ACCREDITATION CANADA



Driving Quality Health Services

Accreditation Report

Trillium Health Partners

Mississauga, ON

On-site survey dates: November 24, 2013 - November 29, 2013

Report issued: December 13, 2013

ACCREDITATION CANADA
AGRÉMENT CANADA

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

Accredited by ISQua

About the Accreditation Report

Trillium Health Partners (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 2013. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

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

Confidentiality

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

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

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

A Message from Accreditation Canada's President and CEO

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

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

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

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

We look forward to our continued partnership.

Sincerely,

Wendy Nicklin
President and Chief Executive Officer

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Section 1 Executive Summary

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

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

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

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

1.1 Accreditation Decision

Trillium Health Partners's accreditation decision is:

Accredited with Commendation (Report)

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

1.2 About the On-site Survey

- **On-site survey dates: November 24, 2013 to November 29, 2013**

- **Locations**

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

  1 Credit Valley Hospital
  2 Infant & Child Development Services Peel and Service Resolution Peel
  3 Mental Health Outpatient Site (2085 Hurontario street)
  4 Mississauga Hospital
  5 Peel Behavioural Services
  6 Queensway Health Centre
  7 Radiologic Clinic Outpatient and Ultrasound Clinic
  8 Watline Renal Care Centre
  9 West Toronto Satellite Out Patient Clinic

- **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 Leadership
  2 Governance

  Service Excellence Standards

  3 Managing Medications
  4 Cancer Care and Oncology Services
  5 Operating Rooms
  6 Surgical Care Services
  7 Critical Care
  8 Emergency Department
  9 Infection Prevention and Control
  10 Ambulatory Care Services
  11 Biomedical Laboratory Services
  12 Diagnostic Imaging Services
  13 Laboratory and Blood Services
  14 Medicine Services

15 Rehabilitation Services
16 Mental Health Services
17 Blood Bank and Transfusion Services
18 Ambulatory Systemic Cancer Therapy Services
19 Obstetrics Services

- **Instruments**

  The organization administer:

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

1.3 Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
 Population Focus (Working with communities to anticipate and meet needs)	70	0	0	70
 Accessibility (Providing timely and equitable services)	115	0	0	115
 Safety (Keeping people safe)	580	13	12	605
 Worklife (Supporting wellness in the work environment)	171	0	0	171
 Client-centred Services (Putting clients and families first)	203	1	1	205
 Continuity of Services (Experiencing coordinated and seamless services)	71	3	0	74
 Effectiveness (Doing the right thing to achieve the best possible results)	850	10	7	867
 Efficiency (Making the best use of resources)	77	2	2	81
Total	**2137**	**29**	**22**	**2188**

1.4 Overview by Standards

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

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

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

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

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	44 (100.0%)	0 (0.0%)	0	33 (97.1%)	1 (2.9%)	0	77 (98.7%)	1 (1.3%)	0
Leadership	45 (97.8%)	1 (2.2%)	0	84 (98.8%)	1 (1.2%)	0	129 (98.5%)	2 (1.5%)	0
Ambulatory Systemic Cancer Therapy Services	46 (100.0%)	0 (0.0%)	0	98 (100.0%)	0 (0.0%)	0	144 (100.0%)	0 (0.0%)	0
Diagnostic Imaging Services	65 (97.0%)	2 (3.0%)	0	59 (98.3%)	1 (1.7%)	1	124 (97.6%)	3 (2.4%)	1
Obstetrics Services	59 (100.0%)	0 (0.0%)	4	74 (100.0%)	0 (0.0%)	1	133 (100.0%)	0 (0.0%)	5
Infection Prevention and Control	50 (94.3%)	3 (5.7%)	0	42 (95.5%)	2 (4.5%)	0	92 (94.8%)	5 (5.2%)	0
Ambulatory Care Services	34 (100.0%)	0 (0.0%)	4	71 (98.6%)	1 (1.4%)	3	105 (99.1%)	1 (0.9%)	7
Biomedical Laboratory Services **	16 (100.0%)	0 (0.0%)	0	36 (100.0%)	0 (0.0%)	0	52 (100.0%)	0 (0.0%)	0
Blood Bank and Transfusion Services **	42 (100.0%)	0 (0.0%)	0	17 (100.0%)	0 (0.0%)	0	59 (100.0%)	0 (0.0%)	0

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Cancer Care and Oncology Services	29 (100.0%)	0 (0.0%)	0	73 (100.0%)	0 (0.0%)	1	102 (100.0%)	0 (0.0%)	1
Critical Care	30 (100.0%)	0 (0.0%)	0	91 (98.9%)	1 (1.1%)	1	121 (99.2%)	1 (0.8%)	1
Emergency Department	31 (100.0%)	0 (0.0%)	0	84 (92.3%)	7 (7.7%)	4	115 (94.3%)	7 (5.7%)	4
Laboratory and Blood Services **	81 (100.0%)	0 (0.0%)	0	95 (100.0%)	0 (0.0%)	0	176 (100.0%)	0 (0.0%)	0
Managing Medications	74 (100.0%)	0 (0.0%)	2	51 (98.1%)	1 (1.9%)	0	125 (99.2%)	1 (0.8%)	2
Medicine Services	27 (100.0%)	0 (0.0%)	0	68 (98.6%)	1 (1.4%)	0	95 (99.0%)	1 (1.0%)	0
Mental Health Services	31 (100.0%)	0 (0.0%)	0	71 (100.0%)	0 (0.0%)	0	102 (100.0%)	0 (0.0%)	0
Operating Rooms	67 (97.1%)	2 (2.9%)	0	30 (100.0%)	0 (0.0%)	0	97 (98.0%)	2 (2.0%)	0
Rehabilitation Services	27 (100.0%)	0 (0.0%)	0	67 (98.5%)	1 (1.5%)	0	94 (98.9%)	1 (1.1%)	0
Surgical Care Services	30 (100.0%)	0 (0.0%)	0	65 (100.0%)	0 (0.0%)	0	95 (100.0%)	0 (0.0%)	0
Total	**828 (99.0%)**	8 (1.0%)	10	1209 (98.6%)	17 (1.4%)	11	2037 (98.8%)	25 (1.2%)	21

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

1.5 Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Safety Culture			
Adverse Events Disclosure (Leadership)	Met	3 of 3	0 of 0
Adverse Events Reporting (Leadership)	Met	1 of 1	1 of 1
Client Safety Quarterly Reports (Leadership)	Met	1 of 1	2 of 2
Client Safety Related Prospective Analysis (Leadership)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Communication			
Client And Family Role In Safety (Ambulatory Care Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Ambulatory Systemic Cancer Therapy Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Cancer Care and Oncology Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Critical Care)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Diagnostic Imaging Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Medicine Services)	Met	2 of 2	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client And Family Role In Safety (Mental Health Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Obstetrics Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Rehabilitation Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Surgical Care Services)	Met	2 of 2	0 of 0
Dangerous Abbreviations (Managing Medications)	Met	4 of 4	3 of 3
Information Transfer (Ambulatory Care Services)	Met	2 of 2	0 of 0
Information Transfer (Ambulatory Systemic Cancer Therapy Services)	Met	2 of 2	0 of 0
Information Transfer (Cancer Care and Oncology Services)	Met	2 of 2	0 of 0
Information Transfer (Critical Care)	Met	2 of 2	0 of 0
Information Transfer (Emergency Department)	Met	2 of 2	0 of 0
Information Transfer (Medicine Services)	Met	2 of 2	0 of 0
Information Transfer (Mental Health Services)	Met	2 of 2	0 of 0
Information Transfer (Obstetrics Services)	Met	2 of 2	0 of 0
Information Transfer (Rehabilitation Services)	Met	2 of 2	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information Transfer (Surgical Care Services)	Met	2 of 2	0 of 0
Medication Reconciliation As An Organizational Priority (Leadership)	Met	4 of 4	0 of 0
Medication Reconciliation At Admission (Ambulatory Care Services)	Unmet	0 of 5	0 of 2
Medication Reconciliation At Admission (Ambulatory Systemic Cancer Therapy Services)	Unmet	0 of 5	0 of 2
Medication Reconciliation At Admission (Cancer Care and Oncology Services)	Met	4 of 4	1 of 1
Medication Reconciliation At Admission (Critical Care)	Met	4 of 4	1 of 1
Medication Reconciliation At Admission (Emergency Department)	Met	4 of 4	1 of 1
Medication Reconciliation At Admission (Medicine Services)	Met	4 of 4	1 of 1
Medication Reconciliation At Admission (Mental Health Services)	Met	4 of 4	1 of 1
Medication Reconciliation At Admission (Obstetrics Services)	Met	4 of 4	1 of 1
Medication Reconciliation At Admission (Rehabilitation Services)	Met	4 of 4	1 of 1
Medication Reconciliation At Admission (Surgical Care Services)	Met	4 of 4	1 of 1
Medication Reconciliation at Transfer or Discharge (Ambulatory Care Services)	Unmet	0 of 4	0 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication Reconciliation at Transfer or Discharge (Ambulatory Systemic Cancer Therapy Services)	Unmet	0 of 5	0 of 0
Medication Reconciliation at Transfer or Discharge (Cancer Care and Oncology Services)	Met	4 of 4	1 of 1
Medication Reconciliation at Transfer or Discharge (Critical Care)	Met	4 of 4	1 of 1
Medication Reconciliation at Transfer or Discharge (Emergency Department)	Met	4 of 4	1 of 1
Medication Reconciliation at Transfer or Discharge (Medicine Services)	Met	4 of 4	1 of 1
Medication Reconciliation at Transfer or Discharge (Mental Health Services)	Met	4 of 4	1 of 1
Medication Reconciliation at Transfer or Discharge (Obstetrics Services)	Met	4 of 4	1 of 1
Medication Reconciliation at Transfer or Discharge (Rehabilitation Services)	Met	4 of 4	1 of 1
Medication Reconciliation at Transfer or Discharge (Surgical Care Services)	Met	4 of 4	1 of 1
Surgical Checklist (Obstetrics Services)	Met	3 of 3	2 of 2
Surgical Checklist (Operating Rooms)	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			
Two Client Identifiers (Ambulatory Care Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Ambulatory Systemic Cancer Therapy Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Cancer Care and Oncology Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Critical Care)	Met	1 of 1	0 of 0
Two Client Identifiers (Diagnostic Imaging Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Emergency Department)	Met	1 of 1	0 of 0
Two Client Identifiers (Managing Medications)	Met	1 of 1	0 of 0
Two Client Identifiers (Medicine Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Mental Health Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Obstetrics Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Operating Rooms)	Met	1 of 1	0 of 0
Two Client Identifiers (Rehabilitation Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Surgical Care Services)	Met	1 of 1	0 of 0
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Managing Medications)	Met	4 of 4	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Concentrated Electrolytes (Managing Medications)	Met	1 of 1	0 of 0
Heparin Safety (Managing Medications)	Met	4 of 4	0 of 0
Infusion Pumps Training (Ambulatory Care Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Ambulatory Systemic Cancer Therapy Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Cancer Care and Oncology Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Critical Care)	Met	1 of 1	0 of 0
Infusion Pumps Training (Emergency Department)	Met	1 of 1	0 of 0
Infusion Pumps Training (Managing Medications)	Met	1 of 1	0 of 0
Infusion Pumps Training (Medicine Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Obstetrics Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Operating Rooms)	Met	1 of 1	0 of 0
Infusion Pumps Training (Rehabilitation Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Surgical Care Services)	Met	1 of 1	0 of 0
Medication Concentrations (Managing Medications)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Narcotics Safety (Managing Medications)	Met	3 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Client Safety Plan (Leadership)	Met	2 of 2	2 of 2
Client 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 Audit (Infection Prevention and Control)	Met	1 of 1	2 of 2
Hand Hygiene Education And Training (Infection Prevention and Control)	Met	2 of 2	0 of 0
Infection Rates (Infection Prevention and Control)	Met	1 of 1	3 of 3
Sterilization Processes (Infection Prevention and Control)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Falls Prevention			
Falls Prevention Strategy (Ambulatory Care Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Ambulatory Systemic Cancer Therapy Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Cancer Care and Oncology Services)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Falls Prevention			
Falls Prevention Strategy (Diagnostic Imaging Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Medicine Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Mental Health Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Obstetrics Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Rehabilitation Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Surgical Care Services)	Met	3 of 3	2 of 2
Patient Safety Goal Area: Risk Assessment			
Pressure Ulcer Prevention (Cancer Care and Oncology Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Critical Care)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Medicine Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Rehabilitation Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Surgical Care Services)	Met	3 of 3	2 of 2
Suicide Prevention (Mental Health Services)	Met	5 of 5	0 of 0
Venous Thromboembolism Prophylaxis (Cancer Care and Oncology Services)	Met	2 of 2	2 of 2
Venous Thromboembolism Prophylaxis (Critical Care)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Venous Thromboembolism Prophylaxis (Medicine Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Surgical Care Services)	Met	3 of 3	2 of 2

1.6 Summary of Surveyor Team Observations

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

Trillium Health Partners is a new organization that was formed in 2011 through an amalgamation of the Mississauga Hospital, The Queensway Health Centre and the Credit Valley Hospital. The merger was based on a mutual decision of the respective boards of directors and is a merger of equals. Fiscal 2013 was the first full year of operations for the merged organization. The combined healthcare organization has 1,268 inpatient beds, 8,171 staff, 1,891 volunteers and 1,094 professional staff. The organization services over 1.5 million patient visits each year including: 61,000 inpatient admissions, 650,000 outpatient visits and 252,000 emergency department visits. The annual operating budget is 944 million dollars. Trillium Health Partners serves a diverse community of over 1.5 million people in one of the fastest growing urban communities in Canada. It is estimated that people speaking 50 different languages are served by the hospital.

The board of directors consists of 12 members and a chair. The board is best described as a policy and governance model with a committee structure that includes: a finance and audit committee, a quality committee of the board, a human resources committee, and a governance committee. The original board of the merged organization was comprised of 6 directors from the Trillium Board (Mississauga and Queensway) and 6 directors from the Credit Valley Board. The chair and vice-chair were appointed from the original members. Board members were appointed to staggered terms to initiate the process of board renewal. The board develops a matrix of skills and abilities that are needed to provide a broad range of input and expertise. The full complement of 13 directors was achieved in the first intake of new directors. All directors are asked to become members of one or more of the standing committees. The board has a rigorous process of education for new directors. The board reviews its functioning annually and evaluates the chair. An evaluation of individual members is undertaken annually that includes a self-evaluation and an interview by the chair of the board.

Fifteen community partners attended the community partners focus group. Trillium Health Partners is well regarded as a collaborative participant. The community partners recognize that in any forum, because of its vast size, Trillium Health Partners could dominate the agenda. However, they are recognized by their partners as being a respectful, collaborative participant. The organization is regarded as being visionary, and communicative. Partners that operate under contract find that Trillium Health Partners is diligent with respect to their deliverables on a contractual basis. The Community Care Access Centre is embedded in the organization. A process has been developed to review all patients who are difficult to discharge. The process has resulted in a decrease of the number of alternate level of care patients to 8-9%, which is much better than comparable organizations.

The leadership has been developed since the merger of the organization. At the present time, a number of positions are acting or interim. Many medical department heads are recent appointees and some division chief positions are interim appointees. The leadership team and the board developed and introduced a new 5 year strategic plan with a mission to offer "a new kind of health care for a healthier community". 2012/2013 was the first full year of the merged organization. Much work is underway to develop a "one hospital culture" for Trillium Health Partners. The leadership of the organization has committed to quality and patient safety, access and sustainabilty as strategic priorities for the organization. Research, innovation and education are a new priority for the Trillium Health Partners. The organization is in its third year since developing the Mississauga Academy of Medicine. Third year clinical clerks are assigned to services throughout the organization. Although some research has been done in the Trillium hospitals for many years, the program is now more focused. The goal is to deliver front line innovation and focus on changes to the system that will improve patient care.

Trillium Health Partners has developed an ethics framework known as the IDEA: Ethical Decision-Making Framework. The framework is based on 4 steps:

1) Identify the facts
2) Determine the relevant ethical principles
3) Explore the options
4) Act
The framework is used for both organizational decision-making and in clinical situations. Trillium has access to 3 ethicists who provide education and guidance.

