the community partners focus group unanimously expressed having a very good relationship with GBGH. They emphasized GBGH is a valued and collaborative partner. They described communication as being open and respectful. Innovative leaders, a can-do attitude, the promotion of Indigenous cultural sensitivity with the support of a patient navigator, doors are open, a what do you need attitude, a good group of doctors, patient focussed, and exceptionally compassionate, were words that resonated during the exchange.

GBGH is commended for its overall focus on Integrated Quality Management. The quality improvement team is comprised of dedicated and committed clinicians, leaders, and physicians who are passionate about creating an environment that is safe and that follows quality and safety standards of excellence.

Quality & Patient Safety Plans are aligned with GBGH's Strategic Plan and embedded within the organisation as described in the mission statement We Make Excellent Care Personal, and a patient organization's mission, vision, and values. Quality and patient engagement are notable drivers in the organisation as described in the mission statement We Make Excellent Care Personal, and a patient representative will soon become a member of the organization's Quality and Safety Committee.

Patient and family-centered care is strongly anchored in the new 2023-2030 strategic plan and continues to grow since its creation in 2017-2018. One Patient and Family Advisor (PFA) is a member of the Quality Committee of the board, and another PFA will soon be appointed to the organization's Quality and Safety Committee. Patient advisors already sit on GBGH's Operations Committee, and their input has led to organizational enhancements such as patient room re-design, entertainment upgrades, and space reallocation. In addition, patient advisors were invited to participate in the selection of the newly appointed chief nursing officer (CNE) and their input is being increasingly sought on a variety of committees and focus groups. The organisation is encouraged to continue its journey to embed the voice of the patient at every level of care and services.

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
	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)

L'Hôpital général de la baie Georgienne GEORGIAN BAY GENERAL HOSPITAL (GBGH) is served by an engaged, talented, and dynamic Board of Directors (board) that is passionate about its role in serving the communities across the North Simcoe Muskoka region. The board is comprised of twelve elected members who participate on a variety of committees such as Audit & Resource, Governance, Quality and Executive Performance and Compensation. Committee membership is allocated based on a skills matrix and on equitable representation. The board sets the tone for the GBGH values of: Inspire Dedication, Patients First, Empower Others, Lead with Empathy, and Think Forward.

The board is commended for providing leadership and support to an organization undergoing important changes including the acquisition of a magnetic resonance imaging machine, the introduction of Meditech Expanse, GBGH's focus on expanding its surgical program, and the development of a business plan to create a mammography program.

In 2023 the board embarked on an internal and external engagement process as the organization developed a seven year (2023-2030)) strategic plan emphasizing a commitment to We Make Excellent Care Personal. The strategic plan is comprised of four key pillars that are spread throughout the organization and departmental goals are well aligned with these initiatives. Family-centered care is a noticeable thread throughout the plan.

In addition to having responsibility for GBGH's financial viability, the board is actively acquiring greater knowledge of the health sector and governance functions. Ongoing education is offered to all board members, and they periodically receive electronic invitations to attend conferences and webinars on health care issues provided by the Ontario Hospital Association (OHA).

The board indicated that they abide by GBGH's clinical ethics decision-making framework; SBAR (situation, background, assessment, recommendation) and provided an example on how SBAR guided the board in supporting a plan to acquire mammography imaging procedures for breast cancer testing and prevention.

In terms of orienting new board members, it was reported by two newly appointed representatives that an in-depth orientation to the hospital and information regarding their role and responsibilities were provided.

The board understands its role as a governing body and is aware that oversight for patient safety, risk management and quality improvement is a fundamental focus of governances. It receives regular reports on GBGH's performance, quality improvement, adverse events, compliments, and complaints, privacy breeches and on patient and family satisfaction. Trends are tracked and variances are noted and questioned. Quality is a standing agenda item and, on a quarterly basis, the patient and family experience office shares with the board patient stories. One area the board could consider moving forward with is the inclusion of a Patient Advisor as an ex officio member of the board.

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	
6.5 Formal strategies or processes are used to manage change.	

Surveyor comments on the priority process(es)

Inspire dedication, patients first, empower others, and lead with empathy reflect the practices and describe the people who work at GBGH.

GBGH has developed a seven-year strategic plan with a process that was inclusive and thorough and included consultations with staff, professional staff, leaders, volunteers, community members as well as with members from the PFAC (Patient and Family Advisory Council). The organization is successful in ensuring that the priorities within the strategic plan are embedded into the work of each department and program. Progress is carefully monitored, and regular reports are provided to the board on a quarterly basis. An annual operational plan is established with key objectives and timelines.

Since the last accreditation survey in 2019 the organization experienced many successes as well as challenges. The launch of a new strategic plan, the creation of a partnership with Indigenous Health Circle, the work involved in GBGH becoming a partially French designated organization, the implementation of Meditech Expanse, government approval for the acquisition of an MRI, GBGH's work expanding its surgical program, the efforts to enhance falls prevention, partnering with four organisations to create My Health Care allowing patients to access their charts remotely, and participation on the Ontario Health Teams. The organization is encouraged to monitor the impact of these initiatives on cost effectiveness and patient safety, quality, and satisfaction. Moving forward, the organization is anticipating growth and expansion and is having numerous discussions on the possibility of building a new state of the art facility. To successfully plan future growth and development, the organization is encouraged to use a detailed operational readiness and transition planning framework. In addition, having a common and formal process for change management is encouraged.

From a patient satisfaction perspective, the Picker patient satisfaction survey responses guided quality improvement initiatives and the organization has adopted Qualtrics for a new patient engagement survey. Information that emanated from the surveys has been helpful to better plan services, such as space re-design and ways to provide care closer to home. The organization is encouraged to continue to seek patient input in planning services and in providing feedback to patients, so they recognize the value that they bring the GBGH.

From a community perspective, the community partners focus group unanimously expressed having a very good relationship with GBGH. They emphasized GBGH as being a valued and collaborative partner. They described communication as being open and respectful. Innovative leaders, a can-do attitude, the promotion of Indigenous cultural sensitivity with the support of a patient navigator, doors are open, a what do you need attitude, a good group of doctors, patient focused, and exceptionally compassionate, were words that resonated during the exchange.

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 resource management team has put rigorous strategies in place to monitor BGBH's financial effectiveness. Managers and directors are held accountable for their budgets. Boundaries are established to help create a clear guideline regarding spending practices. Annual budget preparation begins at the unit level with the previous year's allocation as a starting point. Initial documentation is prepared by the finance department and shared with frontline managers for review and confirmation. The finance department promotes the importance of building capacity around data and puts mechanisms in place to excite teams to engage in financial conversations. There are regular meetings between the senior leaders and managers to determine cost pressures and ongoing budget monitoring. The organization practices regular benchmarking and holds discussions with peers to learn what others are doing to reduce costs. This rigorous process includes analysis of workload and utilization data and includes assessment of risk and opportunity. It is felt that managers are effectively using their financial reports to manage their portfolios. New managers are provided with an orientation to financial reports and budget preparation. Managers appreciate the constant support they receive from the finance department to better manage their budgets. The Green Team initiatives, creative human resources management, LED lighting, and the chiller replacement are examples of cost saving strategies that were highlighted.

The board is engaged in the operational budget planning process however it does not wade into operational discussions. It receives information on the financial performance of the organization as well as a comprehensive report on activity levels.

Capital budgets are built with input from the various departments. Both the operating and capital budgets are approved at the board level. GBGH demonstrates the value of community services by engaging in a multitude of shared services including My Health Care, the GBGH@Home program, crisis intervention support with Wendat Community Programs, and Trillium Gift of Life Network partnerships, to name a few. The ethical decision framework provides guidance for resources allocation prioritization and decision making.

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)

At GBGH, the department of human resources provides support to approximately 767 Staff and four bargaining units, 232 professional staff including, physicians, midwives, and dentists and 117 volunteers.

The human capital team is very cohesive and supportive to the organization. There is a strong sense of commitment to GBGH's values and to compassionate care.

The organization is constantly concerned about retaining and recruiting qualified personnel and physicians and has put in place several strategies including partnerships with colleges and offering professional development opportunities, Kudos to the Crew peer-to-peer recognition program, a massage chair, hybrid scheduling, education funds, 'in the moment' milestone awards, mentorship opportunities, a coping club, drop-in classes, flu vaccinations for families, emphasis on the development of a wellness program to foster work life balance and to ensure easy access the employment assistance program (EAP). Since EAP services are also offered to families of staff, the organization may consider changing 'EAP' to EFAP (employment and family assistance program). The organization is also concerned about staff fatigue and refers to sick time indicators to monitor fatigue and to address fatigue related issues with staff.