At the time of the survey, Trillium Healthcare Partners was faced with a significant ethical dilemma. It was recently discovered that there were a number of possible interpretation errors in computed tomography (CT) scans over a period of time. The organization elected to notify all patients who were potentially affected. An external expert was engaged to review the CT scans and to provide a report to the organization. Steps were taken immediately to put in place measures that will reduce the likelihood of recurrence. Trillium Health Partners has committed to be transparent throughout the process.

Trillium Health Partners is in a strong financial position. The organization was in a surplus position in fiscal 2013 and has working capital of $70 million. The Quick Ratio is 1.16. Despite the challenges imposed by the funding formulas, senior management presented a balanced budget for fiscal 2014 to the board. Trillium Health Partners received a clean audit for fiscal 2013. In 2013, the newly merged Trillium Health Partners foundation raised over $29 million from fundraising activities.

Trillium Health Partners has over 2,000 volunteers who play an important role in the delivery of care to patients. They are present in all areas of the hospital, the clinics and the emergency departments. A key role for the volunteers is to ensure that patients get to the right location. They also help families and friends locate patient locations.

The staff at all sites are committed and engaged. Enthusiasm is a hallmark of all the care teams that were encountered during the accreditation survey. The workforce is diverse, reflecting the community of Mississauga. At the care team level, managers have empowered their employees which contributes to the engagement of the staff. Likewise, the engagement of physicians is an important driver of the success of the organization. Complementing the empowerment and engagement of the staff are recognition programs and events. At each quality huddle, a member of the staff is recognized for their contribution to the well-being of the patients. The organization has developed a formal health and safety wellness program and absenteeism due to illness is relatively low compared to other healthcare organizations. Staff orientation is harmonized at all sites due to the efforts of the directors, managers and educators. The organization has used the "new grads program" of the Ministry of Health and Long-term Care as a recruitment strategy. A talent management program is in place for senior management personnel and the program will be extended to director level over the next year.

The commitment to quality is evident throughout Trillium Health Partners. The board has an effective quality committee which receives reports from clinical services. The board is accountable for quality and safety. Senior management has dedicated substantial resources to quality and patient safety. Quality improvement is most apparent at the point of care and front line programs play a key role in driving quality and patient safety. The quality improvement framework puts patients and families at the centre. The framework is based on staff, community partners, excellent results based on key outcome measures, effective planning and efficient processes. The most visible manifestation of quality at the front line are the quality and patient safety boards. The boards are posted in public areas, emphasizing transparency and accountability of staff. The boards are also used as a tool for patient education and for front-line staff recognition. Each board contains the "big dot reports" and a focus for the team. The focus for the team displays performance on a selected hospital-wide metric, a program-wide metric and a unit-specific metric. Each day, a quality huddle is held on the unit. All staff are encouraged to attend. The huddle is used to communicate to staff, review the performance against the selected metrics and to recognize an employee of the day. The huddles are well received by all staff in the organization at all sites.

Trillium Health Partners offers a full range of medical services. Cardiac services and neurological services have been rationalized to the Mississauga site. Cancer care and the chronic kidney disease program including haemodialysis, peritoneal dialysis, is centred at the Credit Valley site. The STEMI program is located at the Mississauga site and emergency medical services (EMS) bypass is in place. The Trillium program has exceptional door to balloon times and very good results. Likewise, the stroke program is centred at the Mississauga site and EMS bypass is in place. The results of the program will be tested against national standards when the program undergoes the stroke distinction program of Accreditation Canada in 2014. The organization intends to take the opportunity to rationalize other services. The advantages of rationalization in healthcare include focusing of expertise, effective use of best practices and cost savings. There is a large complement of beds in the organization for rehabilitation and complex continuing care. These services are distributed at all sites under one director. The service offers excellent care for all patients. The team has developed an early discharge group known as the joint discharge operation. This group meets on a daily basis and identifies patients who may be difficult to discharge at or near the time of admission. The team identifies and mitigates barriers to discharge. As a result, the number of alternate level of care patients is 8-9%, which is much better than comparable organizations. A very broad range of services are offered in ambulatory care clinics including medical clinics, surgical clinics, oncology clinics, paediatric clinics, mental health clinics, etc. There are an excess of 653,000 clinic visits at the three sites.

Client satisfaction is relatively high as measured by the Picker Survey. Approximately 75% of all patients report that they would recommend the organization to others. During the accreditation survey, most patients interviewed by team members were either satisfied or highly satisfied with the care received. Negative comments related to parking as an access issue, poor coordination of clinics in complex patients visiting many clinics, length of stay in emergency department both for admitted and ambulatory patients, fasting patients for elective procedures delayed by more urgent cases and navigation problems. The surveyors collectively interviewed about 80 patients.

Trillium Health Partners is facing 6 significant risk issues.
1) Trillium Health Partners has updated significant areas of their facilities and projects are ongoing. The operating rooms at the Mississauga site are small and outdated. Patient flow is impacted and there are significant issues related to sterility that may pose a risk to patients. The emergency department was built in the 1960s and patient care areas are small, impacting on patient flow. Privacy is an issue in all three emergency departments. Given that volumes are projected to grow by an average of 5% per year, this issue will continue to worsen.
2) At both the Mississauga site and Credit Valley site, admitted patients have significant wait times before transfer to a nursing unit. Research has demonstrated that delay before transfer has a significant impact on morbidity and mortality. The Canadian Association of Emergency Physicians has recommended that all patients be transferred within 8 hours. The aggregate time for the two sites is 23.8 hours from time of admission (29.8 from time of triage). Although this has improved over the past year, it continues to pose a risk for patients.
3) Merger of policies, procedures, goals and objectives is proceeding at differing levels across the programs, although all directors indicated that they are in support of completing the process as rapidly as feasible. A significant issue that may ultimately impede progress is the presence of a nursing union at the Queensway and Mississauga sites and non-union nursing at the Credit Valley site. In order to facilitate the merger, this issue should be addressed.
4) Charting and information technology are different at Mississauga/Queensway and Credit Valley sites. This is a risk for patients who access services at both sites. It is also a risk for staff who move between sites. Migration to a common platform and uniformity of charting is recommended.
5) Standardization of equipment is underway. In the interim, the use of some equipment is potentially hazardous, particularly as staff move between sites. The best example is the IV infusion pumps. The Colleague Guardian is used at the Mississauga and Queensway sites and the Hospira Pump is used at Credit Valley. The

pumps are set up differently and operate differently. Most staff are trained on one or the other infusion device. The risk occurs when staff move between sites.

6) Sterile reprocessing is the highest risk faced by Trillium Health Partners. The organization has entered into a long-term contract with SteriPro to reprocess sterile equipment used throughout the organization. The decision was taken because the existing reprocessing system at the time of merger did not meet standards in many locations at the various sites. Many of the internal deficiencies are detailed elsewhere in the accreditation report. Many pieces of equipment and surgical instruments are sent to an off-site reprocessing facility. There are two significant issues with this practice. Equipment for transfer to the external facility is stored in plastic bags. The standard requires that surgical instruments be soaked within 1 hour to prevent build up of dried material. The second issue is the number of defective trays being discovered, particularly by the surgical team. They have been presented with trays that have split wrappings, trays with broken or missing instruments and trays with instruments that have hardened detritus from prior cases. Defective trays are found on a daily basis and often 6-8 deficient packs are found each day.

The organization has taken a number of measures to mitigate the risk to patients. They have appointed a senior associate vice-president to oversee the issues related to sterile reprocessing and provided significant resources to manage the risk. The vice president reports to senior management on a weekly basis and the reports are forwarded to the board. All packs in the surgical suites are inspected and opened before patients are admitted to the operating room. This has reduced efficiency in all operating rooms. Furthermore, when a deficient pack is discovered, a significant delay in the start of surgery occurs before the instruments are replaced. The organization is working with infection prevention and control (IPC) to insure that the there are no consequences to patients. To date, there is no evidence that patients have been harmed as a result of the reprocessing issue. The organization is encouraged to insure that the operational deficiencies related to sterile reprocessing in relation to the contract are corrected to the satisfaction of the IPC Department, the users and ultimately the patients.

Section 2 Detailed Required Organizational Practices Results

Each ROP is associated with one of the following patient safety goal areas: safety culture, communication, medication use, worklife/workforce, infection control, or risk assessment.

This table shows each unmet ROP, the associated patient safety goal, and the set of standards where it appears.

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Communication	
Medication Reconciliation At Admission The team reconciles the client's medications with the involvement of the client, family or caregiver at the beginning of service when medication therapy is a significant component of care. Reconciliation should be repeated periodically as appropriate for the client or population receiving services.	· Ambulatory Systemic Cancer Therapy Services 9.14 · Ambulatory Care Services 8.3
Medication Reconciliation at Transfer or Discharge The team reconciles the client's medications with the involvement of the client, family, or caregiver at interfaces of care where the client is a risk of medication discrepancies (transfer, discharge), when medication therapy is a significant component of care. Reconciliation should be repeated periodically as appropriate for the client or population receiving services.	· Ambulatory Systemic Cancer Therapy Services 16.3 · Ambulatory Care Services 12.2

Section 3 Detailed On-site Survey Results

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

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

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

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

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

See Appendix B for a list of priority processes.

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

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

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

3.1 Priority Process Results for System-wide Standards

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

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

3.1.1 Priority Process: Planning and Service Design

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization engaged approximately 23, 000 people while designing the terms of the merger of the 3 legacy hospitals.

"Physician on a page" is a highly effective method to provide information to physicians about their practice.

The planning and service design team indicated that greater engagement of the front-line staff would be desirable.

The team also indicated that the data mangement sytem is not fully integrated between the two sites.

3.1.2 Priority Process: Governance

Meeting the demands for excellence in governance practice.

Unmet Criteria		High Priority Criteria
Standards Set: Governance		
11.4	The governing body monitors and provides input into the organization's strategies to address client flow and variations in service demands.	

Surveyor comments on the priority process(es)

The governing body has effectively managed the transition through the merger of the legacy hospitals to the Trillium Health Partners in terms of board roles, responsibilities, policy and by-law development and board operations. The new board adopted staggered terms to ensure that there would be a mix of new and experienced members.

Board members receive a comprehensive orientation to the organization, its programs and operations. The board members are encouraged to serve on board committees and are mentored on the committees by experienced board members.

The board has adopted a rigorous process to evaluate the functioning of the board as a whole, the functioning of individual board members and the chair.

The merged board drove a process that included 26,000 "touches" with stakeholders to develop the mission statement and strategic plan for the new merged organization.

The board has oversight through the board quality committee for quality, safety and risk management. This is a major focus for the Trillium Health Partners board.

The board receives reports on quality, safety, adverse events, near misses and critical events. Recently, the board and the Trillium Health Partners used the ethical framework and an approach of transparency to disclose as early as possible errors in diagnostic imaging. The approach chosen was patient-centred, fair and effective. The board and the organization are commended for the actions taken.

3.1.3 Priority Process: Resource Management

Monitoring, administration, and integration of activities involved with the appropriate allocation and use of resources.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Trillium Health Partners has a working capital surplus of approximately $70 million and a capital ratio of 1.3. The financial position is very strong, providing margins for contingencies and capital expansion in relation to the strategic plan.

New resource allocation is based on the strategic plan. The organization has established a strategy management working group that advises leadership on new programs and capital projects based on the strategic plan.

The fiscal strategy working group reviews operations on a monthly basis, particularly in relation to procedure based funding programs and advises the leadership on steps to be taken to ensure the most efficient use of resources within the programs. The working group is broadly based with input from front line personnel including physicians.

Variance analysis is undertaken annually. The audit for fiscal 2013 was presented without comment or additional notes to the financial statement.

Although considerable progress has been made in adopting single policies for financial and capital resources, there are policy areas that remain separate following the merger. The organization is encouraged to continue to work towards amalgamating all financial and capital policies.

3.1.4 Priority Process: Human Capital

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The human capital priority process included a team meeting with representatives of the human resources portfolio, a follow-up meeting with a smaller group of team members, a review of human resource files, as well as extensive validation discussions throughout the organization. Trillium Health Partners (THP) is commended for its focus on talent management. The completed review at the senior team, with the plan to cascade into the director and manager levels is noted with approval. Appropriate, proactive talent management will go al long way to ensuring the organization attains its strategic goals and objectives. Linking the plan to an overarching compensation plan will position the organization well on a go-forward basis. "The People Strategy" developed by the team was done so in an inclusive manner and appropriately aligned the programs goals and objectives with the broader organizational objectives. As the strategy is currently in draft form, moving ahead to refine and finalize should be a priority. The organization is also commended for its workforce plan and is urged to update the 2006 - 2010 copy shared with the survey team. It is recognized and appreciated that moving forward on these types of initiatives will very much hinge on activating the new human resource information system that has been purchased and is not yet operational.

The team had a good discussion around the employee "life-cycle," including focusing on the recruitment process, on-boarding, continuing education, staff appraisals, goal setting and overall retention. It is clear that the organization places significant emphasis on this as reflected in the success that have been achieved. Innovative recruitment strategies are in place, including the "refer a friend" program for positions deemed hard to fill by the organization. The on-boarding of volunteers was also noted with approval, with a very clear passion and commitment exhibited towards the volunteer program. Of note, discussions throughout THP with volunteers in all areas of the organization highlighted a heartening commitment and dedication of those committed to this program. In light of the breadth and depth of the areas where volunteers are active in the organization, continuing with the comprehensive orientation program will be important.

A good discussion ensued around the LiveWell: Integrated Employee Wellness Program. The organization and more specifically those driving this program are to be commended. The wellness objectives were noted with approval and the mix of wellness programs, healthy workplace initiatives, psychosocial interventions and injury prevention approaches clearly reflect the priority the organization places on supporting a healthy workforce. The innovative and supportive initiatives such as movement classes, laughter yoga and mini massages, amongst many others, were noted with approval. "Events" such as Stairtober were creative ways of advancing wellness by keeping things fresh in the organization and keeping members of the team motivated. Finally on this area, the establishment of the cross-site healthy workplace council is commended. Maintaining focus on the important topic of wellness will require a strong infrastructure such as this to succeed.

The survey team reviewed the most recent results from the Employee Engagement Survey and discussed them with the team. It is evident that priority has been placed on drilling down through the organization to identify contributing factors to the results and to implement strategies to address concerns. There appeared to be somewhat of a disconnect between the results and the actual tone of the organization which was found to be extremely positive overall. This implied that perhaps external forces at the time of the survey may have artificially influenced results. Notwithstanding this, continuing to focus on the results, addressing opportunities for improvement is important. As the merger continues to evolve, regular surveys, with open, frank discussion throughout the organization will be important.

The organization has a strong commitment to safety, for patients, staff, physicians and volunteers as is evident through the various programs offered throughout THP. Integrating certain aspects of the joint occupational health and safety committees by standardizing to one terms of reference will help focus efforts in a consistent manner, and initiatives such as the Registered Nurses' Association of Ontario (RNAO's) best practice "horizontal violence" program will further enhance the culture of safety.

The surveyors were impressed with the organization's commitment to ongoing professional development. On-line training opportunities, starting with orientation, through leadership development, through "back to school" all reinforced this commitment. Discussions with staff across the organization reinforced this commitment as all asked about development opportunities. Educational priorities were also well developed at all levels of the organization through a thoughtful review of needs against strategic priorities of the organization.

The program has much to be proud of, most notably driven by a culture to support, develop and strengthen the people associated with the organization. Looking ahead, continuing to enhance the strengths noted will be important, as will ensuring that programs and services are aligned to take full advantage of the opportunities that will present as the merger evolves. Harmonizing systems, aligning staff, strengthening development opportunities and being recognized as an enabling business partner by all in the organization will form part of the focus of a human resources portfolio that will continue to drive innovation and creativity across THP into the future.

3.1.5 Priority Process: Integrated Quality Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization has committed major resources to continuous quality improvement (CQI) and patient safety, including 6 full-time staff and additional supports for the program. Also, there is a considerable investment in the quality boards and the huddles that are instrumental in bringing quality to the front line staff.

Best practice guidelines are widely used by the clinical programs in the organization.

Risk management is embedded within the overall quality program.

The staff in the organization understand the concept of adverse events and near misses. There is a high level of reporting and the integrated quality management team is certain that all events accompanied by harm to the patient are reported. They are less confident that near misses are fully reported. A new reporting system that is more user friendly will be rolled out in the near future across all sites, and with education, the team intends to increase the level of near miss reporting.

Critical events are thoroughly reviewed and the system changes are implemented. Recent examples including actions taken were discussed during the meeting with the team.

Prospective analyses and failure mode and effects analyses (FMEAs) are undertaken several times each year.

Process and outcome measures are well-aligned with the strategic plan.

A number of performance measures are tracked on a monthly basis and reported to the team and at least quarterly to the board. 5 indicators are tied to the quality improvement plan. Three of these measures are quality based, one based on sustainability and one based on access. The access measure is emergency room wait times. Recently, this was recorded as 29.8 hours. The Canadian Association of Emergency Physicians (CAEP) recommend a wait not to exceed 6 hours. It is recommended that the organization review the target (42 hours) and work to achieve the level recommended by CAEP.

The Patient Safety Culture Tool identifies the fact that the organization is recognized by staff for actions on issues relating to quality and patient safety. To further strengthen the organization's just culture, the organization has made a commitment to share learnings, recommendations, and improvements with staff after a patient safety incident occurs. This includes not just the staff involved in the incident but also other staff who are aware of the incident and would benefit from the learnings.

The team is encouraged to ensure that patients understand the patient role in patient safety. The organization has developed an excellent brochure for patients, but do not know if the brochure is effective.

3.1.6 Priority Process: Principle-based Care and Decision Making

Identifying and decision making regarding ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

It is evident that principle-based care and decision making is supported throughout the organization. The board has incorporated such principles in the formulation of a number of policies related to conflict of interest, receiving of gifts, respect for diversity as well as a whistle blower policy. There is a research ethics board (REB) that has been established and, as well, there is an array of organizational policies that embody these principles, e.g., code of conduct, conflict of interest, a complaint process and workplace violence. Of particular note, the board approved the current ethical framework for the organization in June, 2012. This framework has been implemented across the entire organization.

There are currently three ethicists on staff, including a senior ethicist who serves as the lead of the regional ethics program. Revenue from the regional program supports this staffing model. The senior ethicist reports to the vice president, patient services, chief nursing executive. The ethics service is structured according to the "hub and spoke" model from two perspectives. In terms of the regional program, the organization serves as the hub and the components of the regional model serve as the spokes. One of the benefits of this model is the building of local ethics capacity in the organizations that subscribe to its services. From another perspective, there is an internal hub and spoke model whereby the ethicists serve as the hub and ethics facilitators at the program levels serve as the spokes. The facilitators support principle-based care and decision making at the program level and, in so doing, continue to build ethics capacity across the organization. Ethical matters are discussed and reviewed on a monthly basis through the ethics forum where educational programs and case studies demonstrating the application of the ethics framework are presented.

The organization is commended for developing and implementing an ethics framework, an evidence-based tool developed on the basis of current literature. Using the acronym IDEA (identify the facts, determine the relevant ethical principles, explore the options and act), there is evidence that the framework has been used at all levels of the organization in order to address ethical issues and dilemmas. As well, it has also been shared with medical learners associated with the Mississauga Academy of Medicine so that they become familiar with the application of the tool.

The REB has been established to oversee and approve research studies carries out throughout the organization. The REB reviews approximately 130 research proposals on an annual basis.The REB is an important element in the emerging academic role of the organization.

3.1.7 Priority Process: Communication

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
11.1	The organization's leaders select and implement information management systems that meet the organization's current needs, and anticipate future needs.	

Surveyor comments on the priority process(es)

A dynamic meeting was held with representatives of team members representing the following areas: communications; information technology (IT); decision support; privacy; clinical informatics and health information to overview and discuss the communications function across the organization. The team was commended for the robust nature of the tools employed to ensure communication, both within and outside the organization. The various channels were well thought out and communicated and included: ask Michelle and Dante e-mail; huddles; hospital communications and announcements; "Taking a Moment" CEO blog; bi-monthly newsletter; leadership forums; town halls; CONTACT TV Show on Rogers; CEO external newsletter; annual report and president's report; and, Partnering for Patients newsletter. These regular communication tools are then supplemented by various program and service publications that are generated as required. A good example of this would be the Inside/Out, a journal of diagnostic imaging at Credit Valley site. The survey team was impressed with the level and depth of information that was distributed across the organization. An analysis of the effectiveness of the various tools employed may help inform the organization as to the tools most effective in various situations. The various avenues for engagement used as the merger developed were impressive and the recent public issue revolving around a specific quality concern put the team under significant pressure to ensure effective, timely communication, the team is commended for how well the situation was addressed from a communications perspective. Communication will need to be a primary area of focus as the merged organization continues to evolve, with face-to-face communication being an extremely important as relationships continue to develop across the various sites.

A good discussion took place around the IT infrastructure that exists across the organization, with a clear recognition that the current situation with disparate systems will not allow the organization to achieve its strategic goals and objectives. The current plan to move to one system is supported. It will be vitally important that the current commitments at all levels of the organization to move forward with these investments occur. The document entitled "Information & Technology Needs Assessment, Final Due Diligence Report" was reviewed as part of this priority process and the team is commended for the comprehensiveness of the report. A number of organizations currently leveraging integrated information technology were referenced in the report and it is clear from an analysis of these organizations that success with integration at all levels, most notably hinges on integrated information systems. Notwithstanding the broader issue of the HIS integration, the organization continues to leverage information technology to improve patient care. The recent successful integration of the PACS System is a good example of this, with direct conversations with front-line clinicians reinforcing this. The organization is also commended for its commitment to initiatives such as e-referrals with the Community Care Access Centre (CCAC) and alerting primary care providers of the admission and discharging of their patients from THP. The "LACE" Tool, a predictive, evidence-based program that looks at re-admission probability was also noted with approval.

The survey team was impressed with the organization's commitment to privacy. Starting with the orientation program, privacy is continually reinforced as an organizational priority. The mandatory training module is noted with approval, as are the efforts to promote a transparent culture in this area. Of interest, signage in the elevators reinforcing privacy was noted with approval.

The organization's decision support framework was reviewed and determined to be a major strength. Ensuring that timely, accurate, actionable information is available to decision makers at all levels of the organization is one of the keys to succeeding in today's ever shifting healthcare environment. The "clinical cube" concept was noted and clearly provided the necessary platform for information sharing. It was also clear that the information was available and understood at all levels of the organization.

The team was commended for its cohesiveness. There was a very clear common purpose across all areas and the programs were well positioned to continue to provide strong support to the organization in all areas. Continuing to focus on strengthening these supports, on developing new and growing existing external partnerships, on continuing to align with the overall strategic goals for the organization will ensure the continuation of a strong communication infrastructure into the future.

3.1.8 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)

Aging infrastructure has been identified by Trillium Health Partners (THP) as one of their major challenges. The physical environment at the Mississauga, Credit Valley And Queensway sites are a mix of old and new. They are challenged to keep up with the ongoing maintenance and space needs related to the older infrastructure. The Queensway site is involved in a major renovation project to upgrade their electric system and to plan for future needs. This has been a three year project that is still ongoing.

The facilities have built-in redundancy with their generator systems. There are weekly checks on their generators to ensure that they will be available in the case of a power outage. Despite the built-in backup systems, the organization ran into difficulty with a recent storm that caused flooding in the Mississauga area. They were required to use their back up generator systems for a number of days and had started to activate their emergency preparedness plan and look at their process for evacuation prior to the power being restored. They felt that the exercise was a better test of their emergency plans than any table top exercise. The Queensway site has added a temporary generator to make sure that power is maintained as they work through the process of upgrading their electrical system. They are working closely with service providers to plan for minimal disruptions as they change over and start to connect up their new power system.

All fire extinguishers checked as part of the tracer in all sites were approved in 2013. The organization holds regular fire drills and have built in a debrief process. They hire an external contractor to check their alarm system on a biannual basis.

Areas observed during the survey were clean and uncluttered. Staff that were interviewed reported that the facility was clean, well-lighted and that the temperature in their work area was good. There are obvious differences in space and ambiance between the old and new sections of each facility.

There have been a number of incidents of code gray related to the air handling system and concerns were expressed by the obstetrics team at Mississauga site about the air handling in baby care areas.

There is a matrix process in place to identify and address infrastructure and maintenance issues which they feel is very effective. Corporate services monitor and report on the effectiveness of their response to maintenance request and post the results.

The organization has an accessibility committee that review all new space projects to ensure that they meet legislation and code requirements.

The organization has been certified by ISO 14001. There was evidence of monitoring and reports on compliance to ISO 140001 standards. Corporate services has developed a review and resolution process to address any issues identified as deficiencies by the ISO evaluation. There is evidence that they implement a root cause analyses and develop a resolution plan that is submitted to ISO to maintain their certification status. Reports and updates on ISO indicators are reported to the board.

Corporate services have quality boards and report on quality indicators that are alignment with the organizations strategic direction. It was noted that the staff take pride in their quality board and the results they have been able to achieve.

There is an active recycling program and the program has set targets for environmental controls and monitor their achievements against the set targets. They are to be commended for the target (35%) they have set on waste management; they are meeting and exceeding that target in a number of their facilities.

It is good to see that environmental staff are considered a part of the interdisciplinary team. The staff feel that they have contributed to the client satisfaction in a very positive way. All of the environment staff interviewed as part of the tracers take great pride in they job and considered their cleaning responsibility as a major factor in patient safety.

THP is to be commended for their energy conservation initiatives which have netted considerable financial savings that are sustainable into the future. They are also to be commended for their blue zone initiative which safely disposes of anaesthetic gases and is making a positive impact on our environment.

The organization is involved in research and is monitoring the effectiveness of their cleaning processes. The organization is to be commended for their support of quality in corporate services with the implementation of positions dedicated to quality.

Corporate services has strong leadership and engaged staff which will be an asset as they continue to develop their merger process.

3.1.9 Priority Process: Emergency Preparedness

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The code plans for Trillium Health Partners have been amalgamated into one plan, which is an important aspect of emergency preparedness. The collaboration with all partners for emergency preparedness is excellent. The emergency preparedness team is knowledgeable with excellent resources. Staff are aware where to locate the code binders and hold code of the month in all areas. The environmental staff expressed the desire to be included in all code training. The facility has two pandemic plans but these will be coordinated into one plan in the near future. The completion of this process to one pandemic plan needs to be a priority and hiring individuals to focus on completion of an integrated pandemic plan shows commitment to this process. The recent code grey debriefing and feedback has provided excellent opportunities for improvement. The patients and family interviewed that were involved stated they felt safe and did not feel at risk. They have already started on many areas for improvement. Fire drills should be planned on all shifts. It should be considered to perform a table top evacuation exercise for the operating rooms at all sites.

3.1.10 Priority Process: Patient Flow

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The new strategic plan for Trillium Health Partners (THP) makes improved patient flow a key indicator for the leadership team and the board. There has been considerable effort to correlate the activities at the three delivery sites so that patients are "in the right place at the right time to get the right service". Measures of emergency department (ED) wait times and "off-loading" are regularly monitored and efforts made to improve the flow. Targets have been set for the "wait-time for a bed" for admitted patients to acute care inpatient beds; the target for 2014 is 42 hours. The ED 90th percentile wait times for THP for Q2 were 29.4 hours. The most recent month, Oct 2013, had an ED 90th percentile wait time of 28.8 hours.

The wait time for inpatient admission is still lengthy and could likely interfere with acute care treatment planning, thus increasing length of stay (LOS) and delaying discharge, overall compounding the original problem. The ED admitted patient is however, still medically managed by the appropriate service although not necessarily in the right place. All relevant literature points to less than ideal outcomes in patients who are not admitted within 6-8 hours, as per guidelines set by the Canadian Association of Emergency Physicians.

There are overcapacity protocols (OCP) in place that are activated quite regularly and hopefully deal with the frequent "surges". Diversion from the ED does not happen, resulting in congestion of ED examination spaces, which then delays emergency medical services (EMS) ambulance off-loading, thereby possibly preventing efficient use of this community resource.

There are regular communications with Community Care Access Centre (CCAC) personnel to facilitate early placement from the ED and also provide access to alternate modes of healthcare services within the community. CCAC members have a permanent presence in the ED to assist with long term care (LTC) placement and improve access to community resources.

The operating rooms (ORs) at all sites have block scheduling with policies and protocols for booking, utilization and prioritisation. The OR regularly reviews utilization and makes allocation modifications based upon usage, demand and priority. Cancellation of an elective surgical procedure is a very rare event and is not tracked as an indicator because of this rarity. Following each discharge, attempts are made by the unit responsible to do follow-up communications regarding the patient's progress, needs and satisfaction with the service delivered.

The ED has a "tracking" system that permits continuous visualization of the ED patient flow and disposition. Bed requests are seen by the "bed desk" in real time and allocations are managed and coordinated by these personnel 24/7. Daily 15 minute bed meetings occur at each site to assist with allocations, requirements, transfers and realignments that keep all players in the loop and facilitate patient flow. The use of Medworxx as a tool to monitor inpatient beds and related requirements has helped immensely. Portering is centrally controlled and each "transfer" is done "just-in-time" as requested. Thought maybe given to having some pre-scheduled transfers for those patients with booked investigations such as DI , PFTs etc.

Patient flow indicators are tracked and reviewed by the leadership team and by the board on a regular basis.

There is an excellent cooperative program, joint discharge operations, that provides a forum for discussions between all parties to facilitate discharge of chronic continuing care patients into the community or an appropriate LTC facility. This process has been very effective in reducing the ALC rate to 8-10% (versus 18-20% provincially).

3.1.11 Priority Process: Medical Devices and Equipment

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

Unmet Criteria		High Priority Criteria
Standards Set: Diagnostic Imaging Services		
8.6	All diagnostic imaging reprocessing areas are physically separate from client service areas.	!
8.7	All diagnostic imaging reprocessing areas are equipped with separate clean and decontamination work areas as well as separate clean storage, dedicated plumbing and drains, and proper air ventilation and humidity levels.	!
Standards Set: Leadership		
9.8	The organization's leaders develop and follow policies and procedures to manage adverse events and incidents involving medical devices, equipment, and technology, including cases involving misuse.	!
Standards Set: Operating Rooms		
12.5	The operating room team appropriately contains and transports contaminated items to the reprocessing unit or area.	!

Surveyor comments on the priority process(es)

The preventative maintenance program across the system is quality based and client focused. The biomedical department should be commended for their process of tagging equipment for repair and the documentation of their preventative maintenance of all equipment. The recent assignment of a lead for the reprocessing of all devices requires the review of reprocessing procedures in the diagnostic imaging (DI), operating room (OR) and medical device reprocessing departments.

The organization has signed a contract with an external provider, SteriPro, for reprocessing. This process is in transition and quality issues with regards to daily incidents were identified during the onsite survey.

The area designated for decontamination in the OR at the Mississauga site does not meet environmental or space requirements found in the Canadian Standards. Soiled case carts were left unattended out in the public hall at the end of the day as there is no space for them to be placed inside the soiled area. This is a risk issue. There is inadequate equipment in this area to meet volumes. The reprocessing of ultrasound probes needs to be reviewed and updated to meet Canadian Standards. The DI area for reprocessing needs two separate rooms and a one-way flow. There are closed in machines available that contain the sterilant, provide a print out and tracking system. The storage of ultrasound probes at all three sites needs to be reviewed. At the Credit Valley site storage of ultrasound probes is in a wood cabinet not enclosed and does not meet standard. Storage cabinets at the Mississauga site are excellent but need to be in a closed room, separate from clients and visitors. The air exchanges, temperature and humidity in all reprocessing areas need to be reviewed to ensure they meet requirements. Centralization of reprocessing should be considered.

The product evaluation process is thorough and the right members are on the committee.

The transport of sterile supplies to the OR requires medical devices to be in closed carts or bins as the clean elevator opens into the external corridor of the OR, not the centre core. This can be achieved by containment of supplies or impervious covers placed over the cart and supplies. The transport of contaminated medical devices are contained, but are not prepared as per requirements of the removal of gross soil, soaked or kept moist and in the open position.
It is advised that the medical device reprocessing throughout the organization be considered to be centralized at each site. The Queensway site has room to expand reprocessing as this site. The physical layout at this site meets all standards and has room to expand production. The facility may want to explore adding the endoscopy service to this site. The Mississauga site has physical space, flow and equipment issues that require correction.

3.2 Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Episode of Care - Ambulatory Systemic Cancer Therapy

- Healthcare services provided for a health problem from the first encounter with a health care provider through the completion of the last encounter related to that problem.