The work life pulse survey that was recently completed identified areas of success and areas for improvement, including better communication, a work-life balance and continued access to educational opportunities. Diversity, Equity, Inclusion and Belonging (DEIB) training is offered, and the organisation provides monthly DEIB forums. In addition, staff members have access to mandatory learning on the Surge e-learning program and education on cultural awareness and sensitivity is provided. The organization may wish to expand training opportunities to include HSO's BC standard on Cultural Safety and Humility. Workplace violence is taken very seriously, and GBGH has developed a robust policy on violence prevention.

Regarding performance conversations, the organization may wish to review the frequency of having those discussions on a quarterly basis. In addition, GBGH is encouraged to develop a formal process to regularly assess leaders' span of control that can be integrated into performance reviews for leaders.

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)

GBGH is commended for its overall focus on Integrated Quality Management. The quality improvement team is comprised of dedicated and committed clinicians, leaders, and physicians who are passionate about creating an environment that is safe and that follows quality and safety standards of excellence.

Quality and Patient Safety Plans are aligned with GBGH'S Strategic Plan and embedded within the organization's purpose statement and values. Quality and patient engagement are notable drivers in the organisation as described in the purpose statement, We Make Excellent Care Personal, and a patient representative will soon become a member of the hospital Quality and Safety Committee.

Several quality and safety initiatives have been put in place throughout the organization and are displayed on departmental quality huddle boards. The boards serve as an opportunity for staff and leaders to huddle' twice a week and to review issues related to quality and safety. Discussions on falls with harm, Falls Friday, the QUEST, medication reconciliation, patient flow, surgical safety checklist, wait times, pressure sore prevention, length of stay, patient satisfaction and patient complaints, are a few examples of topics discussed. Since the quality huddle board is a new GBGH initiative the organization may wish to assess its structure and value especially with respect to building staff capacity around quality and safety. In addition, the organization is encouraged to create a repository that collects quality huddle board data that is up to date and easily accessible.

One area that was highlighted as a success was in relation to the good-catch approach to safety as well as the process for disclosing incidents and accidents. Trends are monitored and reported and opportunities for improvement are developed. For example, a robust hospital wide falls with harm prevention program was developed following a high incident of patients falls with harm. Teamwork and consistent efforts to put in place an action plan to reduced falls resulted in a drop in falls from 4.99 to 0.99 per cent. The organisation may wish to consider submitting to Accreditation Canada their Falls with Harm Initiative as a Leading Practice.

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 organization has a well-established Ethics Committee, with access to an ethicist and with representative membership including a Patient and Family Advisory Council member, the chief of staff, the physician quality lead, and the Indigenous patient navigator. The committee recently went through a refresh to ensure alignment of the ethics framework, committee membership, and focus on the organization's mission, vision and values.

The Ethics Committee is guided by a robust policy and the SBAR framework which meets ethical legal requirements. The SBAR framework/process is used as a decision-making tool and standardized approach to uncover and work through ethical issues or dilemmas. The committee is to be commended for adopting an action-oriented approach to ensuring ethics capacity building across the organization through access to ethics resources, tools, and education, all of which are accessible to staff, leaders, patients and families. In-person and online lunch and learns are well attended. The committee was recently introduced to ChELO, a checklist for meeting ethical and legal obligations, as an approach to support staff and leaders in patient-centred decision making for patients at end of life.

The ethics team strives to get below the surface to prompt key questions related to the complex issues that reflect the current clinical and non-clinical environment. Examples of the SBAR framework in action include engaging front line staff in working through the framework during rounds and huddles, navigating complex patient care issues, navigating health human resource challenges, guiding quality of care reviews and debriefs, patient capacity and SDM determination, and facilitating end of life and MAiD discussions. Patients and families are actively engaged in the process as relevant to the issue or case. The team describes current ethical challenges as health human resource challenges, complex patient discharges, end of life discussions and increased workplace violence incidents.

The organization recently finalized a research partnership with Royal Victoria Regional Health Centre (RVH) to participate in and expand research activities focused on improving patient care, care outcomes, and enhanced access to resources for team members. GBGH will be able to leverage existing resources provided by the RVH Research Institute to streamline procedures, training and ideas. The RVH director of research is engaged with the ethics committee, to ensure ethical research practices are followed.

The ethics team are commended for embedding debriefing as a team/committee function, related to the lived experience and social-emotional and moral impact of navigating complex ethical dilemmas and supporting difficult human and system decisions.

Priority Process: Communication

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Communication is a key organizational priority, with a strong aim to create and deliver timely, consistent and transparent communications to internal and external stakeholders, including the Foundation, schools, regional hospital partners and community health partners, including Indigenous partners. There is a comprehensive communications plan and calendar, with tactics and products intentionally aligned to the organization's strategic plan 2023-2030.

The team is proud of their ability to be action oriented and well positioned to deliver nimble, real-time communications, with an intent on sharing good news, current challenges, and future opportunities shaped by internal, regional and provincial priorities. Communication themes focus on delivering and expanding on care close to home, with key messaging guided by a narrative of excellence, growth and community-mindedness.

Multiple modes of communication are used to good effect as per staff, team, and stakeholder feedback, anchored by responsible use of social media and partnerships with local media and journalists. External and patient-facing written communication is delivered in both English and French and language translation services are accessible over –the phone 24/7 to patients and families. A local French language radio station has been positively received by the community.

Communication approaches are evaluated, and strategies are monitored with results used to enhance communication strategies. An emphasis on staff and team recognition is to be commended, including the Kudos to the Crew peer-to-peer recognition initiative. Patient and family advisers are engaged with the team and the organization's strategic plan was developed with their input.

Data and information management systems meet the needs of the organization and are assessed for effectiveness and improvement. There are up-to-date policies and procedures in place, with seven regional policies that ensure safe access and include robust physical and technical safeguards for EMR (electronic medical record) safety. One highlight is the auditing tool within EMR (Haystack) which monitors EMR access breaches daily. Requests for access to information are monitored by Privacy and adhere to privacy policies and legislation. The 'my health care' patient portal is active with over 30,000 patient subscribers and enables timely access to medical records for patients. Teams are provided with timely access to evidence-based tools (UpToDate), research-based evidence and leading best practice information.

Decision support provides integral support to the communication team by providing statistics and data to guide clinical and non-clinical decision making. In the team's words, decision support helps to tell the story. The decision support team is committed to data quality and validity across CARE4 hospitals and to meet external reporting requirements.

The team is encouraged to continue to prompt and share stories and narratives from patients, families and staff that tell the good news stories, and celebrate and surface excellence in care delivery and the value of the people at GBGH.

Priority Process: Physical Environment

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

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

During this survey there was an opportunity for the surveyor to meet with the leadership team responsible for the physical environment, tour areas within the site and talk to staff. There is a knowledgeable and engaged leadership that spoke highly of their dedicated team.

The leadership team reviewed how policies and protocols related to standards for physical environments are being implemented. While Georgian Bay General Hospital (GBGH) built in the 1970s is an aging building overall the physical environment is well maintained. The leadership attributes this to their 100 per cent compliance with preventative management.

There continues to be a challenge with space, in the emergency department a nutritional space has been converted into a nursing touchdown space, for an optimal work environment or to confidentiality. Capital funding has been requested to expand into an adjacent area to enlarge this space.

The team is proud of the initiatives undertaken to minimize the impact of GBGH's operations on the environment. The Green Team Committee which has representatives from many aspects of the organization are to be recognized for their work. Some of the highlights of this work are the implementation of six EV charging stations, multi-stream bins available throughout the organization for recycling of waste and organic material, the conversion of D-cell batteries within hand sanitizers to a smaller battery to reduce the impact of the larger battery waste on the environment along with other initiatives.

Much of the monitoring of heating, ventilation, temperature, and humidity is being done by an outside contractor, Honeywell. Policies and procedures are in place to address and mitigate risks associated with any deviation from applicable standards, legislation, and regulations.

There are several projects ongoing and more to commence soon throughout the organization. Since the last survey there has been an upgrade to the medical reprocessing department. Currently a refit of the sprinkler system to meet the provincial standards is ongoing. There are plans to commence the construction of a building to house the new MRI and a new approach to wayfinding is expected to be implemented in the next few months.

The environmental services supervisor sits in on bed huddles and is involved in patient flow quality improvements. The surveyor had an opportunity to speak with EVS staff who explained the process of notification when a patient is discharged, and the bed needs to be cleaned. The ownership and pride they take in being part of the team was evident, and they understood how overcapacity can affect patient and staff safety.

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)

GBGH has an Emergency Preparedness Plan and Business Continuity Plan in place. The Emergency Preparedness Committee provides oversight for all emergency planning. The committee is encouraged to include PFAC in their membership. The Business Continuity Plan, approved in November 2023, is new since the last Accreditation survey. The Emergency Preparedness Committee is encouraged to continue ongoing evaluation of the plan during its implementation stage.

The strong preventive management program can be attributed to prevention of system failures and unplanned outages within GBGH.

GBGH has a mock code schedule and tracks numbers in attendance. Mock codes are followed by debriefs for lessons learned. The team spoke of the advantage of the debrief form, which can be found in Meditech, for keeping track of action plans for quality improvements.