Clinical Leadership

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

Competency

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

Episode of Care

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

Decision Support

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

Impact on Outcomes

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

Medication Management

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

Organ and Tissue Donation

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

Infection Prevention and Control

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

Surgical Procedures

- Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge

Diagnostic Services: Imaging

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

Diagnostic Services: Laboratory

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

Blood Services

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

3.2.1 Standards Set: Ambulatory Care Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
8.3	The team reconciles the client's medications with the involvement of the client, family or caregiver at the beginning of service when medication therapy is a significant component of care. Reconciliation should be repeated periodically as appropriate for the client or population receiving services.	ROP
8.3.1	The team provides documented rationale for the selection of target clients or populations to receive formal medication reconciliation.	**MAJOR**
8.3.2	There is a demonstrated, formal process to reconcile client medications at the beginning of service, and periodically as appropriate for the client or population receiving services.	**MAJOR**
8.3.3	The team generates or updates a comprehensive list of medications the client has been taking prior to the beginning of services (Best Possible Medication History (BPMH)).	**MAJOR**
8.3.4	The team documents any changes to the medications list (i.e. medications that have been discontinued, altered, or prescribed).	**MAJOR**
8.3.5	The team provides clients and their providers of care (e.g. family physician) with a copy of the BPMH and clear information about the changes.	**MINOR**
8.3.6	An up-to-date medications list is retained in the client record.	**MAJOR**
8.3.7	The process is a shared responsibility involving the client and one or more health care practitioner(s), such as nursing staff, medical staff, pharmacists, and pharmacy technicians, as appropriate.	**MINOR**

12.2	The team reconciles the client's medications with the involvement of the client, family, or caregiver at interfaces of care where the client is a risk of medication discrepancies (transfer, discharge), when medication therapy is a significant component of care. Reconciliation should be repeated periodically as appropriate for the client or population receiving services.	ROP
12.2.1	The team provides documented rationale for the selection of target clients or populations to receive formal medication reconciliation, and the risk points during service delivery where reconciliation will be conducted.	**MAJOR**
12.2.2	There is a demonstrated, formal process to reconcile client medications at interfaces of care where the client is at risk of medication discrepancies (transfer, discharge), and periodically as appropriate for the client or population receiving services.	**MAJOR**
12.2.3	The team documents any changes to the medications list (i.e. medications that have been discontinued, altered, or prescribed).	**MAJOR**
12.2.4	Upon transfer or discharge, the team provides clients and their providers of care (e.g. family physician, next provider of care) with a copy of the up-to-date medications list and clear information about the changes.	**MAJOR**
12.2.5	The process is a shared responsibility involving the client or family, and one or more health care practitioner(s), such as nursing staff, medical staff, and pharmacy staff, as appropriate.	**MINOR**
13.5	When conducting reprocessing in the ambulatory care setting, the team follows manufacturers' instructions for cleaning, disinfecting, and reprocessing diagnostic devices and equipment.	

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 survey visit included a broad assessment of ambulatory programs across all sites and programs operated by Trillium Health Partners (THP). Programs visited included but were not limited to: out-patient physiotherapy at both the Queensway and Credit Valley sites; hand therapy, renal dialysis, stroke unit, spine clinic, family care centre, fracture clinics, diabetes education unit at both the Mississauga and Credit Valley sites; surgical out-patient and medical out-patient, cardiac diagnostic, cardiac rehab and heart functions clinics, and sleep lab at the Queensway site;

All services were asked how they defined their service population and how they assured themselves that the needs of the population base were being addressed. Some programs, such as diabetes, actively pulled patients to the program through proactive marketing while others, such as out-patient physiotherapy responded to broader community based service changes such as the Community Care Access Centre (CCAC) no longer providing post hip and knee orthopaedic rehabilitation. There was a mix of OHIP and WSIB offered services in some cases. Wait list were applicable and appropriately managed. Where waits were long, contact was made with patients to maintain relationships and to track any condition changes. With multisite services, efforts to level-load wait times are being made at times. All programs set annual goals and objectives and all align with the corporate goals and objectives of the organization. Indicators are tracked through tools such as quality boards are regularly used to report and discuss statistics. An area of focus on a go forward basis may be a broader look at programmatic goals in parallel with the tracking of corporate goals such as hand hygiene and patient identifiers.

A number of the programs had regular interaction with other organizations and/or networks to ensure coordination of care and service. The Ontario Renal Network is a good example of this, as are the community based partnerships developed and maintained. Infant and Child Development Services Peel, Service Resolution Peel and Peel Behavioural Services are good examples of programs that have well developed, high functioning relationships with partners outside the organization.

All areas visited were very open to supporting learners, with all students met feeling that the experience with THP was a very worthwhile one.

All areas visited, as appropriate, had very clear equipment maintenance protocols and procedures that all complied with Accreditation Canada guidelines and standards.

Priority Process: Competency

The interdisciplinary nature of all teams was impressive. Different models of care were followed, with teams wrapped around individual patients or patients assigned to individual care providers who then acted as navigators, ensuring that the clients received the care they needed. Where team meetings were held, the positive dynamic was evident and ensured good coordination of services. Efforts were made to ensure that staff had the necessary skills to function effectively in a team environment and all felt comfortable. All programs had strong orientation programs and, where recently hired staff where engaged, all supported the comprehensiveness of the program. Through the human resources team meeting, a review of the orientation program, notably the on-line, advanced aspects of the program were noted with approval.

Every staff member met, and all employee files reviewed reflected regular, annual employee performance appraisals. Through this process, individual goals were set, with goals being aligned to the overall corporate strategies. A robust mandatory training program existed for all staff, with audits performed to ensure that training was being completed in a timely manner.

Priority Process: Episode of Care

The ambulatory care programs surveyed all placed the client and their families at the centre of their program. Patient-centred care is clearly a priority throughout, with care plans developed and put in place as appropriate and necessary. Cardiac rehab was a good example of this, where 4 month plans are developed and monitored with patients. The renal unit's effort to develop and enhance home dialysis is another example where new models of care are aimed at improving the patient experience. Family engagement was noted with approval across all areas. Where care planning is necessary, patients and as appropriate, families, are very much involved on an ongoing basis. Where care is provided to children, active engagement of parents is

noted with approval. There is also clear evidence that programs facilitate access to other programs where waits are an issue. This was clear in the community programs reviewed as well as programs that had services across multiple sites in THP. Ambulatory programs also make efforts to reduce waits and or avoid admissions in other areas of the organization. A very good example of this is the DART through cardiac rehab.

Medication reconciliation was not evident in all areas visited. The heart function lab at the Queensway site had a very comprehensive medication reconciliation process, with evidence of this noted with approval in a discussion between a nurse and a family member during a visit. Most areas had the necessary space available to easily address patient confidentiality and privacy and, where this was a challenge, "work-arounds" ensured good solutions.

Patient records were noted to be complete although there was a wide range of formats followed, ranging from almost exclusively on line, through to paper-based systems. As the IT platform is standardized across THP, efforts to standardize record keeping practices across the ambulatory programs will prove beneficial.

Priority Process: Decision Support

The survey team was impressed with the efforts made to ensure that programs and services were delivering best practice care across all disciplines. All programs participated in educational opportunities and, as appropriate, research in an effort to ensure currency. Comprehensive reference libraries, and professionally prepared education material for patients and staff are available. As needed, materials are prepared in multiple languages. An area of focus, particularly in light of the lowering average age of the population, will be on-line education and the use of social media as a communication tool with patients.

Training opportunities were clearly available, with team presentations at conferences being a wonderful example of the philosophy of innovation of the programs visited.

Priority Process: Impact on Outcomes

Significant time was spent with all programs understanding patient flow, confidentiality, registration and quality monitoring. All team members involved in registering of patients were comprehensive in their approach and ensured that two identifiers were always used, that patients at risk of falls were appropriately identified and that, as appropriate, clients and families were engaged in discussions around safety. With respect to safety, it was noted with approval that the safety of staff, particularly those working in the community, was defined as a priority.

Risk management was discussed with all teams and was addressed appropriately. Staff were aware of the processes to follow in the event of a safety concern, either for a staff member or a patient, and understood the importance of documenting the same. Where events were sentinel in nature and/or when disclosure was necessary, there were members of the team conversant in the processes to follow. The organization is commended overall for its focus on disclosure and more broadly, ethics. All programs were active with client satisfaction surveys, with improvements being made as appropriate on an ongoing basis. Tools reviewed were well thought out, and information shared with staff was comprehensive. The detailed presentation on the hand therapy unit was a good example of this.

Quality boards were noted with approval across all areas visited. Staff were well aware of the importance of attending huddles and appreciated the importance of these types of tools in advancing quality across their respective portfolios.

3.2.2 Standards Set: Ambulatory Systemic Cancer Therapy Services

Unmet Criteria			High Priority Criteria
Priority Process: Episode of Care - Ambulatory Systemic Cancer Therapy			
9.14	When medication therapy is a significant component of care, the team reconciles the client's medications with the involvement of the client, family or caregiver at the beginning of service. Reconciliation should be repeated periodically as appropriate for the client or population receiving services.		ROP
	9.14.1	The team provides documented rationale for the selection of target clients or populations to receive formal medication reconciliation.	**MAJOR**
	9.14.2	There is a demonstrated, formal process to reconcile client medications at the beginning of service, and periodically as appropriate for the client or population receiving services.	**MAJOR**
	9.14.3	The team generates or updates a comprehensive list of medications the client has been taking prior to the beginning of services (Best Possible Medication History (BPMH)).	**MAJOR**
	9.14.4	The team documents any changes to the medications list (i.e. medications that have been discontinued, altered, or prescribed).	**MAJOR**
	9.14.5	The team provides clients and their providers of care (e.g. family physician) with a copy of the BPMH and clear information about the changes.	**MINOR**
	9.14.6	An up-to-date medications list is retained in the client record.	**MAJOR**
	9.14.7	The process is a shared responsibility involving the client and one or more health care practitioner(s), such as nursing staff, medical staff, pharmacists, and pharmacy technicians, as appropriate.	**MINOR**
16.3	The team reconciles medications with the client at referral or transfer, and communicates information about the client's medication to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.		ROP
	16.3.1	There is a demonstrated, formal process to reconcile client medications at referral or transfer.	**MAJOR**
	16.3.2	The process includes generating a comprehensive list of all medications the client has been taking prior to referral or transfer.	**MAJOR**
	16.3.3	The process includes a timely comparison of the prior-to-referral or prior-to-transfer medication list with the list of new medications ordered at referral or transfer.	**MAJOR**

16.3.4	The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made.	**MAJOR**
16.3.5	The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff and pharmacists, as appropriate.	**MAJOR**

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: 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: Episode of Care - Ambulatory Systemic Cancer Therapy

The ambulatory systemic cancer therapy (ASCT) program is a regional program that has a dual reporting relationship to Cancer Care Ontario and Trillium Health Partners (Adults) and Paediatric Oncology Group of Ontario (Paediatric Oncology). During this survey the following service areas were reviewed: systemic therapy at Credit Valley and Queensway sites; radiation therapy at Credit Valley site; cancer screen and diagnostics at Credit Valley site; and paediatric oncology at Credit Valley site.

The paediatric oncology program work closely with Toronto Sick Kids as one of their satellite program and are able to provide services to children close to their homes. They have developed strong relationships with their clients and families and have implemented a process where their paediatric oncology clients do not have to go to the adult emergency when they run into difficulty, but can be admitted to the inpatient unit; this has eliminated long waits and has improved client/family satisfaction.

The team feels they provide a unique experience in that they consider the whole family when developing treatment plans and care.

The teams at each site have done a remarkable job at keeping down wait times and are meeting, and in some cases exceeding, the benchmarks set by Cancer Care Ontario in their systemic and radiation services.

All of the clients interviewed in the three sites expressed their gratitude to the staff and have a high level of satisfaction with the services provided by Trillium Health Partners.

The teams are composed of staff that have training and education in providing services to their client populations.

The team has developed a spills kit that is provided to clients on home administration of chemotherapy. They have been asked to present on their spill kits at the provincial Quality and Safety Network this coming week.

Although the ASCT programs have not fully implemented medication reconciliation at admission or transition points there are plans to roll out the organization's medication reconciliation process in June of 2014.

The program has developed a number of education classes and material to address issues specific to their oncology client population needs. Clients report that they receive the information they need and feel comfortable that they can ask the staff for information at any time.

The program has developed a well follow-up breast clinic run be a nurse practitioner. She facilities the transiting process from hospital care to the client's family physician on discharge. She also acts as a support for the client and family physician. They are planning to expand the service to include colo-rectal cancer clients.

Priority Process: Clinical Leadership

The adult ambulatory systemic cancer therapy program (ASCT) provide regional services as part of Cancer Care Ontario (CCO) and has a dual reporting relationship to CCO and Trillium Health Partners. They have representation on the Regional Systemic Treatment Program and the Regional Quality and Safety Network.

Their commitment to quality has been recognised and they are the only Canadian hospital that have been able to submit a quality initiative to the American College of Clinical Oncology. The quality initiative is designed to develop processes and education on oral chemotherapy. This is a multidisciplinary submission lead by pharmacy within the ASCT program.

The program manager collects monthly utilization data and has been able to increase resources to address high volume times within the Queensway clinic. They have implemented the two day model which has reduced wait times and improved client and staff satisfaction. Although they are striving to see their systemic therapy clients within the two day model the team has developed criteria to identify clients where it would be best to have their chemotherapy administration on a one day model.

Clients felt that the scheduling system in place met their needs and that there is some flexibility in the system to accommodate their need for changes. The program may want to look at the possibility of extended hours of service some time in the future if indicated.

The program has access to drug navigators who work to ensure that clients have access to the chemotherapy drugs that they need. This has been very beneficial in relieving clients from the financial distress related to costly chemotherapy and the navigators have received ample positive feedback from clients that has added to their job satisfaction

Priority Process: Competency

The interdisciplinary teams work well within their respective settings. One of the strengths they identified in assisting them to meet and exceed their wait time targets is their physician engagement. The oncologists were actively involved in the merger process and increased their clinical times to address wait time issues.

In discussion with staff it is obvious that they are invested in interdisciplinary team functioning. Clients were also able to comment on the cohesiveness of the team and how well they work together to provide quality seamless care.

The team has a number of processes available to coordinate service through rounds, combined charting areas, case reviews and team meetings. The protocols are standardized and in most cases available on their OPIS (Oncology Patient Information System) system.

There is a robust orientation program for new staff that includes a general orientation to the organization, interdisciplinary functioning and unit/service specific. Staff interviewed felt that they had received a comprehensive orientation.

Priority Process: Decision Support

Charting within the program is a combination of electronic and hard copy. Services areas in the various sites are at different staging of implementing their electronic charting. This fragmentation makes it difficult to do interdisciplinary charting. They would benefit from an integrated computer system that links each of the three sites where ambulatory systemic cancer therapy is provided.

The team is engaged in research in the pharmacy and about to start a nursing research project in the paediatric oncology area. They are aware of the applicable research and ethics protocols.

They are actively involved in the Regional Systemic Treatment Program Committee and the Regional Quality and Safety Network.

Priority Process: Impact on Outcomes

All clients admitted to ambulatory systemic cancer therapy services are screened for risk of falls by the admission clerk when they register for treatment. Anyone deemed to be at risk as per their screening criteria is provided with a falls sticker applied to their green wrist band so that all staff within the clinic are aware.

The team report to Cancer Care Ontario (CCO) on a number of indicators and state that they are meeting and or exceeding the targets set by CCO. As a regional program they have the resources to develop client educational material, policies and procedures which they readily share with many organizations and have been instrumental in assisting smaller organization by providing guidance and access to their material.

The clients and family members interviewed were able to identify that the staff talked to them about safety issues and they had received the brochure on safety. The PARTNER information on client safety was posted in key areas throughout the facility.

Staff were aware of the need to report adverse incidents, near misses and sentinel events and were able to provide examples of when they have reported events. They felt that there was a culture of safety within the organization and were comfortable that the process is a learning opportunity to promote client safety.

Priority Process: Medication Management

The process for prescribing, mixing, dispensing, transporting and disposing of systemic cancer therapy medications is well controlled within this program. The combined effort of the pharmacy and nursing staff ensure that all safe guards are in place for safe medication management. There are multiple double check systems implemented to ensure that the right medication gets to the right person.