Debriefing occurs for staff following critical events. Because outside resources are used to facilitate these debriefs, occasionally delays occur. There is an opportunity for GBGH to complete in-house training of staff with the tools for debrief facilitation so incident debriefing occurs within the first 24 to 72 hours to provide the most effective support to staff.

IPAC is involved as a clinical resource in pandemic planning. During the recent COVID-19 pandemic the infection control specialist was invited to sit on the Emergency Operations Committee (EOC).

Priority Process: People-Centred Care

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

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

Surveyor comments on the priority process(es)

Patient and family-centered care is strongly anchored in the new 2023-2030 strategic plan We Make Excellent Care Personal and continues to grow from the previous strategic plan from 2018-2023. One Patient and Family Advisor (PFA) is a member of the Quality Committee of the board, and another PFA will soon be appointed to the organization’s Quality and Safety Committee. Patient advisors already sit on the GBGH’s Operations Committee, and their input has led to organizational enhancements such as patient room re-design, entertainment upgrades, and space reallocation. In addition, patient advisors were invited to participate in the selection of the newly appointed chief nursing officer (CNE) and their input is being increasingly sought on a variety of committees and focus groups.

The Patient and Family Advisory Council (PFAC) is an energetic group comprised of fourteen members who are highly engaged and passionate about patient centered care. Each member takes great pride in being a PFAC representative and in being involved in a variety of hospital related affairs. The committee members meet monthly, twelve months a year. They participated in the creation of the PFAC terms of reference and put together a 2023-2024 PFAC work plan comprised of objectives, goals, timelines, target completion dates, accountabilities, and status updates.

During the accreditation survey exchange, PFAC members expressed their appreciation towards sound communication from the GBGH leaders and being kept well informed. Some members enjoyed educational opportunities that are offered, and solid collaboration with GBGH staff, physicians, and leaders. When they were asked about ways the organization could improve, comments about having an onsite walk-in clinic and better access to care for mental health patients were expressed. Members stated enjoying completing the patient satisfaction survey that was emailed to them. On that note, it will be important for GBGH to use outcome and patient experience data to improve processes, garner efficiencies and improve care.

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)

Overcapacity is an ongoing issue with patient admissions waiting almost daily in the emergency department (ED). Actions have been taken to manage the overcrowding by opening six surge beds adjacent to ED and four surge beds in ambulatory care. While this is not ideal it has resulted in an improvement in patient flow and wait times within the ED.

The organization has strategies, processes, and protocols in place to address overcapacity. The surveyor was able to observe evidence of the overcapacity protocol with overhead pages of alert levels each day.

There is a strong and passionate team leading patient flow including a patient flow coordinator along with three patient flow navigators that work with several other partners and staff to advance patient flow.

Bed meetings are held twice a day to discuss bed capacity, availability, and demand, along with human resource needs. All departments are represented at these bed huddles. There is a visual display board available. With the implementation of Meditech the organization should investigate the possibility of implementing an electronic version of this bed board that can be updated in real time.

The GBGH@Home program offers 16 weeks of care in the community to patients that qualify under this program. The organization is encouraged to embed the program into the ED to prevent unnecessary admissions.

Most patients are admitted under a hospitalist model. Recently there has been an additional nurse practitioner hired to work with the hospitalist to assist with workload. The hospitalist handover of patients occurs Fridays each week, at times this becomes a barrier to discharge planning. Handover earlier in the week when more clinical resources are available would be ideal and GBGH is encouraged to consider this.

There is an obvious lens on patient flow within the organization with the anticipated roll out of the corporate flow project in December. This is a program managed initiative with buy in from physician groups. The organization is encouraged to ensure the PFAC lens is added to the membership of this committee.

Priority Process: Medical Devices and Equipment

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Since the last survey the organization has undergone a significant redevelopment of the Medical Device Reprocessing (MDR) Department. The surveyor had the opportunity to visit and speak with the engaged, compassionate staff and leadership of this department.

There is no longer reprocessing occurring outside of the MDR Department. All scopes and probes are transferred from the areas of use to MDR. The leadership team ensures that all staff involved in cleaning and reprocessing of devices and equipment are qualified and competent.

Preventive maintenance programs for all medical devices, medical equipment and technology are implemented through service agreements with vendors for newer equipment and through the preventative management program within the organization for all other equipment.

The surveyor had an opportunity to speak with the frontline staff of the MDR. They are passionate and knowledgeable about their work. They spoke about the accessibility of the leadership team daily and more formally through huddles held twice weekly, where any concerns can be brought forward.

Currently there is a tracking system in place for scopes and probes through an electronic barcoding system. There is an opportunity for improvement with the addition of an electronic instrument tracking system, for which a capital equipment request has been made. The tracking of instruments is currently done manually and is time consuming and may result in delays to patient care.

Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Point-of-care Testing Services

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

Clinical Leadership

- Providing leadership and direction to teams providing services.

Competency

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

Episode of Care

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

Decision Support

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

Impact on Outcomes

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

Medication Management

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

Organ and Tissue Donation

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

Infection Prevention and Control

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

Diagnostic Services: Imaging

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

Transfusion Services

- Transfusion Services

Standards Set: Ambulatory Care Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Ambulatory Care is a robust program serving patients across multiple services. The program is responsible for providing primary and secondary healthcare to the North Simcoe community, both outpatients and inpatients. The program is anchored by an Ambulatory Care operations committee, with an engaged chief of department and representative leadership team. Care is provided by an integrated and engaged healthcare team. A centralized booking and admission system in Meditech Expanse enables timely and safe patient access to ambulatory services and supports patient and family awareness of appointment times, necessary preparation and access to the my health care patient portal.

Program leaders and teams engage in developing goals and objectives that link with the organization's strategic plan and foster engagement and a safety culture. The program patient and family adviser sits at the Ambulatory Operations Committee and engages in goal setting with the program team. The adviser is engaged in reviewing patient education material, service design, and program and process improvement.

The program has improved processes, resources and infrastructure to ensure cleaning and reprocessing of reusable devices occurs in MDRD. Provision of patient care in the ambulatory area occurs across multiple modalities and providers. The team works hard to optimize scheduling of patients and care delivery by multiple providers in the ambulatory space. GIMRAC (general internal medicine rapid assessment clinic) bookings have been optimized and streamlined, where post-ED patients receive rapid access to out-of-hospital care and timely follow up appointments.

Priority Process: Competency

The ambulatory program provides a comprehensive orientation for nursing staff that is linked to mentorship and coaching support by a peer nurse. Orientation aligns to the care delivery model in the area and includes endoscopy and peri anesthesia. New and existing nurses can access skill and scope development opportunities included IV starts and endoscopy training.

The manager conducts regular 1:1 meetings with staff and performance conversations with staff are up to date. Staff can access ongoing professional development, education and training. The team are commended for how they welcome and integrate new graduate nurses and clinical externs (nursing students) to the program, with mutual benefit in coaching, mentoring and education.

Priority Process: Episode of Care

The program is commended for developing a process where requests for ambulatory services and referrals are centrally reviewed by a physician for appropriateness and level of urgency which in turn optimizes patient safety, timely access, and overall coordination of care. The program leaves open booking slots in the early mornings for urgent add-on endoscopy cases. Patients in the ambulatory service who require specialized out of town care, for example cancer and orthopaedic care, are connected to virtual consults and care services via the Ontario Telemedicine Network (OTN). Space has been dedicated in the ambulatory area for a dedicated OTN registered nurse to assess patients and connect them to their virtual appointments.

Diagnostic and laboratory testing are accessible to patients and the program is commended for impacting patient experience and safety by facilitating the relocation of the laboratory to be more proximal to the ambulatory area.

Medication reconciliation is an area of strength in the program. Built within the ambulatory care module and in partnership with pharmacy, GIMRAC and stress testing were identified (based on risk assessments) as areas where patients would benefit from medication reconciliation. Transfer of accountability processes are audited and evaluated via feedback via Qualtrics patient satisfaction surveys, and the patient experience office.

Priority Process: Decision Support

The ambulatory care module in Meditech Expanse has been well received by staff and clinicians. Meditech optimizations are in progress with an aim to transition to a fully electronic system. Paper documents are scanned into Meditech.

Current optimizations are designed to support patient experience and quality of care. For example, a patient and family focused Patient Tracker tool was developed within Meditech, where families can access the internet to track a family member's progress during their clinic visit. A representative from decision support sits on the Ambulatory Operations Committee which facilitates benchmarking and review of

support sits on the Ambulatory Operations Committee which facilitates benchmarking and review of relevant program data for tracking and decision making.

Priority Process: Impact on Outcomes

The incident management system in Meditech is used by staff to report patient safety incidents, near misses/good catches and equipment/system safety issues. Patient safety incidents are disclosed to patients and debriefed in ambulatory operations and weekly team huddles. The manager follows up with patients and families directly as possible. The RVH Quality & Patient Safety Consultant can work with the team to navigate patient safety incidents and the patient experience office is available for support. The organization quality, risk and safety lead attends huddles and safety debriefs.