Although medication reconciliation has not been fully implemented with the ambulatory systemic cancer therapy services there are plans in place to roll out the organization's medication reconciliation processes by June 2014.

The organization has implemented the dangerous abbreviations list and have also implemented the Tall Man process for sound alike medications.

There are processes and guidelines in place to handle spills of systemic cancer therapy medication. The organization has developed a spills kit that is provided to each client when they are involved in administering their medication at home. They are provided with a comprehensive education on medication management and spills management.

All protocols are computerized through their OPIS (Oncology Patient Information System) system and readily available to staff. The staff feel that this system has gone a long way in promoting client safety.

The pharmacy staff are involved in a number of research projects and have been instrumental in developing and submitting a proposal to the American College of Oncology to develop a quality initiative on developing processes and education on oral chemotherapy medications.

3.2.3 Standards Set: Biomedical Laboratory Services

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

Surveyor comments on the priority process(es)
Priority Process: Diagnostic Services: Laboratory
Please see comments under Laboratory and Blood Services: Diagnostic services, Laboratory.

3.2.4 Standards Set: Blood Bank and Transfusion Services

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

Surveyor comments on the priority process(es)
Priority Process: Blood Services
A standardized process for handling requests for blood and blood components is in place including urgent requests where the recipient's identity is unknown. No drugs or medications are added to blood components. There are many standardized procedures in place to infuse transfusions including the identification and management of transfusion-related reactions, length of transfusion among others. There are processes in place for the recalling and disposing of blood and blood products.

3.2.5 Standards Set: Cancer Care and Oncology Services

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The oncology services covered during this survey included the inpatient oncology units at the Mississauga site and at the Credit Valley site.

The organization had identified oncology clients were admitted all over their facilities in off-service beds. As such, these clients were not experiencing the level of care that they could receive from staff who specialize in oncology services. This led to the creation of oncology units, which now provide care for oncology, and in some cases, palliative patients on the same unit with staff specifically trained to treat and care for oncology and palliative care clients. The result of this change in service provision has created a high level of client and staff satisfaction.

The team completes a palliative care discharge checklist that is designed to facilitate Community Care Access Centre (CCAC) referrals for home care. The team works closely with their CCAC partners and have received good feedback on how useful the form is for improving the transition of client services from the program to CCAC.

The oncology units have developed quality boards that outlines their goals and objectives. Each unit has developed quality initiatives that include hospital wide goals, program goals and unit goals, all of which are aligned to the strategic directions of Trillium Health Partners (THP). The teams review their quality board on a regular basis. A huddle was observed during the survey and it was obvious from the discussion that staff are fully engaged in the quality process. They are encouraged to continue to work to merge their initiatives from each of these units so that they can do some comparative data analyses between sites.

Staff interviewed during the onsite survey indicated that they have the supplies and equipment needed to perform their job. The units at both facilities are spacious and staff state stated they enjoy working in this environment. They have developed an effective interdisciplinary team approach to care.

The team members feel that they have the support needed to provide quality cancer and oncology services. They have made a strong commitment to providing clinical placement opportunities for students from a number of professional disciplines. THP has a robust volunteer service.

Priority Process: Competency

Each oncology unit have access to nurse educators who are responsible for the ongoing learning needs of the nursing staff. There is an annual commitment to train nursing staff on infusions pumps. The educators are able to provide evidence of lists of staff who have attended this year's annual infusion pump training.

Staff interviewed identified that they have ample access to education and training specific to the deliver of cancer care. The De Souza course is mandatory for all new staff and they have made good progress in making sure that their existing staff also have the opportunity to attend this course. The staff have also received training on the foundations of oncology care, oncology nursing certification and palliative care.

All staff interviewed indicated that they had received a performance review within the last 12 to 18 months. They reported that the review included developmental needs and that they were supported in getting the education and training they had identified as a priority.

Part of the review of their quality board includes staff recognition. Staff are invited to recognize members of the team for their contribution. Team members report that staff recognition is an active part of their quality review and is greatly appreciated.

Priority Process: Episode of Care

The teams in oncology are interdisciplinary and inclusive. Bullet rounds were observed at the Mississauga site that included nursing staff, social workers, physiotherapists, occupational therapists, rehab assistants, dieticians, pharmacist and a physician. All team members were engaged in the process which included a thorough review of each client. Client profiles were update as the rounds progressed through the use of a mobile computer system.

Clients interviewed at the Mississauga and Credit Valley sites indicated a high level of satisfaction with their service and in particular with the staff in both of these units. Clients report that they have access to social workers and spiritual workers for emotional support and counselling. They report that staff are very good at assessing their emotional needs and offering them support.

Staff are encouraged to inform clients about how to address their issues and concerns. Clients interviewed indicated that they were not informed about how to place a complaint. The information is available in their admission package which is provided to each client and may need to be re-enforced verbally by the staff.

Clients are provided with a copy of the organization's Simple Steps for Your Safe Hospital Stay (PARTNERS) brochure which outlines their responsibilities to promote client safety. This information is also posted in key areas throughout the units. Once clients were given clues by the surveyor as to safety issues, they were able to verbalize that the staff had discussed the information with them but they had not necessarily recognised it

as their responsibility. The staff are encouraged to introduce their discussion on safety by using language that emphasizes that safety is everyone's responsibility and that the client has an important role in promoting safety.

The oncology program has a wealth of information available to clients that is posted on the unit for easy access. Their quality board is also posted on the unit for staff, clients and families to view.

Priority Process: Decision Support

Client records within the organization are in a transition mode, with some parts of the record in hard copy while other parts are recorded electronically. Each unit is at slightly different stages of developing their electronic charts. They feel that they are able to maintain continuity of information within the team through their bullet rounds, case reviews and their client profile documentation. There is a possibility of fragmentation of client information with the chart divided as it is. At the Mississauga site there is no interdisciplinary charting of progress notes as some of the team members chart in hard copy while others chart electronically. At the Credit Valley site all team members chart on an interdisciplinary progress note in hard copy with some tests results reported electronically.

The oncology unit at the Credit Valley site does not have access to their electronic orders OPIS (Oncology Patient Information System) and are required to print the protocols off in hard copy to have the physicians manually compete protocols for the dosages for medication.

Priority Process: Impact on Outcomes

The organization monitors client satisfaction and the team receives feedback on the overall results for the oncology program on site.

The oncology units at Mississauga and Credit Valley are beginning the process of merging their protocols and policies. They are encouraged to continue this valuable work to further enhance the culture of one program two sites.

The teams routinely screen clients at risk of falls and measure their fall rates as a unit goal for their quality improvement initiative. There is an electronic process in place for adverse events reporting and staff report that they feel comfortable in reporting incidents. Staff commented on the safety huddles they use to review adverse events as a learning process and an opportunity for improvement.

Client satisfaction is a corporate priority which is reflected in the programs quality boards. Teams have adopted the AIDET (Acknowledge, Introduction, Duration, Explanation and Thank You) approach as an action plan to improve client satisfaction.

3.2.6 Standards Set: Critical Care

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
2.2 The team's goals and objectives for its critical care services are measurable and specific.	
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

For the purposes of this review, all of the intensive care units at Trillium Health Partners (THP) were visited during the survey . At the Credit Valley site, a coronary care unit, a general intensive care unit (ICU) and a neonatal intensive care unit (NICU) were assessed. At the Mississauga site, a critical care unit (CCU), a NICU, a general ICU, and a post cardiac surgery unit were assessed. The overwhelming topic of concern at each site was the ongoing incomplete amalgamation into THP. On the whole this is being met with a very positive attitude, but with cautious anticipation and general cooperation.

The leadership personnel at THP is very impressive. They all knowledgeable and capable people. The enthusiasm for their work is palpable. They all run very open and cooperative teams, and it appears the attitudes of the clinical leaders have rubbed off onto all the members of their teams. All the members of their teams are eager to share the knowledge of their units and are proud of their accomplishments and the job they are doing. The general morale is very high.

There is a plan for a combined steering committee for the critical care areas at THP, that will assess and manage the higher level of organization. Many of the services provided have been vetted by the Local Health

Integration Network (LHIN) and other provincial bodies that allocate acute care resources. Some of the delivery areas have had longstanding goals and objectives, policies and procedures and standards. The objective now will be to consolidate and be sure that these are the same at both sites. The establishment of the overall steering committee is a step in that direction.

Priority Process: Competency

Several team members from each unit were interviewed during the survey. They all had adequate basic training, and all had additional specialized training. There is an orientation and mentoring process in place for all new members. There is continuing medical specialty training offered, both on a voluntary and compulsory basis, depending on the program. All areas have adequate support from interdisciplinary personnel. Roles and responsibilities are clearly delineated however, there is the possibility of sharing at all levels.

Excellent evidence of ongoing inter-team communication and ability to contribute to the monitoring and ongoing development of the team was displayed. Performance evaluations are current and informal feedback is provided on a regular basis. " Bullet" rounds" are held daily and huddles occur to keep all team members informed of patient progress. Handover rounds are done at the bedside -providing improved patient contact and information exchange at all levels, including the patient and family.

Priority Process: Episode of Care

Overall the most impressive characteristic of all the teams surveyed is the enthusiasm for their units and their role in the unit. This applies from the head administrator down to the cleaning staff. Everyone feels valued and that their opinion counts in the running of their unit. Staff were not shy about sharing their opinions about their part in running the unit, even in the presence of their superiors. The activities of the teams of all units assessed were very patient and family centered. Priority was given to interaction with patients and their families. The psychosocial needs of the patient and their families are assessed at the time of admission and ongoing assessments are made on a regular basis. Every effort is made to keep the patient and their family aware of developments. Provisions are made for ongoing medical support for the patient and family after discharge as well. If the patient has advance directives for care, such as DNR preference, this is discussed to ensure the patient fully understands the consequences of their choice.

Nurses on the units are aware of the patients' medications and their effects and side effects, but medication management is done by a clinical pharmacist, who was available on all units surveyed. Medications are reviewed both by the attending nurse, and by the clinical pharmacist upon admission and discharge to/from the unit. A best possible medication history (BPMH) is made up for each patient by the clinical pharmacist.

All units practice appropriate protocols for DVT prevention and pressure ulcer prevention. Many other protocols are in place, depending on the nature of the unit. All protocols are reviewed and updated regularly, and staff members are expected to be proficient with them. Staff are reassessed on most protocols annually. All staff have an annual review and assessment with feedback.

Priority Process: Decision Support

The teams for all units surveyed have a commitment to accurate recording of all pertinent patient information in an easily accessible way. Confidentiality is well understood by the staff. Guidelines for care are available and are reviewed on a regular basis. All team members receive updates and training on new technology. The charting is always accessible, but sometimes charts are difficult to find or not readily accessible to all team members in a timely fashion. Also, progress notes are kept in a piecemeal fashion with separate note areas for doctors, nurses and support services.

Priority Process: Impact on Outcomes

All the units visited had excellent protocols in place to have a positive impact on outcomes. General protocols for DVT, pressure ulcers and many other protocols are being used. Any adverse events are thoroughly reviewed by the leadership as well as by the staff of each unit in general. Positive events and outstanding nursing care are also celebrated.

The team and team leaders keep the family and the patient well informed on a formal and informal basis. Staff are readily available to the patient and the family at all times. There are care maps and plans that permit continued monitoring and re-evaluation of all patients. Transitional information is complete and "hand-offs" would appear to be seamless.

Priority Process: Organ and Tissue Donation

The Trillium Gift of Life protocol is followed by all units, and all staff have a thorough understanding of it. This protocol is instituted quite often and the staff in all units are appreciative of the service and support provided. There would appear to be no conflicts of interest and the program runs very smoothly. Final discharge paperwork is not complete without recognition of notification to this program.

3.2.7 Standards Set: Diagnostic Imaging Services

Unmet Criteria	High Priority Criteria
Priority Process: Diagnostic Services: Imaging	
4.1 The physical environment has clear signage in place to direct clients to the imaging service.	
Surveyor comments on the priority process(es)	
Priority Process: Diagnostic Services: Imaging	

A total of 7 hours was spent within the 3 diagnostic imaging programs across Trillium Health Partners (THP) during the survey. Modality specific discussions took place in the following areas: mammography, nuclear medicine, bone mineral densitometry, ultrasound, computed tomography (CT) , magnetic resonance imaging (MRI), general radiography, and angio. Efforts were made to speak with staff in all areas, with discussions revolving around a number areas.

The team is commended for its efforts to invest in the overall structure of the program to reinforce accountability across the system. A new manager at the Mississauga site and a medical program director across all sites are noted with approval. The response to the recent public dialogue in diagnostic imaging at THP has been appropriate and has reflected the organization's commitment to ongoing quality improvement. All necessary disclosure channels were followed, and the organizations's ongoing auditing efforts are noted with approval. Unfortunately, any health care system is susceptible to errors and our obligation as health leaders is to make every effort to improve processes to limit these errors, and to continually learn from and improve systems of care for our patients as a result our experiences.

The program's overall commitment to quality was evident. Quality boards were visible throughout, and appeared to be regularly viewed. At least one site was "bringing the board" to the modality staff which, if possible, may want to be addressed as it does not reinforce one of the principles of huddles which is: bring different perspectives to bear on issues. That said, all modalities were very engaged in quality and were very aware of the importance of continually addressing improvement opportunities. A good example of this was the focus across the CT modality to continually reduce radiation exposure, either in individual studies or through alternate modalities.

Wait lists were managed appropriately with significant efforts placed on minimizing as appropriate. Level loading across sites was an area of focus if it was felt it could be of benefit to patients with MRI and breast biopsies. All staff were asked about processes followed for equipment maintenance and safety protocols. All processes were well documented and staff were well versed in all requirements. Radiation safety officers were in place and the survey team had an opportunity to review safety protocols in place. All staff were aware of the safety protocols they needed to follow, including their responsibility to involve their clients in safety discussions. Radioactive waste disposal was handled per standard, with staff being very aware and supportive of the processes to follow. Ultrasound probe reprocessing was reviewed and is addressed further in another section of the report. That said, areas for improvement were noted and are being actioned by the organization.

Processes utilized to monitor individual staff performance were noted with approval. Random auditing of technician work was regularly performed, with discussions individually or at modality meetings serving as

good venues to address opportunities for improvement. Radiologists were also involved in these discussions and provided valuable input into discussions. Protocols are continually under review and are being standardized across the 3 programs. With respect to radiologist quality assurance, the peer review processes under review are noted with approval.

Space was reviewed and seen is appropriate for the services provided. Certain areas were more accessible however all were deemed to met standards for service delivery. Upgrades are ongoing in selected areas, including the addition of an angio suite and a new digital radiography x-ray room. Signage and distance is somewhat of an issue, most notably at the Credit Valley site, however, the use of staff in directing and/or escorting patients to satellite waiting areas addresses this. As appropriate, staff are engaged in the planning of new space and the acquisition of new equipment, this is noted with approval. Education appears to be available for staff, including the mandatory on-line requirements, as well as conferences and other organization initiated opportunities.

The tone across all modalities across all sites was extremely positive, with staff very much engaged in their work, committed to improvement and very focused on providing the very best patient experience. This was reinforced through discussions with both patients and families and was evidenced through the written, formal feedback reviewed during the survey. The ongoing efforts to integrate services through the merger could continue to have a very positive impact on the delivery of medical imaging across THP. There is a clear commitment at the leadership level to see this occur and staff are very focused on ensuring that the services they offer are structured in the best possible way to meet patient needs.

3.2.8 Standards Set: Emergency Department

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.2	The team's goals and objectives are linked to benchmarking of bed availability in the Emergency Department, time to admission, client diversion to other facilities, and wait times.	
2.7	When delivering Emergency Department services, the team has access to equipment and supplies appropriate to the needs of the community or catchment area.	
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
6.7	The team measures ambulance offload response times, and sets and achieves target times for clients brought to the Emergency Department by EMS.	
6.8	The team monitors ambulance offload response times and uses this information to improve its services.	
7.7	The team informs clients in the waiting area of wait times for assessment and treatment.	
11.2	The team coordinates the client's services within the organization's in-patient health care services and with other health services outside the organization.	
Priority Process: Decision Support		
13.2	Staff and service providers use information technology to share information with the interdisciplinary team.	
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) consists of 3 locations: Mississauga site (100,000 visits), Credit Valley Site (100,000 visits) and Queensway Urgent Care Centre (65,000 visits) The medical and clinical leaders are responsible for unifying the policies, procedures and practices at the three sites. While this is a work in process, there is agreement that all new policies apply at all three locations. The review of policies is ongoing with an ultimate goal of complete unification.

The Mississauga site is a dated facility with marked space limitations. The space limitations are exacerbated by a large number of admitted patients most of the time. Credit Valley is a newer facility but is still space-constrained. Queensway Urgent Care Centre is a more modern facility that was constructed to accommodate 40,000 patients and currently serves over 65,000.

The major risk issue for the ED is patients admitted to the ED and awaiting placement on a nursing unit. The problem is prevalent at both the Mississauga and the Credit Valley sites. Although the wait time is greater at the Credit Valley site, the disruption of work flow is greater at the Mississauga site due to the much more limited available space.

The quality board at each site reflects the overall strategies of access and sustainability. Wait times are tracked at all sites and reported in daily huddles as are hand hygiene rates and patient satisfaction.

Privacy is a major concern at the Mississauga site because of limitations of space and the configuration of the unit. It is a lesser concern at Credit Valley, and Queensway, but still an important issue.

Priority Process: Competency

The organization has developed a position known as the diagnostic imaging (DI) controller, who facilitates the timing of DI procedures and ensures patients are properly prepared for the procedure. This has significantly improved flow in the ED at the Mississauga site. Other positions that have been developed and that improve patient flow or care include: geriatric nurse practitioner at the Credit Valley site; a physiotherapist, a speech language pathologist and a part time occupational therapist at the Credit Valley Site; and a flow coordinator at the Queensway and Mississauga sites.

The organization has used the provincial new grad initiative of the MOHLTC as a recruitment strategy for staff in the ED. This allows for an intensive and effective training to occur. Senior staff participate by mentoring and supporting new graduates in the department. It is noted that the ED has a high turnover of staff, particularly in nursing, hence the importance of the program and the support from senior staff personnel.

All ED staff are trained in de-escalation techniques for control of violent patients.

Priority Process: Episode of Care

The three emergency departments at Trillium Healthcare Partners are active and busy units. The Mississauga and Credit Valley sites operate 24/7. The Queensway site is open 14 hours each day and is an urgent care centre. All patients who ask for service are managed. The Credit Valley site has developed a system to offload ambulances and the average time is currently 27 minutes. At the Mississauga site, offload is a lingering problem. Emergency medical services (EMS) personnel frequently wait over 2 hours before offload is complete.

The medical record at the Mississauga and Queensway sites is a paper record. At the Credit Valley site, it is a hybrid record with some digital components and others paper driven. At all three sites, PACS and clinical results are available electronically.

Triage at all sites is completed well within acceptable time limits and re-triage is done frequently. Patients are distributed to lower risk vs higher risk areas based on their triage status. All patients levelled 1 or 2 based upon Canadian Triage and Acuity Scale (CTAS) are seen by a physician immediately. All routine lab services are available 24/7, but CT scan is unavailable between 2200 and 0700 at the Credit Valley site and ultrasound is unavailable except by call back after 2200.
Pain is assessed by the triage nurse and the team in the area to which the patient is sent. A 10 point scale is used and a pictograph is used for patients who are unable to communicate due to language barriers. The pain assessment includes a follow-up if pain medication is administered.

A formalized transfer process occurs at all locations, and a direct communication between the sending nurse and the receiving nurse is done.

Medication reconciliation is done for all patients who are admitted to the unit.

Priority Process: Decision Support

The record at the Mississauga site is a paper record. The team has access to lab results through Meditech and imaging results through the PACS system. The record at the Credit Valley site is a hybrid record. A number of pre-printed order sets are used for frequently encountered problems.

Priority Process: Impact on Outcomes

All staff are trained in de-escalation techniques for violent patients. Also, trained security personnel are present in the ED at all times.

The quality board and daily huddles are used to address organizational and unit based quality initiatives including patient safety undertakings.

It is noted that patient satisfaction is relatively low at the present time, based on recent survey data. The most frequent complaint is about wait time, whether or not the patient is admitted. It would be of value to determine if the satisfaction is higher in the Rapid Assessment Zone vs other areas of the ED and whether satisfaction is different amongst patients admitted through the ED and awaiting bed placement.

Priority Process: Organ and Tissue Donation

The primary role for organ donation in emergency department is tissue donation. Trillium Gift of Life is notified of all deaths occurring in ED. The team has developed an algorithm to ensure all measures necessary have been considered. The team works with critical care for solid organ donation.

3.2.9 Standards Set: Infection Prevention and Control

Unmet Criteria		High Priority Criteria
Priority Process: Infection Prevention and Control		
4.7	The organization reviews and updates its policies and procedures at least every three years, and as new information becomes available.	
10.4	The organization monitors its heating, ventilation and air-conditioning (HVAC) systems and the air quality in its physical environment.	!
12.4	The staff member soaks, flushes, and cleans each device in a timely way to remove inorganic and organic matter on the device.	
13.4	All endoscope reprocessing areas are equipped with separate clean and decontamination work areas as well as storage, dedicated plumbing and drains, and proper air ventilation.	!
13.11	The organization stores endoscopy devices in a manner that minimizes contamination or damage.	!

Surveyor comments on the priority process(es)

Priority Process: Infection Prevention and Control

The infection prevention and control (IPC) team at Trillium Health Partners (THP) gathers meaningful and current data that is used to affect program, policy and education provided to staff. The allocation of knowledgeable staff resources to the infection control program is to be commended. The IPC team is excellent and very patient focused. The monitoring of environmental cleaning along with the dedicated and quality oriented staff is strength of the organization.

The endoscopy suite at the Mississauga site requires consideration for renovation. The space requires two separate rooms, a one-way flow, proper ventilation, and more square footage. The present space lacks all of these requirements and is an occupational health and safety risk. Due to the restricted space and design of the area, patient flow, confidentiality and equipment flow require improvement but in the present setting the staff performs the procedures to the best of their ability. The endoscopy staff is well trained, knowledgeable and quality focused. Storage of endoscopes requires a closed clean area, but the cabinets do not have Hepa filters and require closed sealed doors to maintain air flow. New cabinets have been approved for purchase and need to meet these requirements.

Policies and procedures are in the process of being amalgamated and it will be important that this is completed shortly to standardize practice across the partners and ensure they meet the three year review. The monitoring of the heating, ventilation and air conditioning in the endoscopy areas, operating rooms and reprocessing areas needs improvement. The process of point of use procedure for instrumentation prior to transport needs to be reviewed as presently sets are transported with gross soil and not moist.

3.2.10 Standards Set: Laboratory and Blood Services

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

The organization has met all criteria for this priority process.

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

The department collects workload and utilization data on a regular basis. Utilization trends are routinely evaluated and there is ongoing review of the impact of demand on workload and staffing.

A new staff category, medical laboratory assistant (MLA) has facilitated the processing of workload across the department.

An impact analysis is conducted for new medical staff coming on board in order to measure the impact of additional tests on \laboratory workload and costs.

Laboratory services are physically located at each site and a new space has recently opened at the Credit Valley site.Space at the Mississauga site is tight and the location of the Queensway site presents risks in the event of flooding. The department provides a full level of services. New equipment designed to provide additional capacity and more efficient processing has been implemented. For example, the state of the art Dimension Vista C500 chemistry analyzer at the Mississauga site and the Lab Line system at the Credit Valley site enhances patient safety by ensuring identification of histology and pathology samples at all stages of investigation.

Roles and practices have been standardized across all sites and there are position descriptions for all roles. The performance of staff is reviewed on a regular basis and risks, turnaround time for reporting of results and other indicators are routinely monitored. Laboratory services are available on a 24/7 basis and delivery of samples is enhanced through the use of a pneumatic tube system.

Laboratory staff inform staff of utilization patterns. Laboratory staff are routinely apprised of changes in legislation and standards that impact on practice.

Comprehensive infection control practices are in place and staff receive training in infection control techniques.

The staff have used the ethics framework and have identified potential applications of the framework.

Processes are in place to deal with spills, safety and reagent control.

The laboratory is commended for the breadth and depth of services provided that support care, for the commitment to patient safety and for the expertise and professionalism of the staff.

Also notable are the innovative practices that have been established. A case in point is the establishment of the clinical genetics service..

3.2.11 Standards Set: Managing Medications

Unmet Criteria	High Priority Criteria
Priority Process: Medication Management	
15.2 The organization has medication delivery turn-around times for emergency, urgent, and routine medications.	
Surveyor comments on the priority process(es)	
Priority Process: Medication Management	

With the establishment of the new organization, the key stakeholders in the medication management priority process have been working diligently to harmonize all policies and process related to medication. Reporting to a single medical advisory committee (MAC), the re-constituted pharmacy and therapeutics committee has been working toward the harmonization of polices and procedures as well as the formulary. This work is proceeding well. The pharmacy department provides significant visionary leadership in this process. The enthusiastic and committed pharmacists and pharmacy technicians on the team make significant contributions to patient care and have contributed to the implementation of many key initiatives in relation to the required organizational practices. Pharmacists are assigned to in-patient and ambulatory care areas and perform a variety of unique roles (e.g. IVto PO step down, vancomycin dosing, pre-operative medication reconciliation, etc).

It is noteworthy that the antimicrobial stewardship program has been in place since 2011. It was initially implemented in the intensive care unit (ICU) area and has continued to grow. Antibiotic utilization has declined by approximately 10% since the implementation of the program and pharmacists are involved in supporting the process across the organization. The process has also been effective in influencing antibiotic prescribing patterns.

It is also noteworthy that the VTE prophylaxis process has been implemented across the organization and there are protocols in place to guide clinicians in the identification of those patients who require VTE prophylaxis as well as for actual treatment. Pharmacy regularly audits compliance with the protocol. Through an innovative use of trained pharmacy students, additional efforts were applied to the identification of patients requiring VTE prophylaxis and this resulted in a significant improvement in VTE prophylaxis rates ate each site. Protocols for VTE prophylaxis also appear on order sets where appropriate.

Policies and procedures have also been implemented to minimize the number of concentrations of medications available, limit the concentrations of heparin and narcotics on patient care areas and to remove concentrated electrolytes from patient care areas. Where stronger concentrations are required, with the approval of the pharmacy and therapeutics committee, mechanisms have been established to control the use of such products and to maintain patient safety. Pharmacy staff audit compliance with these policies on a regular basis.

The organization has also approved a list of "do not use" abbreviations and these are manifested in all order sets, pharmacy system output and elsewhere. The "do not use" listing appears in all medication administration records (MAR)binders across the organization. Pharmacy staff regularly audit compliance with this policy.

It is also evident that staff use two identifiers when entering medication orders (in pharmacy) and when administering medication to patients. There is also evidence that nursing staff receive ongoing training on infusion pumps.

Although Medication Reconciliation is not part of the medication management priority process, the role of pharmacy staff in implementing this process across the organization is commended. The department has trained a number of pharmacy technicians to conduct best possible medication histories (BPMHs) against which admission orders are subsequently reconciled. The impact of this initiative is that approximately 90% of all inpatients receive medication reconciliation of admission. There are also processes in place for medication reconciliation of transfer and at discharge . Pharmacy staff have been instrumental in facilitating compliance with this policy.

There is considerable quality monitoring in place in pharmacy as drug use evaluation pharmacists play a significant role in supporting the work of the pharmacy and therapeutics committee and by conducting medication use evaluation initiatives such as the restrictions against the use of codeine in children and adolescents.

Pharmacy is also committed to education on many fronts and presents pharmacy grand rounds on a monthly basis. One recent presentation was on the new oral anticoagulants. It is also a training site for pharmacy students, pharmacy technician students, Pharm D students among others. Approximately 110 students will be trained at THP next year as a function of the new pharmacy curriculum at the University of Toronto.

In terms of systems, the technology supporting medication management have not been harmonized at this point in time as there are differences across the sites. Pharmacy utilizes the relevant modules of the Meditech system , however, the versions are not identical. As well, there are two types of intravenous pumps in use across the organization, one site using the Baxter pump and the other using the Hospira pump. There are two systems in place to generate medication reconciliation reports, however, there is a plan in place to harmonize these by standardizing on one. Medication orders are being hand written, as opposed to a computerized physician order entry (CPOE) system. Order sets currently in place will serve as a precursor for CPOE. The documentation of medication administration is still done manually on the MARs generated by the pharmacy system. The process of bar-code verification of medication administration is being piloted on some units at the Credit Valley site. In terms of technology, the Credit Valley site has implemented Omnicell units for ward stock and narcotics across the site. These units have not been implemented at the Mississauga site.

In terms of physical space, the size of the pharmacy at the Mississauga site is 6,600 square feet and the size of the Credit Valley site pharmacy is 6,400 square feet. The intravenous preparation room at the Credit Valley site is outdated and does not meet USP 797 standards and as such cannot be used to prepare cytotoxic preparations. Consideration should be given to renovating this room up to USP 797 standards.

3.2.12 Standards Set: Medicine Services

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
2.2 The team's goals and objectives for its medicine services are measurable and specific.	
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 integration of two acute care institutions with a new organizational format has presented many challenges and opportunities to this group. The physician lead for general internal medicine is in an interim position and will be replaced in 6 weeks. However a great deal of work has been done to facilitate integration of the programs with early alignment of service delivery, integration of physicians, polices and procedures. Some pre-merger programs have been enhanced (e.g. diabetes outpatient clinic, acute stroke and dialysis services). The team is addressing goals and objectives that can be applied and measured across all sites but this process is in its early development stage and not yet measurable.

There is, and has been considerable, consultation with the community and varied stakeholders as to the services required and desired. Location of these services is deemed important from an efficiency point of view and from a '"dislocation" aspect. The strategic plan of the merged organization has been a significant driver and overall the intent is to provide as much care as possible within the community to minimize hospitalizations and keep the inpatient space for those that need true acute services.

The Mississauga Academy of Medicine will be a significant driver in the ongoing development and maturation of the entire structure and onus for this program.

The paediatric services are a model of planning response to community need and service delivery. The Credit Valley site has been designated as a regional paediatric site and takes some guidance from the LHIN and the

province with regard to service provision. The leadership team is very cognizant of the changing dynamics and the desire to consolidate services yet provide a suitable environment and location for the community users. There is ample evidence of data collection and application utilizing best practice and evidence based guidelines in all areas and the desire to fully integrate the program from the legacy organization is very strong. The attitude, enthusiasm and confidence of the staff is palpable.

Fast tracking of oncology patients by avoiding the ER, is an excellent method to maintain continuity and consistency of care for a vulnerable cadre of patients. The Credit Valley oncology program is closely linked with Sick-Kids Hospital and the control of the transition into the adult world is with them. There needs to be consideration of trying to ally this adult care with the adult care programs at the Credit Valley site.

The patient and family- friendly environment at the Credit Valley site is tremendous and has the ability to fulfil the whole community needs for the foreseeable future.

Priority Process: Competency

There are strong multidisciplinary teams with all the skills necessary to provide the varied services required. Clinical educators help orient, educate and mentor all staff; they are an integral component of the care team. Skill assessment is done regularly in conjunction with the clinical leaders and documentation is kept on location.

The staff all feel very confident in their abilities to provide suggestions, report adverse events and discuss quality issues both within team meetings and the huddle formats. Team members recognize and laud their team members when appropriate. The manager is responsible for regular performance evaluations and gets feedback from the clinical leaders etc.

Priority Process: Episode of Care

There is tremendous sense of "team" on all units in all sites. There is enthusiasm, engagement and cooperation among all caregivers and a full sense of shared responsibility for the patient. Patients are acutely aware of the team and who is responsible for looking after their needs. Care plans are in place and regularly reviewed, modified and updated by the team members in a forum that permits continuity of care but also provides opportunities for education of the staff. Follow-up phone calls to discharged patients is just beginning for some units but there is plan by the program to have this fully utilized in the near future.

All risk issues are identified at an early stage and education is provided and regular monitoring occurs. Ethical issues may be identified by team members and access to ethicist consultation is easy to acquire. All staff are aware of the process. Death with dignity is important and there are processes in place for grief debrief and counselling.

Priority Process: Decision Support

Charting is a combination of electronic and paper-based, hopefully this will be consolidated at some future point. All service providers have good access to this information and there is adequate computer stations for use by all providers.
Clinical pathways are no longer used on a regular basis, however best practice and evidence-based guidelines are utilized throughout the organization with standardized approaches and consistency of care delivery. There is some difference between the two sites, however the overall teams are in the process of consolidating and modifying some of the processes for utilizing this information.