Quality improvement is a program focus and evidence of the safety culture in the area. Quality huddles occur weekly, and staff make suggestions for improvement. Key program indicators and quality metrics are tracked and reported/posted, including Qualtrics patient satisfaction data, and relevant program metrics. The program is commended for integrating patient and family feedback to enact change. For example, feedback from a patient who shared that she had experienced past physical trauma prompted the addition of a question on the patient questionnaire on patient history of trauma, an important integration of a key aspect of trauma informed care.

The patient and family advisor is an active member of the team and the program is encouraged to continue to embed patient and family centred care across the program by collaborating with the patient advisor to support program development and process improvement projects. The program is encouraged to continue to streamline their quality boards and to conduct daily huddles at the quality board to focus on embedding and monitoring safety and quality indicators, and to continue to celebrate good catches and staff recognition.

Standards Set: Critical Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.7	There is a framework for providing outreach critical care within the organization and/or to other organizations, if applicable.	
2.9	A universally-accessible environment is created 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		
The organization has met all criteria for this priority process.		
Priority Process: Organ and Tissue Donation		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The critical care unit is a six-bed Level 3A ICU. It is a closed unit and intensivist led, and nursing care is provided entirely by RNs. The team is interprofessional and includes support from respiratory therapists, professional practice leaders, ward clerks, physio and occupational therapists, speech language pathologists, dietitians, social workers and others.

Interprofessional collaboration was evident in the approach to patient rounding. These were team based, focused on the patient, and allowed each team member to offer their opinion or suggestion for care. The exchanges were professional and collegial with the result that each team member was clear on their roles, next steps, and the plan for the patient. The culture was one in which any team member could speak up and/or debate a point in a safe manner.

As conversations occur related to reopening the two other rooms, the organization is encouraged to consider implementing a critical care outreach team at the site. Outreach occurs informally now with unit staff calling a friend for an assessment or another set of eyes, however as staffing challenges continue and increasingly new and/or agency staff are used, these informal approaches are unlikely to remain effective.

Priority Process: Competency

The patients on the unit benefit from the comprehensive staff education and orientation program that includes funding for required courses including advanced cardiac life support (ACLS), additional training using external vendors for ECG interpretation, and access to a critical care education fund to support further learning. The unit participates in a variety of provincial programs including one that allow them to pay for books and program fees for RNs to obtain their critical care certification in exchange for a return of service commitment. This approach has also been used to support a critical care float program that supports RNs working in other areas of the facility, the ED for example, to work in the ICU.

Priority Process: Episode of Care

Handover policies and procedures are well understood and involve person to person systems review and an at-the-bedside conversation to complete the HEAL (High-risk medications/infusions, Equipment/environment, Armbands, Lines) safety check. This work is complemented by purposeful hourly rounding including as related to pain, elimination, environment, and position (PEEP). The transfer of accountability process was observed, and the patient and family member spoken with were able to describe how shift change and other handovers worked on the unit.

The orientation of patients and families to the Whiteboard was also evident, and in one instance a family member flagged that the whiteboard had not yet been updated (rounds had just finished) and the RN used that as an opportunity to review the recently changed patient care plan with the patient and family.

Although not specific to the critical care area the unit makes use of the Essential Care Partner (ECP) program to support ongoing and anytime family (as defined by the patient) involvement in supporting the daily needs of the patient. ECPs receive enhanced orientation to the area and are supported to be comfortable in being with and caring for clients in the critical care unit.

There are a few opportunities for improvement related to the physical space of the unit. The team are aware, and plans are in place to replace room doors, remove wooden sinks, and complete other renovations to the space including as related to accessibility for the patient washroom.

Priority Process: Decision Support

The unit makes use of standard order sets and protocols, and during rounds collaboratively discusses the rationale associated with any deviation, such as the determination to support a patient's hypokalemia with additional KCl following a team based clinical review. This collaborative approach and use of data to understand the care delivery ensures an engaged and effective team-based approach to care.

Priority Process: Impact on Outcomes

The team has a well understood quality monitoring approach. Staff can point to the key initiatives they are pursuing, for example a collaboration between the antimicrobial stewardship program and the ICU related to administering an IV antibiotic more slowly, at a lower dose to support care.

During the initial days of the COVID-19 response at a time when practice was changing frequently the team were quickly able to implement practices based on others' experiences to support their patients; for example the practice of proning ICU patients was proving useful in other settings and was quickly incorporated on the unit and subsequently supported with policies and procedures that permit it to be a consideration for care today.

The team clearly articulated the SBAR approach associated with addressing ethical issues and outlined conversations they have had with the accessible ethicist and at the Ethics Committee.

Priority Process: Organ and Tissue Donation

The team is to be commended on their approach and commitment to supporting conversations related to organ and tissue donation. The team is a member of the Trillium Gift of Life Network and has been recognized on many occasions for their work, including most recently for having a 100 per cent approach rate for eligible donors.

Standards Set: Diagnostic Imaging Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Diagnostic Services: Imaging		
4.4	The client service area includes a space for screening clients which respects confidentiality issues prior to their diagnostic imaging examination.	!
4.7	The client service area includes a space with appropriate equipment and staff for clients to recover following the examination.	!

Surveyor comments on the priority process(es)

Priority Process: Diagnostic Services: Imaging

There is strong medical and operational leadership with increased onsite radiologist presence at the site; now at two days/week.

The partnership with the Royal Victoria Regional Health Centre allows the radiologist group to provide support remotely and onsite at GBGH and ensures continuity of service should a sudden health human resource challenge emerge. The multi-site practice environment provides other advantages including quality assurance approaches such as peer-review.

There is a well-established inter-professional committee with PFAC membership that addresses a wide variety of DI specific items including those related to staff and public safety (for example testing per the Healing Arts Radiation Protection (HART) guidelines), quality metrics, and utilization and demand information. The department has implemented their own local patient experience survey that is completed in real time with clients in the department and shared at the committee.

There is an opportunity to consider the use of diagnostic reference levels to support quality discussions related to their X-ray or CT practice. Specifically, whether the dose used for the patient is appropriate for the selected procedure. The inter-professional DI Operational Committee is ideally situated to review these data should they become available as part of the DI quality program.

The move to Meditech Expanse has been cited in other areas as not complementing clinical workflow, however it has introduced some key safety features that are well received by clinicians. In the context of diagnostic imaging the prompting to the radiologist when there has been a preliminary note added by another practitioner for an exam (for example an emergency department physician reading an x-ray) ensures that appropriate follow-up or feedback is provided when the radiologist’s impression is different than the initial impression.

The small size of the site and the department allows for personal 1:1 connection between staff. They know each other, can share feedback quickly, and can work together to identify improvement opportunities. This interpersonal approach works at this time but given planned expansions that will add modalities, and eventually a new hospital, consideration of how clinical workflows will be designed to support these approaches when they are no longer workable is encouraged.

In addition, there are staffing challenges in the diagnostic imaging area, as there are across the country. Of note the MRTs who are working in the department are all from the local area and were able to identify other MRTs from the local area who were in training; they could not recall a non-Ontario trained MRT ever coming to work in the department. If this is accurate and given the planned long-term expansion and ongoing health human resource shortages across Canada, there may be an opportunity to consider how to position Midland as a destination for individuals trained elsewhere. The staff would recommend GBGH as a place to work to their colleagues which bodes well for future recruitment and retention.

Standards Set: Emergency Department - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The emergency department (ED) of GBGH has 40,400 yearly visits. This is seasonal with spikes in numbers during the summer months with an influx of tourists in the area.

The ED has a Clinical Operations Committee that consists of multidisciplinary team members along with the very important role of PFAC member. This committee reviews data metrics for: ED Length of Stay (LOS) admit, time to Physician Initial Assessment (PIA), time to inpatient bed, ambulance offload times, and PIA and ALOS data.

The ED has two seclusion rooms available for patients requiring the necessary increased observation. Security is present and available in the ED. Staff are equipped with alert buttons as an added safety measure. Equipment and resources are readily available to team members.

The ED works closely with its partners in the community. Quite notable is the relationship with EMS services. The partnership has resulted in the implementation of an offload nurse within the ED to improve patient flow and turnaround times for EMS.

The ED staff speak highly of the team's cohesiveness and the supportive environment. Recruitment initiatives have resulted in improvements in vacancies from 72 per cent to 99 per cent, with all positions being filled by January 2024.

Policies are in place to address workload during periods of high volume, for example ED/MD callback policy and an increase in nursing full time equivalents during the peak summer season when ED visits increase.