Priority Process: Impact on Outcomes

There is abundant safety and educational materials available for patients and families and the service team is very aware of all safety issues such as falls prevention, hand hygiene and pressure ulcer prevention. The institution of quality huddles allows for a forum for immediate identification and mediation of risks.

There is awareness of the need to report possible adverse events and the staff is very comfortable with the process and appreciate the feedback from quality/risk assessors. Much of this information is exchanged at the huddle rounds. Disclosure, where necessary, is done with a team of caregivers and quality team members.

3.2.13 Standards Set: Mental Health Services

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The mental health program provides care to a wide variety of patients for both in-patient and out-patient settings at Trillium Health Partners (THP).The program is structured across five "pillars": acute adult mental health, ambulatory adult mental health services, child and adolescent services, medical psychiatry services/specialized services and seniors mental health services. Program leadership includes a chief and medical director and program director dyad. Each pillar is lead by a physician/clinical manager dyad. An advisory group to the mental health program and clinical programs committee support this structure.

It is evident that the structure of this program has yielded a number of benefits in terms of access to services, the integration of service delivery across the program, accountability and continuity of care such that patients do not fall through the cracks. It is evident that all elements of the program work together and implement appropriate hand-offs as required so that patients can move from one level of care within the program to another as dictated by their clinical status. It is also evident that the pillars are not silos as staff have cross-pillar roles and responsibilities.

As well, from a human capital perspective, program leadership have adopted an approach to leadership whereby the goal of the structure is to establish an environment where all front-line staff feel engaged in the process and intake ownership for their role in the development of the program. The interdisciplinary approach to care is an essential part of the service delivery model. As this model continues to develop, it is also evident that there is an increasing emphasis on incorporating academic vigour into the decision-making process. Staff are encouraged to provide suggestions supported by the literature. The ability to conduct research and to publish is also evident as per the mental health first aid for seniors initiative.

The program has an inclusive process for developing its goals and objectives. There is an annual visioning day and four goals have been developed including the development of a partial hospital program and improving the intake process. Program goals are linked to the organization's strategic plan. Of particular significance is the proposal to create a central intake process in conjunction with the LHIN.

There is evidence of collaboration with other organizations and stakeholders. Through the "Pro Quest" system, for example, staff at THP can view clinical records of patients coming from other hospitals in the Toronto area.The Child and Youth service ,for example, has conducted focus groups with community agencies and has working relationships with school boards.

It is also evident that there is a culture of safety across the program and staff were very forthcoming in providing examples. It is evident that there is a commitment to patient safety and many examples of tools that have been implemented, in particular, an emphasis on safety in care planning. There is also mandatory staff training in crisis Prevention Intervention (CPI) and the revised processes for seclusion and restraints through the use of least restraints, de-escalation and the offering of medication has correlated with a significant reduction in code white calls, by approximately 50%. All staff in the program receive suicide prevention training through the ASIST program (Applied Suicide Intervention Skills Training) every two years. A 2007 publication documented the impact of this program on outcomes.

Patient satisfaction surveys have been conducted and staff are encouraged to interact positively with patients according to the AIDET (Acknowledge, Introduction, Duration, Explanation and Thank You) approach. There are daily huddles at the quality board and AIDET is one of the quality measures tracked on a daily basis. Physicians participate in the daily huddles as well. The program has developed a document entitled "your rights and responsibilities" for patients.

Incidents are documented and tracked in the RiskPro system and the implementation of corrective action is undertaken as a team. There is no culture of blame evident in the workplace. Staff have indicated that there is a supportive culture and that they have been provided training in a variety of modalities including CPR, non-violent crisis intervention, suicide prevention, code white among others.

Priority Process: Competency

It is evident that there are highly-functioning interdisciplinary teams across the program and that each member has defined roles and responsibilities. Members of the team understand each other's roles.

As indicated in the Clinical Leadership section, staff across the program collaborate to provide continuity of care for all patients so that patients can move from one level of care to another within the program as required. Staff receive a variety of training , for example, ASIST suicide prevention training.

All staff have position descriptions and performance reviews are carried out on a regular basis.

Priority Process: Episode of Care

The majority of in-patients are admitted through the emergency department (ED) where there is a triage system in place to assess the degree of risk. If the presenting problem is sufficiently severe, the patient will be admitted following medical clearance. The organization is commended for assigning a psychiatrist to the ED to assess these patients. In the case of seniors, some may come from home, long term care (LTC) or a medical unit in the hospital. In this regard, a noteworthy initiative has been implemented whereby a

screening tool is used to identify seniors on acute care units whose behaviour is such that the acute care unit is not a suitable place for them. If they meet certain criteria, they are then transferred to the seniors' mental health unit where appropriate care is provided. In the eating disorders service, referral is made by a physician, followed by an an initial assessment after which time the patient will be assigned to the in-patient unit and subsequently day hospital and then a transitional program. The program is commended for implementing a psycho educational program for those who are awaiting admission. This has the effect of preparing the patient for the admission and providing interim strategies for dealing with their symptoms. In most cases, this allows for a smoother transition through the process. One of the innovative services in place is the telemental health service whereby potential patients referred by family practitioners and other community partners are interviewed remotely through teleconferencing. There is a centralized intake in place to receive referalls and to perform triage. The ambulatory care seniors' mental health program takes referrals and conducts comprehensive home visits as necessary to assess the clinical and safety needs of potential patients.

Assessment is carried out by psychiatrists and members of the various disciplines from their perspectives. There is evidence of ongoing risk assessment in terms of suicide risk, falls risk and mental status. Risk assessment tools are standardized and available online. Medication reconciliation on admission is part of the initial assessment and there is evidence that this process is in place. Pharmacists support this process across the program. Patients are also assessed for any co-existing medical issues.

In terms of service planning, care plans are developed with the input of patients and families. Once the plan is developed, it is reviewed and updated as necessary. The care plan is online and changes to the plan are flagged. In the eating disorders service, an eating assessment is conducted and a plan is put in place geared to normalization of eating patterns and weight gain restoration such that target of reaching the normal BMI range is achieved. Families are invited to receive education and support around this process.

Treatment consists of a range of modalities including pharmacotherapy and psycho-social. On the seniors' in-patient unit, there is very little psychotherapy but considerable health teaching as well as GPA (gentle, persuasive approach).

There are various types of follow-up post-discharge. In the seniors' in-patient program, there is follow up through LTC facilities with the aim of reducing re-admission rates. In the eating disorders service, patients are offered names of resources post-discharge and are offered ongoing treatment with one of the psychiatrists.

Priority Process: Decision Support

There is evidence that the program uses current literature and evidence-based approaches for the design of its service delivery models. Program service deliver models are then constructed in the order set format. Order sets are evidence-based as well. Of particular note is the design of the eating disorders program.

The program also uses evidence -based decision making in making proposals for change. For example, it was determined that there was evidence that partial hospitalization can be as effective as in-patient care, hence, the inclusion of the development of a partial hospitalization program into the program's goals.

Evidence-based approaches were also used in the development of wait list management and the implementation of new practices.

Staff characterized the culture of the program as one of learning and provided many examples of learning opportunities.

Several examples of innovation and research were identified. The physician in the seniors' program has developed a screening tool for the detection of delirium in patients on medical units that may be used to asses and transfer patients out of the medical unit into the seniors' mental health program where they receive targeted care.

In the child/adloescent program a research proposal has been submitted to the research ethics board (REB) for the evaluation of a modality called ACT (acceptance and commitment therapy) which is similar to CBT (cognitive behavioural therapy) and potentially useful in mood regulation.

Of particular note is an initiative called the child and adolescent mental health task force which has been established to design the future state of child and adolescent mental health at THP. The major focus of this initiative is children and adolescents who present to the ED. Care of these patients will require changes in the way that they are triaged assessed and discharged, changes will also be proposed in terms of surge strategy and regional beds.

Data is used extensively to evaluate the program in terms of quality, access and sustainability in the form of a balanced scorecard generated by decision support. The program uses this data to review the impact of the program and to make adjustments as required.

The teams use tools such as MH-RAI and OMARS for patient assessment.

Priority Process: Impact on Outcomes

It is evident that the program utilizes data to inform the ongoing development of the program. Internal and external benchmarks are utilized to measure progress in achieving goals.

Risk assessment processes are embedded into the patient assessment processes and are repeated regularly to identify changes in levels of risk. There are ongoing safety risk assessments carried out across the program. Patients and families are participants in this process.

The organization utilizes the RiskPro software to document incidents and adverse events and all staff have immediate access to this program. Results and trends in incidents are shared with the program. Adverse events are disclosed in accordance with policy.

Patient satisfaction surveys are in place to determine patient perspectives on the quality of care that they receive.

3.2.14 Standards Set: Obstetrics Services

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Trillium Health Partners (THP) has one obstetric program at two sites, Mississauga and Credit Valley. The birthing suite, obstetric unit and the sexual assault and domestic violence unit were surveyed at the Mississauga site and the birthing suite and the mother baby units at Credit Valley were surveyed.

The birthing suite and obstetrics teams at both sites have developed program and unit goals and objectives which are aligned with the organizations strategic directions. The teams review their goals, objectives and results at regularly scheduled huddles. It was obvious that the staff have taken ownership of the process and were fully invested in achieving their targets.

The front line staff are aware of the organization's ethical format and were able to give examples of when they have made use of the ethical format and their ethical consultant to work through client related issues.

The teams have been heavily invested in the MORE ob (managing obstetrical risk efficiently) program and are continuing to develop their baby-friendly initiatives.

Clients interviewed during the survey spoke about how different their birthing experience was at the Mississauga site as compared to another hospital with a previous delivery, and in particular mentioned how much they appreciated that they had their baby room in on a 24-hour basis. They also talked about how the staff took care of the baby's needs in the room. The example they used was the baby baths. They also talked about the skin to skin initiative and that staff were very good at answering their questions and providing

them with the education they need. This was also confirmed at the Credit Valley site by clients interviewed at that site. A client was able to compare their experience at the Credit Valley site from a previous delivery at that site three years previously and express her opinion that her present experience was much improved on this occasion.

The teams at both sites are committed to improving client satisfaction and appear to be making very good progress based on the discussions with clients and families during the survey process. This organization has a very robust student and volunteer support program.

The programs collect information about their community and their clients. A recent example was the work they did with the LHIN to look at high risk pregnancies and how to serve that population better. They surveyed their client population and were able to give an example where they had received feedback that they were not responding in a timely way to call backs to the clients in their high risk pregnancy program. They looked at their communication process, made improvements, which translated into improved client satisfaction.

Priority Process: Competency

The interdisciplinary team is comprised of physicians, nurses, midwives, social workers, educators, manager, anaesthetist, ward clerks, and cleaning staff. Other team members are added when indicated such as pharmacy, dietician, physiotherapist and occupational therapists.

The medical staff are to be commended for their engagement as full participants in the interdisciplinary team process.

The teams feel that they have adequate space to maintain their interdisciplinary functions and meet regularly at rounds, case reviews and team meetings to facilitate and coordinate services to their clients.

The teams use the healthy workplace survey as a measure of their ability to function well as a team. They also feel that their commitment to the MORE ob program has improved their team functioning.

Nursing staff credentials and licensing are reviewed by human resources who notify the manager if any staff have not completed their licensing requirements within the annual deadline. Allied Health staff do a similar process through their professional practice units.

The organization has a robust orientation program for new staff that includes a general orientation to the organization as a whole, interdisciplinary practice as well as service specific orientation.

Staff in the obstetric units are required to use a number of different infusion pumps and receive training on the different pumps annually. They also have access to a nurse educators to assist them with the pumps if required. The educators maintain lists of all nursing staff education.

Each staff interviewed during the survey process had received a recent performance review within the last 12 to 18 months. They felt that the appraisal process was fair and that they were encouraged to identify developmental needs. They stated that they felt supported in achieving their education and training needs.

Staff recognition is a process built into the daily huddles with a posted recognition of exceptional service.

Priority Process: Episode of Care

The staff within the obstetrical program are the major factor in the client satisfaction. All clients and families interviewed at both sites spoke very highly of the skill and compassion of the team. Their commitment to quality care and their quality improvement initiatives are obvious. They have made tremendous progress in improving client satisfaction and in implementing their baby-friendly initiatives. The obstetric service has developed comprehensive educational material on their website to provide information about their services as well as for safe baby care.

Clients and families interviewed during the survey identified that they had the opportunity to tour the facility prior to delivering at the Mississauga site and that they have access to the information they needed to inform them about the birthing process and the services offered at that site. Credit Valley site has taken a different approach to informing clients by supporting the family practitioners and obstetricians in providing that information to client at their offices in the community setting. Their wellness nurse liaises with the physicians and Public Health to provide a seamless continuity of care from inpatients through to community care.

The client's record is divided with a portion of the chart completed electronically and a portion in hard copy. This has made it difficult to get a full picture of the client's assessment and progress.

The birthing units are based on a primary care nursing model with the nurse following the patient from admission and as the circulating nurse for the patient's C-section. This is also the nurse who is responsible for transporting the mother and baby form the operating room (OR) to the obstetrical unit. Nursing staff report that their workload is monitored to ensure that they are maintaining a balanced schedule to reduce stress and fatigue. Clients interviewed stated that they had access to services when needed and that staff respond quickly to address their questions and needs.

The population the organizations services is multicultural. They have developed their education and information materials in a number of different languages to meet the needs of the different cultural groups. They also have access to interpreters to assist clients who have difficulty with understanding English.

The teams are able to provide clients with access to emotional support, counselling and bereavement services. Social workers are an integral part of the team and are actively involved in addressing psychosocial issues to facilitate a good discharge processes. The teams have developed processes to assist each other in dealing with their own emotional stress related to complex birthing situations and bereavement issues. The birthing suite team at Credit Valley have developed a comprehensive program to assist mothers and their families through the bereavement process.

Clients are informed of their rights and are provided with information both verbally and in writing about their role in promoting safety with a brochure titled PARTNER. The clients interviewed were not able to identify that they have been informed of a formal complaints process. They felt that they could take their concerns to the staff and program manager if they had any issues. The organization is encouraged to verbally remind clients of their complaint process.

Although the team indicated that they have access to necessary diagnostic services, results and reports; they did indicate that they did not always receive ultrasound reports in a timely fashion.

The team at the Mississauga site has separated the clean and sterile supplies as suggested on their previous accreditation report. They do not have the capability to monitor humidity in the sterile storage area at the moment but there are plans in place to address this issue in the future. All sterilization is done centrally and is recorded for tracking purposes through the central sterilizing process.

Priority Process: Decision Support

Staff have ready access to client files, the only exception they noted was that they cannot get access to some of their information when the computer system is down. All access to client's electronic records is password protected.

There is evidence that the team maintains an accurate and up-to-date record for each client but as stated previously the record is divided between an electronic portion and a hard copy portion. Part of the team record their progress notes electronically while other team members record in hard copy. It is difficult to get a clear picture of client progress with this fragmentation of the records. It is hope that as they develop their electronic charting capabilities that all disciplines and all charting will be done in one medium.

The program has an established mechanism for sharing information between providers at transition points. Staff stated that they had received training on their information systems and were easily able to pull up the information on the client's electronic record.

The policies, procedures and protocols reviewed were comprehensive and referenced to best practice. The teams have been working with the MORE ob program for ten years and are implementing the WHO well baby initiative.

The organization is involved in research and are aware of the protocols, standards and consent processes.

It was noted that the program has protocols for each site, for example there is a protocol for induction of labour. Prostaglandin and cervidil for cervical ripening at both sites which were last reviewed in 2010 at the Mississauga site and in 2009 at the Credit Valley site. Creating a standardized protocol that can be adopted by both sites will be beneficial in promoting a women's and children's health clinical program at THP.

The organization has implemented a THP women's and children's clinical program committee which should be a good stepping stone to facilitating the concept of one program at two sites. They have developed a draft terms of reference and have identified a number of sub-committees on joint policy and education, ambulatory care, operations and baby friendly initiative. In discussion with the women's and children's program directors, there are future plans to review policies, procedures and protocols with the intent to create program policies, procedures and protocols. They are encouraged to actively engage in this process.