Priority Process: Competency

All staff working in the ED are required to be certified in Advanced Cardiac Life Support, Pediatric Advanced Lile Support and Canadian Triage Acuity Scale. Staff are provided with opportunities to complete other courses including Non-Violent Crisis Intervention, Trauma Nursing Care Course.
New members of the team are provided with one-to-one mentorship with an experienced ED staff member for a period, depending on their skill levels.
Critical care skill days provides opportunity for ongoing education to staff.

Priority Process: Episode of Care

All patients presenting to the ED are evaluated using the eCTAS tool. Medical directives are completed as necessary immediately following triage. The organization has a robust French/English translation service using staff within the organization. An external translation service provider is available as needed for other languages.

Medication reconciliation is completed in the ED with the BPMH completed by pharmacy staff during the day and after-hours admissions completed the next morning. Clients are monitored for suicide risk during triage and a self-harm assessment tool is completed for all patients at risk. Communication tools are used for care transition between long-term care and ED. Staff and clinicians spoke of improvements in quality of care since the implementation of this tool.

Documentation of information during care transitions are noted in the patient's chart. Currently there is no evaluation or audit of this practice. There is an opportunity for the organization to pull this information from Meditech to evaluate for continuous quality Improvements.

Priority Process: Decision Support

The ED has moved to full online documentation through Meditech. Physicians use patient order sets for all admissions.

Patient self-registration kiosks are no longer present while the organization evaluate the process for areas of improvements.

Benchmarking of QI metrics is evaluated against other similar sized organizations within the province.

Priority Process: Impact on Outcomes

The ED tracks several key metrics related to patient flow. The DART is available to all staff within the ED. Recently surge beds outside the ED have been made available; while these beds are not ideal, they have resulted in improving patient flow within the department.

The organization is encouraged to continue to track the impacts of over capacity on the ED and its patients.

Priority Process: Organ and Tissue Donation

The organization received the Provincial Eligibility Approach Rate Award from the Trillium Gift of Life Network. This award is presented to organizations that achieved above 90 per cent of organ and tissue discussions with eligible patient and family members. GBGH had achieved a rate of 100 per cent!

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

Unmet Criteria	High Priority Criteria
Priority Process: Infection Prevention and Control	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Infection Prevention and Control

The Infection Prevention and Control (IPAC) team of GBGH consists of a director, a manager and one IPAC specialist. During the pandemic this staffing was increased to two specialists. The team has access to an infectious disease physician at the Royal Victoria Regional Health Center (RVH).

The team is knowledgeable and spoke highly about the relationships it has with other team leads in the organization. They feel their voice is heard by senior leadership and their expertise in infection prevention and control is regularly requested for decision making.

The IPAC Committee consist of a multidisciplinary team including a PFAC member. The committee is required by its terms of reference to meet at least six times per year but often will meeting monthly when necessary.

Outbreak management was evident throughout the survey with two units on outbreak due to respiratory illness. Outbreak management meetings are held regularly during this time with all stakeholders involved present. Information related to units in outbreak can be found on the website both internally and externally. Enhanced cleaning and visitor's restrictions were in place.

An aging infrastructure complicates infection prevention and control and GBGH. Four-bed wards make it difficult to manage outbreaks. The overcapacity beds on each unit are not equipped with hand hygiene sinks or washrooms for patients. Several renovations throughout the building puts an added workload on the IPAC team who are responsible for oversight related to IPAC standards.

The organization may wish to evaluate resources and staffing especially related to oversight of infrastructure and outbreak management and consider flexing up to two IPAC specialist at peak times.

Huddle boards throughout the organization contain paper documents. Consideration of having wipeable surfaces and laminated documents on all huddle boards is encouraged.

Standards Set: Inpatient Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Two clinical inpatient units were visited; one was primarily a medical unit and the other had a mix of medical and surgical patients. Both units had space for palliative care and additional spaces for surge. The two units work together to ensure comparable quality of care for both areas. The new managers in each area have committed to a philosophy centred around patient care as opposed to competition and as a result, even though they are operated as distinct units they will collaborate for care. This collaboration includes sharing staff during times of unexpected shortages and joint educational sessions.

Resource requirements and gaps have been articulated to the site leaders and there is ongoing work to improve the physical spaces through room conversions and initiatives like adopt-a-room.

The skills mix on the unit is appropriate for the population and inter professional rounding and an overall collegial work environment was observed.

Priority Process: Competency

There has been a significant turnover of staff in both clinical areas since the last survey on both units. The team is actively pursuing enhanced retention strategies and augmenting current staffing levels using agency staff. These staff are well supported by the professional practice lead and the pilot clinical scholars' program. The clinical scholars are experienced RNs who work a regular rotation that includes evenings, nights, and days but do not take a case load. They are available to support all staff with at-the-elbow support, and when not called will round and provide support as needed. Staff really appreciate the access to their expertise, particularly after hours and on weekends when other supports are not available.

Staff on the unit have numerous training opportunities that range from Surge based e-learning, to onsite in services from clinical experts such as vacuum-assisted wound closure techniques, to site recognized certification associated with swallowing assessments, to formal bridging courses with a corresponding return of service commitment. This has been identified as a strength by the team.

Priority Process: Episode of Care

There is a skilled and collegial interprofessional team that supports quality clinical care in these areas. Key processes are in place, consistent with organizational policy, to ensure that patients are safe. These processes include regular monitoring and evaluating of risk factors for a variety of factors ranging from falls to violence, to pressure injury development.

The management in the area follow through on incident reports that are submitted, including providing feedback to each reporter once the review of the event has been completed. This was demonstrated by one of the managers, and subsequently a staff member raised this unprompted as an example of how management is paying attention to the needs of the team.

The team appreciated the introduction of the essential care partner (ECP) approach and identified opportunities to make this program even better through streamlining the administration and improving the timeliness of having a family member designated as an ECP.

The Clinical Scholar program is a pilot program that has been clearly identified as being helpful for both real-time clinical support and for retention. There is concern that since it is a pilot program, and funded externally, that it might be at risk of defunding in the future. The GBGH leadership are encouraged to ensure they evaluate this program to determine whether/when to push for permanent funding. The nighttime support was particularly well received by staff. On a similar bent the introduction of experts able to provide behavioural support assessments (BSA) has greatly improved the care for reactive patients. The BSA coupled with the patient watcher request process has, according to staff, greatly reduced incidents of worker and patient harm. This program is reportedly also externally funded for a pilot period.

Similar to the rehabilitation area these inpatient units flagged a gap in service related to the limited availability of allied health personnel on weekends; their experience is that patient gains made during the week are lost or stalled over the weekend, and that this in turn is resulting in longer lengths of stay for some.

Priority Process: Decision Support

The staff are comfortable using the new Meditech Expanse electronic health record and were able to highlight many positive attributes of the system, including generating task lists, following medication orders, and even being able to easily submit an incident report.

In addition to the Meditech system there are other local information systems supporting care conversations - a key example of this is the updated request and review process for patient watches. Staff outline the rationale for their request and indicate other options/plans that have been pursued on an electronic request form that then allows the manager to review the request and rationale and approve it as appropriate in a timely manner.

Priority Process: Impact on Outcomes

Both teams (2N and 2E) are engaged in discussions related to their unit's data, performance, and improvement opportunities. The huddle boards are positioned in hallways, and as a result the teams huddle around them infrequently, however information that is found on those boards is routinely brought into the nursing station and discussed at huddles. One positive aspect of having the boards in the hallway is that they are freely accessible to patients and families; family members were seen reading the items and others reported that they had.

Each unit has two surge capacity beds which are essentially cubby spaces that have been outfitted to support a stretcher and a patient. There are criteria associated with being able to use these spaces and those are clearly communicated to the staff and to the families. All recognize that this situation is not ideal and, given the capacity demands, that these spaces which were intended to support a temporary surge are constantly in use.

One item raised by the team that puts pressure on their ability to achieve the improvements they would like is being required to accompany patients on transfers. Currently, all transfers to the Royal Victoria Regional Health Centre (RVH) require an RN to accompany the patient regardless of the patient's clinical needs. The site has sent PSWs with those patients from time to time against policy and without repercussion, however, there does not appear to be an ability for the sending site to exercise discretion in determining when and who to send to accompany a patient. There is an opportunity to revisit the RVH policy from the perspective of smaller sending sites to optimize care for the patient being transported, care at the sending, and care at the receiving site.

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

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

Surveyor comments on the priority process(es)
Priority Process: Medication Management

The pharmacy team is highly engaged in all aspects of medication management. There is clear evidence of tremendous teamwork and a shared pride in their work product. The director and manager of the program are both experienced pharmacists (although not a job requirement) and are able to use their knowledge to help prioritize improvement opportunities and address operational concerns.

The work of the pharmacy team is well supported by a Pharmacy & Therapeutics (P&T) Committee that reports to the organization’s Medical Advisory Committee. The P&T Committee is active, inter-professional and supports the organization's overall medication management approach. There is evidence of an annual review of its terms of reference and changes to membership over time, and meeting minutes show evidence of quality, safety, and usability conversations. All order sets involving medications are reviewed and approved at this committee following extensive stakeholder feedback and engagement. The inclusion of a professional practice member on the committee helps ensure that medication administration considerations and associated improvement ideas include the perspective/impacts on all healthcare providers.