Priority Process: Impact on Outcomes

The team has developed unit specific goals that are reviewed regularly at their huddle sessions. They are making progress towards their targets and it is obvious from the lively discussion at huddles that they are invested in quality improvement. Staff were also aware of the indicators they are benchmarking and were proud of the fact that they were exceeding provincial outcomes in a number of their indicators. They post this information which is readily available for staff and clients to review.

The team is well versed in the importance of using two client identifiers. Clients interviewed confirmed that staff regular use two identifiers prior to providing services or procedures.

The team have modified their falls screening process to make it more specific to their client population. Any client identified at risk for a fall is provided with a falls prevention strategy and staff make sure that service providers are aware of the client's risk for falls. An example of an improvement they have made is the fact that clients and families are not to carry babies in their arms when walking on the unit but are to use the mobile cribs to protect mother and baby from falls.

In the Credit Valley Hospital, the staff looked at a project to change a process on how they draw blood for baby blood work as required by the province. The team partnered with laboratory services and changed the process with a transfer of function that has the nurses on the unit do the blood draw. They have evaluated the process and have noted that their recall rates are below the provincial benchmarks.

3.2.15 Standards Set: Rehabilitation Services

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
2.2 The team's goals and objectives for rehabilitation services are measurable and specific.	
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

Trillium Health Partners (THP) is a large organization with several areas providing rehabilitation services at all three sites. The level of rehabilitation is aligned with the acute care service provision including: cardiac rehab , neuro-muskuloskeletal, and long term continuing care. The new program also has responsibility for palliative care, complex care and primary care. There is evident passion amongst the leaders of this program and a keen sense of the need to improve services , decrease the institutional aspects of care and to integrate patients back into the community or an appropriate alternate facility.

The team has had considerable input from the community partners and also rely on the standards and directions that are being developed by the Regional Rehabilitation Council in conjunction with the directions from the LHIN. This group is slowly developing some goals and objectives with considerable input from the staff who acknowledge the ability to have input generated at the patient level and rising upwards through the unit managers and director. The organizational strategic plan is in the forefront as these goals are expanded and implemented.

The integration of legacy organizations has depleted previous barriers for sharing, transferring, and placement of patients within the units that are now available to THP. The rehabilitation services have been recognized as a "best practice spotlight organization".

The McCall centre is a collaborative effort between THP and Extendicare--policies , procedures and standards are the same as in the THP facilities. The 140 beds are a mixture of long term care, complex continuing care and interim level rehabilitation beds. The staff are very dedicated and the turn over is very low, presenting possible succession risks. Patients and families are very happy with the services provided. A recent redevelopment of this site has made it amenable to patients from all acute care sites , community and other institutions in the region.

Priority Process: Competency

The rehab service delivery teams, in each location, appear to be extremely cohesive and have great respect for each other. They deliver their various service components as a "family" with ongoing sharing, support and professionalism. New staff undergo relevant orientation and mentoring with the providers. All staff verbalised that performance evaluations were completed and that opportunities are available for education and career development. Recognition is evident through "shout-outs" that occur at staff huddles to compliment and recognise achievements.

Priority Process: Episode of Care

The entire care team shares a responsibility for the continuing management of the patient. Admission is completed with appropriate input concerning medications, transition notes, education and treatment / discharge plan. Input from the family and patient is incorporated into the development of care plans and regular updates are provided to the family either one-on-one or through team conferences.

All sites have access to required diagnostic services and acute care consultations and relocations are facilitated when necessary. Effective discharge planning is facilitated through the joint discharge operations (JDO) with cooperation of all parties (e.g. acute care, CCAC, LTC etc).

Priority Process: Decision Support

Record keeping is still a combination of paper charts and electronic records. Staff know how to access both modalities, but there are difficulties if one is not familiar and does not know where the pieces are. There is a need to amalgamate the IT systems and make the access to patient information seamless. Consideration should be made to consolidate the progress notes into a multi-intra disciplinary format so that the patients 'story" is consistent and in continuity.

There is a great deal of standardization and comparison with other like service delivery systems. The use of standardized approaches within best practice and clinical practice guidelines will benefit patient outcome an improve organizational efficiency.

Priority Process: Impact on Outcomes

Safety, both patient/family and staff, is a significant topic for all and is often addressed in the huddles, held regularly in all locations. All safety aspects such as falls, hand hygiene , pressure ulcers etc are discussed, monitored and reported through the leadership team and board.

Incident reporting mechanisms are in place and the staff is fully aware of these reporting tools and they are given appropriate feedback to "close the loop". Adverse events are investigated ,discussed and disclosed. Risks are identified early and patients and families are "on notice " with continued verbal and written education. Where necessary, entry and exit to units is controlled and monitored.

3.2.16 Priority Process: Surgical Procedures

Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge

Unmet Criteria		High Priority Criteria
Standards Set: Operating Rooms		
3.4	The surgical suite has three levels of increasingly restricted access: accessible areas, semi-restricted areas, and restricted areas.	!

Surveyor comments on the priority process(es)

The organization has committed excellent education resources to the surgical program teams and staff expressed satisfaction with educational opportunities. The surgical team is committed to quality and patient focused care. The staff interviewed across all sites were happy, felt valued, and comfortable to express their opinions. The quality boards and huddles are attended by all of the team and staff expressed feeling valued and the opportunity to contribute is accepted and valued.

Medication reconciliation at admission, transfer and discharge was observed and staff demonstrated understanding and importance of their roles in this process. Clients interviewed had received education in hand hygiene, fall prevention, medication and pertinent education on their surgical procedures. The staffing of a pharmacist on the units is an excellent resource not only to assist with medication reconciliation but also for patient education. The collaborative care design on the surgical two units at the Mississauga site provides clients with excellent care and this was expressed by all clients interviewed. The reduction in call bell times and assistance with client care has improved with this model. Every patient is called the next day after surgery by this team and the surveys assist in them examining their care and practices to make improvements.

The transfer of accountability on the orthopaedic unit has patients and family feeling safe and expressed that this process makes them feel informed and safe. The use of the white boards at the Mississauga site on the surgical floors provides a snap shot of all patients on the unit in one location and is used for reporting on change of shifts. This is an excellent practice that should be considered at all sites. The new ceiling lifts at the Credit Valley site provides staff with an excellent resource to reduce occupational health and safety issues for staff and reduce falls for patients. The fall program is an excellent safety tool and is being practiced at all sites. At the Mississauga site, two of the surgical floors use the white board for reporting and this process is an excellent process and patient focused.

The operating room (OR) team is quality patient focused from the environmental staff to the physicians. The OR team is collaborative and an atmosphere of mutual respect by all partners was observed. The use of a registered practical nurses and registered nurses is an excellent model of practice. At the Credit Valley site, the use of the acute surgical model has provided continuity of care for patients along with a reduction in night surgical procedures and this practice might be considered at all sites. At the Mississauga site, the delivery of sterile products to the OR requires closed bins or carts as the elevator opens into the high traffic corridor and therefore not having closed bins or carts is an infection control issue. At the Credit Valley site, the bins of sterile supplies are located outside the ORs in the patient and high traffic corridor so all supplies must be contained.

The investment by the facility in providing four hours every month of paid education for the OR nurses will provide excellent opportunities for learning, and staff expressed how important this is to them. The OR won the "applause award" and they were very proud of this accomplishment. At the Credit Valley site, the urology and opthamology surgical areas do not have three zones and does not have a closed door between the operating area and the patient care area. There are plans to build new operating room theatres and consideration to move these surgical rooms in the same area should be considered. Reusable hats area used as head covers in the OR. Canadian Standards require that these hats be in house or contract laundered so this practice needs to be examined and acted on as an infection control issue.

The Credit Valley site has decommissioned all flash sterilizers and do not flash any instruments. I commend the work that took place to accomplish this practice and they should be commended. At the Queensway site, there has been no flash sterilization for two years so consideration should be given to decommission the flash sterilizers at this site. The physical space for the surgical program at this site is excellent.

Section 4 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.

4.1 Governance Functioning Tool

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

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

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

- **Data collection period: November 1, 2012 to February 25, 2013**
- **Number of responses: 12**

Governance Functioning Tool Results

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1 We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations.	0	0	100	92
2 Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	0	0	100	94
3 We have sub-committees that have clearly-defined roles and responsibilities.	0	0	100	96
4 Our roles and responsibilities are clearly identified and distinguished from those delegated to the CEO and/or senior management. We do not become overly involved in management issues.	0	0	100	95
5 We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decision-making.	0	0	100	92

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
6 Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	92
7 Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	96
8 Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	0	0	100	95
9 Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	0	0	100	94
10 Our governance processes make sure that everyone participates in decision-making.	0	0	100	92
11 Individual members are actively involved in policy-making and strategic planning.	0	0	100	87
12 The composition of our governing body contributes to high governance and leadership performance.	0	0	100	91
13 Our governing body’s dynamics enable group dialogue and discussion. Individual members ask for and listen to one another’s ideas and input.	0	0	100	93
14 Our ongoing education and professional development is encouraged.	0	0	100	86
15 Working relationships among individual members and committees are positive.	0	0	100	96
16 We have a process to set bylaws and corporate policies.	0	0	100	95
17 Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	96
18 We formally evaluate our own performance on a regular basis.	0	0	100	72
19 We benchmark our performance against other similar organizations and/or national standards.	0	17	83	64
20 Contributions of individual members are reviewed regularly.	0	0	100	58

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
21 As a team, we regularly review how we function together and how our governance processes could be improved.	0	8	92	76
22 There is a process for improving individual effectiveness when nonperformance is an issue.	0	33	67	52
23 We regularly identify areas for improvement and engage in our own quality improvement activities.	0	0	100	77
24 As a governing body, we annually release a formal statement of our achievements that is shared with the organization's staff as well as external partners and the community.	8	0	92	82
25 As individual members, we receive adequate feedback about our contribution to the governing body.	0	8	92	65
26 Our chair has clear roles and responsibilities and runs the governing body effectively.	0	0	100	95
27 We receive ongoing education on how to interpret information on quality and patient safety performance.	0	0	100	80
28 As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	94
29 As a governing body, we hear stories about clients that experienced harm during care.	0	0	100	83
30 The performance measures we track as a governing body give us a good understanding of organizational performance.	0	0	100	90
31 We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	0	0	100	84
32 We have explicit criteria to recruit and select new members.	0	8	92	79
33 Our renewal cycle is appropriately managed to ensure continuity on the governing body.	0	0	100	87

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
34 The composition of our governing body allows us to meet stakeholder and community needs.	0	17	83	91
35 Clear written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	94
36 We review our own structure, including size and sub-committee structure.	0	0	100	87
37 We have a process to elect or appoint our chair.	0	0	100	92

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2013 and agreed with the instrument items.

4.2 Patient Safety Culture Tool

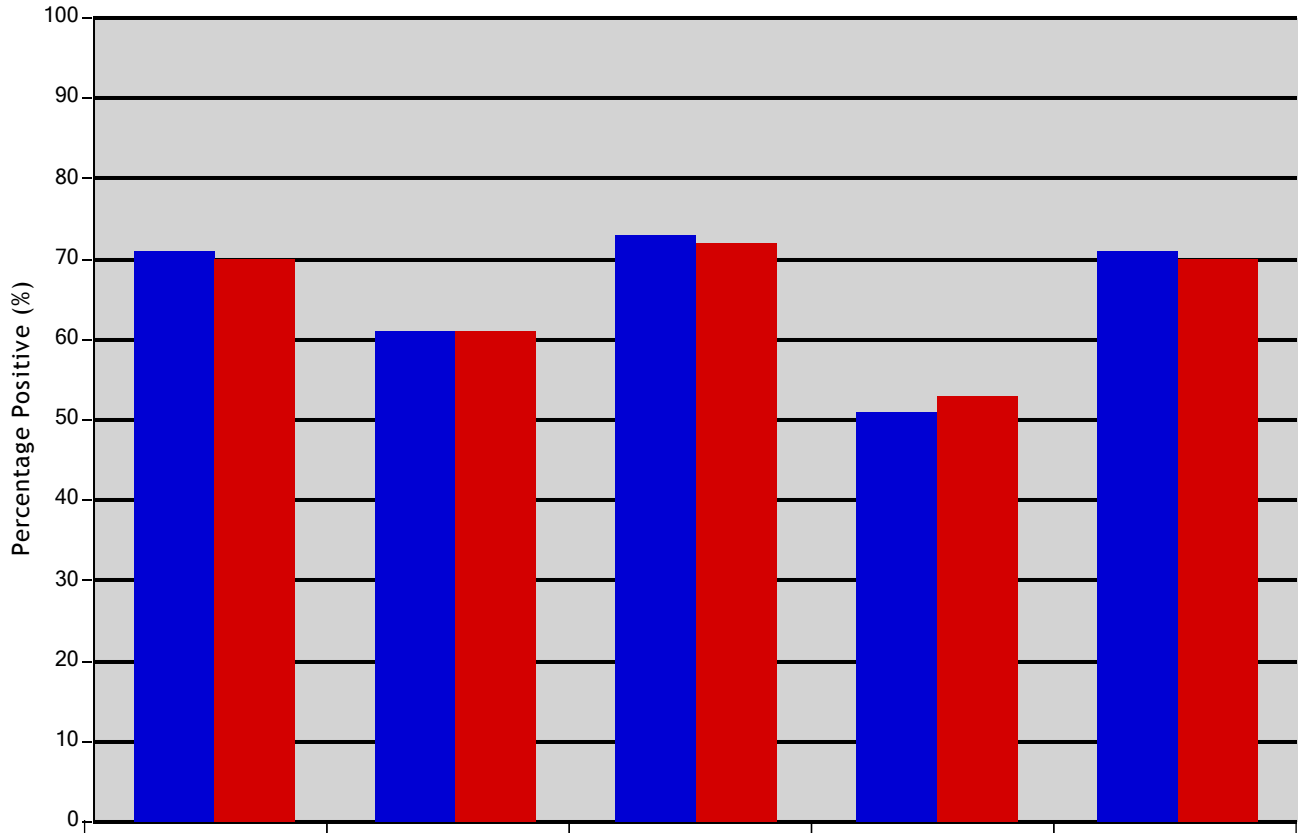
Organizational culture is widely recognized as a significant driver in changing behavior and expectations in order to increase safety within organizations. A key step in this process is the ability to measure the presence and degree of safety culture. This is why Accreditation Canada provides organizations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

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

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

- **Data collection period: November 1, 2012 to December 19, 2012**
- **Minimum responses rate (based on the number of eligible employees): 358**
- **Number of responses: 3198**

Patient Safety Culture: Results by Patient Safety Culture Dimension



	Senior leadership support for safety (valuing safety)	Supervisory leadership support for safety	Patient safety learning culture	Communication barriers/talking about errors	Overall perception of patient safety
	71%	61%	73%	51%	71%
	70%	61%	72%	53%	70%

Legend

Trillium Health Partners

* Canadian Average

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

4.3 Worklife Pulse Tool

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

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

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

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

Section 5 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.

Undergoing Accreditation has been an important milestone for Trillium Health Partners (THP). It was the first independent look at our quality and delivery of safe patient care, and it will provide us with a baseline for quality as a new hospital. This opportunity has allowed us to showcase the great work that we do on a daily basis – work that contributes to providing quality and safe care to our patients, as well as demonstrating that we are meeting all the Accreditation standards.

We are even stronger today because of our Accreditation journey as our preparation activities for Accreditation helped move us forward in reaching our goals of quality, access and sustainability. Striving for our accreditation goal has has inspired our staff, physicians and volunteers, who showed tremendous passion, dedication and teamwork in our pursuit of excellence. Some amazing work has been done in preparing for Accreditation, which has reinforced our culture of quality and patient safety.

THP strives for continuous improvement, and we truly value Accreditation Canada's insight into how we can continue to strengthen the quality and safety of patient care. Your recommendations will assist us in our pursuit of excellence.

It has been a true honour to have Accreditation Canada surveyors join us at Trillium Health Partners for the on-site visit. We would like to extend a heartfelt thank to each of the Accreditation Surveyors for their time and expert review of our quality practices and safe patient care. We appreciate their time and commitment to establishing and maintaining standards that ensure hospitals across Canada can develop, grow and provide patients with the safest and best care possible.

Appendix A Qmentum

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

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

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

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

Action Planning

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

Evidence Review and Ongoing Improvement

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

Appendix B Priority Processes

Priority processes associated with system-wide standards

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

Priority processes associated with population-specific standards

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

Priority processes associated with service excellence standards

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

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