Medication reconciliation compliance overall is routinely tracked, reported, and is high with dedicated pharmacy team members involved in ensuring that a Best Possible Medication History is available on admission and used throughout the patient journey. There were challenges noted by the team related to being able to consistently complete the medication reconciliation process on discharge; largely related to the additional process steps associated with the transition to Meditech Expanse. The pharmacy professionals are not able to access or view the same view as physicians and as a result are unable to easily support physicians who may be new to the process or system; this is particularly problematic when the conversation occurs virtually through telephone or other means. Consideration is encouraged to providing pharmacists with the ability to view/navigate physician views if this is an aspect of their duties that is expected to continue.

On a related note, the transition to Meditech Expanse also resulted in some loss of reporting/audit functionality for the Antimicrobial Stewardship Committee (ASP). The Expanse system can support more detailed ASP data however the associated workflow is cumbersome and as a result data that were previously reported are not being reported today. The ASP program is led by a pharmacist with a passion

for this work and that has resulted in numerous evidence-informed activities, including those related to new antibiotic administration guidelines.

The pharmacy demand/activity at GBGH is increasing, and the allocated space is insufficient. This is a known challenge for the area, however the result of this is that space considerations as opposed to quality are dictating some aspects of department flow, for example storing overstock supplies in clinical spaces. The physical space also has implications for the sterile compounding area given that the fume hood and related venting and air handling do not meet recommended standards. The team is to be commended for their additional efforts to demonstrate sterility which in turn has allowed the continued and approved use of the space for this function and the corresponding cost savings to the organization. This is a known opportunity for the team, and when addressed in future builds/renovations will provide the organization with additional opportunities related to enhancing this service and moving beyond their current 24 hour beyond-use-date limitation.

Standards Set: Obstetrics Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The obstetrical program continues on a robust path of revitalization, service expansion, and capacity building. Data is available to confirm capacity for growth and expansion of local delivery of women's health at GBGH. Growth of services and programming in women's health and obstetrical services are a core component of the plan for future hospital expansion.

Robust regional partnerships underpin the program, including a partnership with Orillia Soldiers' Memorial Hospital (OSMH), a Level II facility for higher risk deliveries and patients needing specialist care. Recruitment of a permanent obstetrician-gynaecologist signalled program growth and the provision of specialized gynaecological care. A Patient and Family Advisor sits on the obstetrics program leadership committee and is actively engaged in core quality improvement processes, service design and planning.

Space is a recognized challenge in the inpatient birthing area. A core focus of the Obstetrics Charter is to work with an architect and consultant to focus on space redevelopment. Also linked to the charter is a focus on recruitment of an additional obstetrician-gynaecologist to the team. The MoreOB obstetrics risk/error reduction program is on the capital list for the program with an aim to promote a culture of patient safety and interprofessional team education.

Priority Process: Competency

New and current nursing staff can access required orientation, education and training, including electronic clinical policies and procedures, and evidence-based obstetric guidelines. Nursing staff receive orientation at OSMH (Orillia Soldiers' Memorial Hosptial) for one month (minimum 10-20 shifts and tailored to their learning needs) to acquire key skills and knowledge. Annual infusion pump training is an area of strength, supported by a robust policy and access to a drug library via the Smart Pump. Annual staff performance conversations are up to date.

Priority Process: Episode of Care

The organisation provides Level I obstetrical services and refers Level II patients to OSMH, facilitated by a strong regional partnership. A program strength is the focus on prenatal and postnatal care, with a prenatal clinic providing early pregnancy care and support, including care for patients who do not have a primary care provider and care for patients who prefer home birth. Midwives care for the needs of new mothers for six weeks postnatal, linking patients to the Healthy Babies-Healthy Children public health program. The program is commended for enabling access to virtual prenatal care for the Indigenous population on Christian Island, facilitated by two Indigenous midwives. Two Francophone midwives support Francophone patients.

Sharing of information during care transitions is a program strength, underpinned by a robust policy and evaluation of effectiveness via audit, patient inquiry, and monitoring of the incident management system (IMS).

Priority Process: Decision Support

GBGH, as a CARE4 hospital partner, has implemented the latest version of Meditech Expanse. The obstetrical program is part of the upgrade and is now linked to a system where clinical and operational workflows can focus on quality and safety of patient care, coordination of care, and access and coordination of information. Meditech Expanse has been well received by staff and the program is encouraged to continue Meditech optimizations to meet patient and program needs.

Priority Process: Impact on Outcomes

The IMS is used to report incidents and near misses, both of which are discussed at the Obstetrics Operations Committee and referred to Quality & Risk for review. Staff and patients are made aware of how to bring forward complaints and compliments, and a physician-provider contact and escalation policy is in place to address emerging patient needs. The program is commended for using the Stop -5 debriefing tool, where the interprofessional team gathers after a case or care event to debrief on what went well and how to improve on performance. Outcomes and learnings from Stop 5 debriefs are shared with the team and leadership. Unit quality boards, daily huddles and safety/quality debriefs are a core program focus, with monitoring of key quality indicators and performance data. The program is encouraged to continue to streamline their quality boards and to conduct daily team huddles at the quality board to focus on embedding and monitoring safety and quality indicators, and to celebrate good catches and staff recognition.

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

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Perioperative and surgical services offer minimally invasive and day surgeries/procedures as well as surgeries requiring an overnight stay. The CARE4 regional hospital partnership provides an integral opportunity for sharing of resources (people, process), policies and procedures, common learning pathways and practice innovations and ideas that advance surgical service offerings, quality of care and team capacity building. The team are commended for commencing ERCP diagnostic testing on site with staff training received at Royal Victoria Regional Health Centre (RVH). Patient quality of life has been enhanced and LOS has decreased.

Clinical and non-clinical safety incidents, reported via the Incident Management System, are a priority safety focus, with a focus on catching errors and near misses. Incidents and trends are reported at weekly huddles and brought forward to the Surgical Operations Committee.

Space and flow in the perioperative areas is a recognized challenge and phased planning is underway to

address this by creating and repurposing space for enhanced patient care and improved flow. The program Patient and Family Advisor is actively engaged in space redesign, currently focused on patient flow for cataract surgery. The team is encouraged to continue to explore innovative, patient-centred solutions to optimize existing space and workflow design.

Priority Process: Competency

The professional practice leader and team are to be commended for developing a PICC line insertion certification program, in partnership with Southlake Regional Health Centre and with vendor support, for GBGH registered nurses. The program serves the entire hospital and provides a key skills-based capacity building opportunity for nursing staff. The Surgical Innovation Program, an in-hospital perioperative program that is part of a six-hospital partnership is a strength. The design and intent of the program for both orientation and ongoing learning is a strength, with learning modules accessible on Surge. Given the cross-functional nursing model of the program, the perioperative, peri anesthesia, and pre/post operative/procedural care focus of the education is of high value. Staff performance conversations are up to date.

Priority Process: Episode of Care

The preoperative admission assessment is a safety focused ‘always event’, providing the patient with key preparation information and time to ask questions. Medical and anaesthetic risk factors are screened. Patients and families are provided with a surgical patient booklet and are made aware of their rights and responsibilities including how to file a complaint as well as a compliment. In partnership with RVH, a quality and safety assurance officer can engage with patients and families to respond to complaints or incidents that have been filed, noting that the manager and team leader will strive to engage directly with the patient and family if a concern or complaint has been shared. Pre-operative and pre-anesthesia checklists are in Meditech and are completed for each patient as a safety standard.

Information sharing at care transitions and the use of an electronic transfer of accountability (TOA) tool is a program strength. There are standardized information sharing practices in evidence across the perioperative care continuum, with daily quality audits of the patient's electronic medical record to ensure data accuracy and completion. The team uses SBAR (situation, background, assessment, recommendation) to guide TOA standard practices. The team is commended for embedding post-operative phone calls in their quality and safety practices.

Priority Process: Decision Support

Meditech Expanse has been well received by staff, with optimizations and customizations tailored to meet program needs and enhanced patient experience and quality of care. For example, a patient and family focused Surgery Tracker tool was developed within Meditech, where families can access a tool on the organization's internet to track their family members' surgery progress. Surgical patients can sign up for the my health care patient portal for access to their medical records.

Priority Process: Impact on Outcomes

Perioperative services standard operating procedures and quality/safety standards underpin the program and relevant metrics are tracked and reported. Quality boards are in evidence in the clinical areas. Patients are emailed a Qualtrics patient satisfaction survey following discharge and results and feedback are reported to the team by the manager as well as posted on the quality board. Weekly quality and safety huddles are conducted. The program is encouraged to streamline their quality boards and to conduct daily team huddles at the quality board to focus on embedding and monitoring safety and quality indicators, and to celebrate good catches and staff recognition.

The patient and family advisor as an active member of the team and the program is encouraged to continue to embed patient and family centred care across the program by collaborating with the patient advisor to support program development and process improvement projects.

The IMS is used to report incidents and near misses, both of which are discussed at the Perioperative Operations Committee and referred to Quality & Risk for review. The RVH quality and safety officer can work with the team to navigate patient safety incidents, which are disclosed to the patient and family. The patient experience office is available for support.

Priority Process: Medication Management

The management of medications in the operating room and across the perioperative service complies with medication management safety standards.

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

Unmet Criteria	High Priority Criteria
Priority Process: Point-of-care Testing Services	
The organization has met all criteria for this priority process.	

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

There is Point of Care testing (POCT) on all units for glucometer testing. The emergency department has two urinalysis analyzers, and the obstetrical unit performs amniotic fluid PH testing. The laboratory leadership are knowledgeable and engaged.

There is an active POCT/Transfusion Committee which is multidisciplinary.

There are Standard Operating Procedures in place that identify the roles and responsibilities of all staff delivering POCT.

The professional practice lead along with laboratory staff deliver a robust training and orientation for all staff required to perform POCT.

Documentation and reports of POCT are automatically uploaded into Meditech and can be viewed in the patient's electronic record.

There has been a recent decline in the usage of the POCT urinalysis in ED. An evaluation of this service is encouraged to identify reasons why.

Standards Set: Rehabilitation Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The unit is divided into 15 Acute Rehabilitation beds, 18 long term, complex continuing care beds, and three dedicated palliative beds. Typically, the functions are physically separated with each area having the appropriate adjunct spaces adjacent to the rooms, however at the time of survey the unit was experiencing a COVID-19 outbreak and as a result cohorting was being used to limit transmission.

The rehabilitation team is interprofessional, provides support for the local area but also continues to accept regional referrals from other areas. They have recently revisited their admission criteria for the unit and have reviewed related MOUs with referring facilities.

The program is described as a goal-oriented program, and each patient's goals are clearly communicated to the care team, the patient, and the family. The physician and operational leaders actively pursue improvements within the confines of available funding and the physical space. Two examples of improvements that were supported by the organization following advocacy by the team are the removal of the tub room to free up needed space for other functions and providing physicians with no-cost access to the UpToDate – evidence-informed practice resource. (Physicians previously had to subscribe and pay on their own.) The leaders in this area of care described a positive relationship with the GBGH senior leadership team and the CEO; they described how accessible they were, that they were willing to hear their concerns, and that positive changes often followed those conversations.

Priority Process: Competency

The team has a variety of staff working to support rehabilitative care on the unit. Each team member has the appropriate credentials and experience and together they determine assignments and priorities based on each client's stated goals.

The team has access to specialized education for their areas of responsibility as well as access to general GBGH education. The team receives initial, regular, and ad hoc training on the infusion devices used on the unit and monitors effectiveness of that training in a variety of ways including return demonstration and through key stroke/infusion pump data (for example overrides) reviews.

The survey provided opportunity to review an incident report involving the unit and verify that there was awareness of the process and investigation of each report.

Priority Process: Episode of Care

The general environment of the unit is one of positivity. There are engaged physician leaders who advocate for care and supports for the area alongside their operational partners. The function of being a goal-based program is helpful in aligning efforts and facilitating a common understanding of care priorities.

There are defined criteria for admission, and the unit willingly supports the organization when demand for space outstrips inpatient capacity. There is an opportunity to revisit/reset the vision for the program given changes regionally that have seen other sites opt out of providing regional support. This revisioning could include reviewing the patient acuity and needs on the unit and matching resources to their care needs. For example, it was noted that a shortage in allied health staff, particularly on weekends results in some patients experiencing deconditioning which then delays transition or discharge. Another example would be patients who, due to unavailability of transitional care, stay longer and have care needs that are different from the unit's established model of care.

The relocation of the gym next to the unit was cited as a positive enhancement for the program. The passionate team supporting rehabilitation continue to seek innovative ways to support their mission, for example working with local manufacturers to replace wooden stairs with purpose-built metal ones to better comply with infection prevention best practices.

It should also be noted that as would be expected in a unit of this type falls prevention is an area of focus. The team works diligently to identify falls risks and deploys several initiatives to prevent injuries in the event of a fall. These rates are tracked and discussed at the CCC operations meeting.

Priority Process: Decision Support

The team follows GBGH standard approaches to assessments and handover. In addition, they routinely work with the Rehabilitative Care Alliance to support processes for standardized referrals and assessments. In addition, they work closely with the patient flow navigator to optimize the appropriate use of the rehabilitation space. This can cause concerns at times however as capacity pressures result in rehabilitation spaces being used for off-service patients which in turn has a negative impact on the team's ability to pursue rehabilitation with other clients.

Priority Process: Impact on Outcomes

The team follows a variety of performance, quality, and safety metrics. Actions are selected based on these results and prioritized per the Operations Committee. The team follows GBGH wide policies and processes related to order set establishment, ethical reviews and others.

Quality huddle boards are displayed in the nursing station, and additional quality improvement (and other information) materials are posted in the hydration station.

Standards Set: Transfusion Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Episode of Care

As per Accreditation Canada this was not observed by the surveyor.

Priority Process: Transfusion Services

The organization has an active POCT/Transfusion Committee in place that consists of a multidisciplinary team. This committee seeks input from the team on how to improve access and remove barriers to transfusion services. The laboratory staff and professional practice work to ensure all staff are trained in SOPs related to transfusions.

Two patient identifiers are performed to ensure that the right patient receives the blood products intended for them.

Currently GBGH does not have a home transfusion service in place although the laboratory provides blood products such as immunoglobulin to patient in the community for self-administration.

The blood bank is in the process of implementing an analyzer that will reduce the manual work involved in crossmatching off blood products. This will address some of the workload concerns within the blood bank itself.

Instrument Results

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

Governance Functioning Tool (2016)

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

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

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

- **Data collection period: February 24, 2023 to March 31, 2023**
- **Number of responses: 6**

Governance Functioning Tool Results

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1. We regularly review and ensure compliance with applicable laws, legislation, and regulations.	0	0	100	94
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	0	0	100	94
3. Subcommittees need better defined roles and responsibilities.	50	33	17	70
4. As a governing body, we do not become directly involved in management issues.	0	0	100	88
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	93

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
6. Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	97
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	0	100	95
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	0	0	100	95
9. Our governance processes need to better ensure that everyone participates in decision making.	67	33	0	66
10. The composition of our governing body contributes to strong governance and leadership performance.	0	0	100	94
11. Individual members ask for and listen to one another's ideas and input.	0	0	100	96
12. Our ongoing education and professional development is encouraged.	0	0	100	85
13. Working relationships among individual members are positive.	0	0	100	96
14. We have a process to set bylaws and corporate policies.	0	0	100	95
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	98
16. We benchmark our performance against other similar organizations and/or national standards.	0	33	67	77
17. Contributions of individual members are reviewed regularly.	0	33	67	68
18. As a team, we regularly review how we function together and how our governance processes could be improved.	0	17	83	82
19. There is a process for improving individual effectiveness when non-performance is an issue.	0	17	83	62

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	17	17	67	85
21. As individual members, we need better feedback about our contribution to the governing body.	67	0	33	44
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	0	33	67	78
23. As a governing body, we oversee the development of the organization’s strategic plan.	0	0	100	96
24. As a governing body, we hear stories about clients who experienced harm during care.	0	0	100	78
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	0	0	100	90
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	0	0	100	92
27. We lack explicit criteria to recruit and select new members.	100	0	0	80
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	0	17	83	91
29. The composition of our governing body allows us to meet stakeholder and community needs.	0	17	83	92
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	95
31. We review our own structure, including size and subcommittee structure.	0	0	100	92
32. We have a process to elect or appoint our chair.	0	0	100	93

Overall, what is your assessment of the governing body's impact over the past 12 months, in terms of driving improvements to:	% Poor / Fair	% Good	% Very Good / Excellent	%Agree * Canadian Average
	Organization	Organization	Organization	
33. Patient safety	0	33	67	81
34. Quality of care	0	33	67	82

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2023 and agreed with the instrument items.

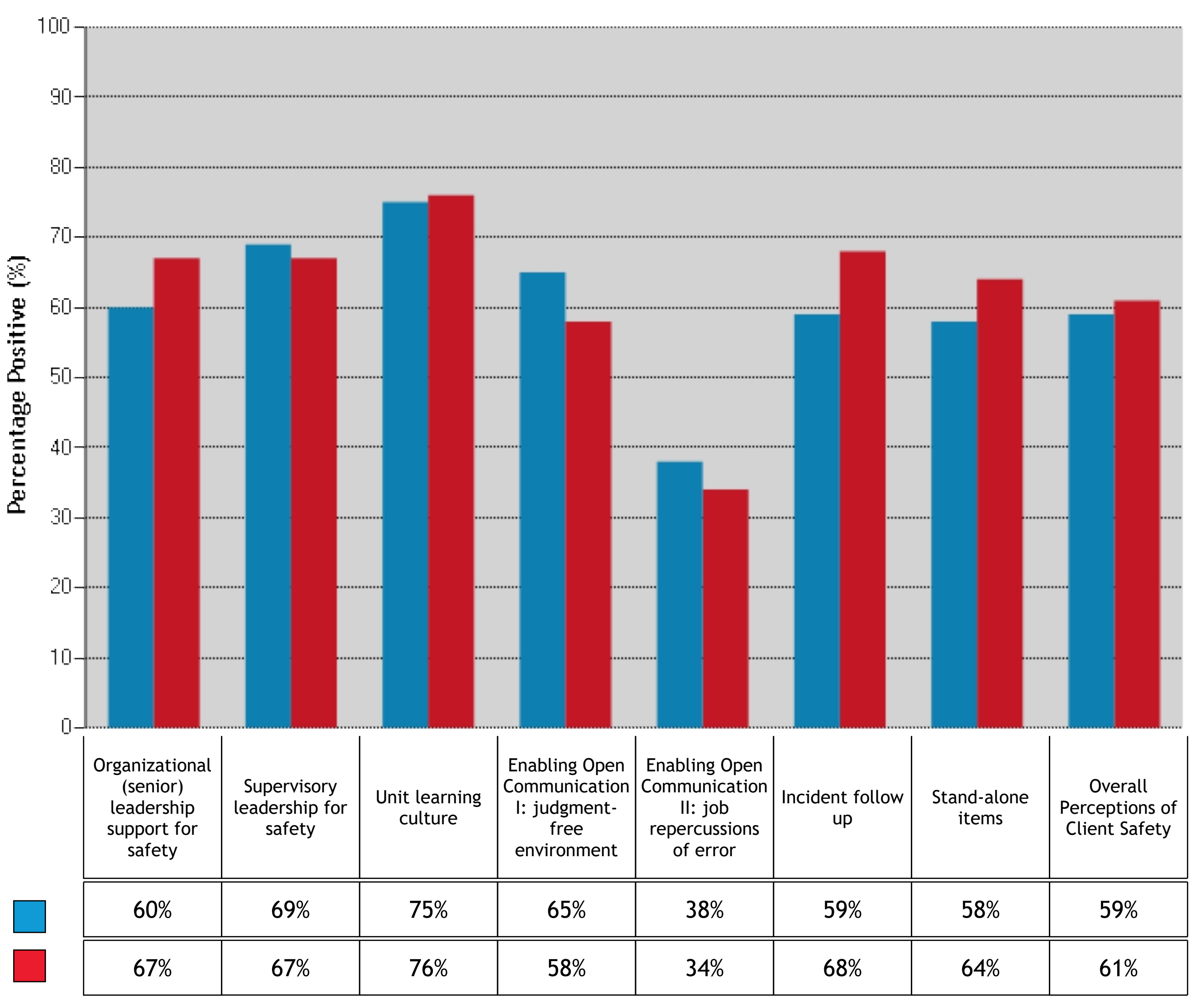
Canadian Patient Safety Culture Survey Tool

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

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

- **Data collection period: May 19, 2023 to June 24, 2023**
- **Minimum responses rate (based on the number of eligible employees): 164**
- **Number of responses: 197**

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
Georgian Bay General Hospital	60%	69%	75%	65%	38%	59%	58%	59%
* Canadian Average	67%	67%	76%	58%	34%	68%	64%	61%

Legend

- Georgian Bay General Hospital
- * Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2023 and agreed with the instrument items.

Worklife Pulse

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

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

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

Client Experience Tool

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

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

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

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

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

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

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

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

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.

2023 Organization Commentary

With a predominantly new Senior Leadership Team within the past two years prior to our survey and many new leaders in the organization since the 2019 survey, GBGH was working on a condensed, two-year timeline to prepare for Accreditation in 2023. Despite the timing challenge, our organization managed to confidently showcase all that we do well at GBGH, meeting all ROPs and 99.7% of standards. We are extremely pleased with our results, which is also translating into a swell of pride among our team members.
We had a very positive experience collaborating with this group of surveyors and would like to thank them for their thorough and fair assessment of GBGH. They worked efficiently to evaluate our strengths and opportunities to improve, while gaining a comprehensive understanding of GBGH, our culture and the personalized, patient-centred care we provide.
Our team is particularly appreciative of some key strategic priorities for our organization, which were recognized during the survey:

- Patient and family-centred care is evident in the new strategic plan
- Drive to improve safety for patients and team members (staff, professional staff, volunteers)
- Ensuring team members understand the connection between our new strategic plan, their work and hospital initiatives (engaged in plan development)
- Growing and aligning our services with community needs
- Having patient advisor representation on hospital operations committees and recent senior-level recruitment initiatives
- Using a new patient satisfaction survey providing relevant and timely program data to integrate patient and family feedback to enact change
- GBGH’s Falls with Harm prevention program was recognized for its efficacy (reduction from 4.99% to 0.99%) and was suggested to be a candidate for a Leading Practice with Accreditation Canada
- Senior team is accessible and willing to hear concerns, after which positive changes often followed
- Team-based rounding in ICU demonstrating a culture of open dialogue and collaboration among care team members
- Clinical scholar program to provide dedicated, at-the-elbow support to less experienced staff, which aids in team members feeling supported and retention
- Well-established ethics committee with an action-oriented approach, access to a renowned ethicist, thorough de-briefing process and a solid ethical decision-making framework (SBAR)
- Partnership with RVH to participate in and expand research activities focused on improving patient care, care outcomes, and enhanced access to resources for team members
- Strong preventative maintenance program keeps aging infrastructure in a well-maintained condition and is attributable to the prevention of system failures and unplanned outages
- Having Infection Prevention & Control sit at the pandemic Emergency Operations Committee (EOC) table

• Use of HEAL and PEEP in at-the-bedside conversations and hourly rounding, plus orientation of patients & family members to whiteboards
• Essential Care Partner program is valuable, particularly in times of outbreak
GBGH would also like to recognize the surveyors for acknowledging some significant challenges facing our hospital. During their time at GBGH, the surveyors were well aware of the hospital's capacity and patient flow situation. Although some of these challenges are related to system issues beyond our control, GBGH is doing what we can to adapt and continue improving the quality of our care. Our team feels the surveyors understood our position, were empathetic to our challenges and were encouraging in our continued efforts to change GBGH's situation for the better of our patients, people and community.
The surveyors also gained an understanding of our future capital priorities and the positive impact these projects will have on better serving our community in the future. The hospital discussed the MRI, mental health program and future hospital during the introduction for surveyors so they could identify throughout the survey how these projects will vastly help GBGH in meeting capacity and flow challenges, albeit well into the future for mental health and a new hospital.
Based on the survey, GBGH received valuable feedback we can use to prioritize short and long-term areas of focus. GBGH will further investigate the following opportunities for improvement:
• Implement a strategy to ensure policies are up-to-date and relevant on a more regular basis
• Ensure code de-briefs are completed within a timely window of the incident taking place (within 24 – 72 hours, explore possibility to train staff in debrief facilitation)
• Add a patient representative not only on the quality committee but also on the Board of Directors
• Create an official Critical Care Outreach Team to replace current informal process
• Develop and implement an electronic bed board to be updated in real time
• Assess structure and value of quality huddle boards with respect to building staff capacity around quality and safety, and create an accessible repository for huddle board data
• Include patient representation on the Emergency Preparedness Committee
• Continued evaluation of Business Continuity Plan to ensure it is relevant and accurate
• Raise awareness of GBGH@Home program within the ED as a patient flow resource
• Transition hospitalist handover to occur earlier in the week, so as not to create a barrier to discharges going into the weekend (currently held on a Friday but there's more clinical resources available earlier in the week to support successful discharges)
• Electronic tracking of instruments through MDRD to improve record keeping and make instruments easier to find
• Investigate opportunities to turn clinical scholar pilot program into permanent funding
• Consider increasing availability of allied health personnel on weekends to improve patient outcomes and flow (patient progress stagnates, increases length of stay)
• Work with RVH to evaluate the validity of always requiring an RN accompany a transfer to their hospital when it could be a PSW in appropriate circumstances
• Provide Pharmacists with the same view in Expanse as physicians to enable better support to physicians, particularly through telephone consults
• Physical space constraints of current Pharmacy department impact workflow and the ventilation system in the sterile compounding area do not meet standards

Our 2023 Accreditation survey was the most significant and tangible success of the entire GBGB crew and highlights all the positive transformation our organization continues to achieve. The recommendations provided by this report will help guide GBGH's actions for the next four years to follow.

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 20 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