ACCREDITATION AGRÉMENT CANADA
Qmentum

Accreditation Report

Toronto East Health Network

Toronto, ON

1-day On-Site Portion

On-site survey dates: November 26, 2021 - November 26, 2021

Report issued: January 14, 2022

About the Accreditation Report

Toronto East Health Network (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 2021. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

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

Confidentiality

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

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

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

A Message from Accreditation Canada

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

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

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

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

We look forward to our continued partnership.

Sincerely,

Leslee Thompson
Chief Executive Officer

Table of Contents

Executive Summary

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

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

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

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

Accreditation Decision

Toronto East Health Network's accreditation decision is:

Accredited with Exemplary Standing

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

About the On-site Survey

- **On-site survey dates: November 26, 2021 to November 26, 2021**

- **Location**

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

  1. Michael Garron Hospital (Toronto East Health Network)

- **Standards**

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

  System-Wide Standards

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

  Service Excellence Standards

  5. Ambulatory Care Services - Service Excellence Standards
  6. Biomedical Laboratory Services - Service Excellence Standards
  7. Critical Care Services - Service Excellence Standards
  8. Diagnostic Imaging Services - Service Excellence Standards
  9. Emergency Department - Service Excellence Standards
  10. Hospice, Palliative, End-of-Life Services - Service Excellence Standards
  11. Inpatient Services - Service Excellence Standards
  12. Mental Health Services - Service Excellence Standards
  13. Obstetrics Services - Service Excellence Standards
  14. Perioperative Services and Invasive Procedures - Service Excellence Standards
  15. Point-of-Care Testing - Service Excellence Standards
  16. Reprocessing of Reusable Medical Devices - Service Excellence Standards
  17. Transfusion Services - Service Excellence Standards

- **Instrument**

  The organization administered:

  1. Worklife Pulse
  2. Governance Functioning Tool (2016)
  3. Client Experience Tool

Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
 Population Focus (Work with my community to anticipate and meet our needs)	50	0	0	50
 Accessibility (Give me timely and equitable services)	92	0	0	92
 Safety (Keep me safe)	630	6	8	644
 Worklife (Take care of those who take care of me)	135	0	0	135
 Client-centred Services (Partner with me and my family in our care)	382	4	0	386
 Continuity (Coordinate my care across the continuum)	72	1	0	73
 Appropriateness (Do the right thing to achieve the best results)	1040	1	3	1044
 Efficiency (Make the best use of resources)	60	0	0	60
Total	**2461**	**12**	**11**	**2484**

Overview by Standards

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

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

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

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

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	50 (100.0%)	0 (0.0%)	0	35 (97.2%)	1 (2.8%)	0	85 (98.8%)	1 (1.2%)	0
Leadership	49 (98.0%)	1 (2.0%)	0	96 (100.0%)	0 (0.0%)	0	145 (99.3%)	1 (0.7%)	0
Infection Prevention and Control Standards	40 (100.0%)	0 (0.0%)	0	29 (100.0%)	0 (0.0%)	2	69 (100.0%)	0 (0.0%)	2
Medication Management Standards	78 (100.0%)	0 (0.0%)	0	64 (100.0%)	0 (0.0%)	0	142 (100.0%)	0 (0.0%)	0
Ambulatory Care Services	47 (100.0%)	0 (0.0%)	0	78 (100.0%)	0 (0.0%)	0	125 (100.0%)	0 (0.0%)	0
Biomedical Laboratory Services **	72 (100.0%)	0 (0.0%)	0	105 (100.0%)	0 (0.0%)	0	177 (100.0%)	0 (0.0%)	0
Critical Care Services	59 (98.3%)	1 (1.7%)	0	103 (98.1%)	2 (1.9%)	0	162 (98.2%)	3 (1.8%)	0
Diagnostic Imaging Services	67 (98.5%)	1 (1.5%)	0	67 (98.5%)	1 (1.5%)	1	134 (98.5%)	2 (1.5%)	1

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Emergency Department	72 (100.0%)	0 (0.0%)	0	107 (100.0%)	0 (0.0%)	0	179 (100.0%)	0 (0.0%)	0
Hospice, Palliative, End-of-Life Services	45 (100.0%)	0 (0.0%)	0	108 (100.0%)	0 (0.0%)	0	153 (100.0%)	0 (0.0%)	0
Inpatient Services	60 (100.0%)	0 (0.0%)	0	85 (100.0%)	0 (0.0%)	0	145 (100.0%)	0 (0.0%)	0
Mental Health Services	50 (100.0%)	0 (0.0%)	0	92 (100.0%)	0 (0.0%)	0	142 (100.0%)	0 (0.0%)	0
Obstetrics Services	72 (100.0%)	0 (0.0%)	1	88 (100.0%)	0 (0.0%)	0	160 (100.0%)	0 (0.0%)	1
Perioperative Services and Invasive Procedures	112 (97.4%)	3 (2.6%)	0	109 (100.0%)	0 (0.0%)	0	221 (98.7%)	3 (1.3%)	0
Point-of-Care Testing **	38 (100.0%)	0 (0.0%)	0	46 (100.0%)	0 (0.0%)	2	84 (100.0%)	0 (0.0%)	2
Reprocessing of Reusable Medical Devices	84 (98.8%)	1 (1.2%)	3	39 (97.5%)	1 (2.5%)	0	123 (98.4%)	2 (1.6%)	3
Transfusion Services **	76 (100.0%)	0 (0.0%)	0	69 (100.0%)	0 (0.0%)	0	145 (100.0%)	0 (0.0%)	0
Total	**1071 (99.4%)**	7 (0.6%)	4	1320 (99.6%)	5 (0.4%)	5	2391 (99.5%)	12 (0.5%)	9

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

Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

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

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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information transfer at care transitions (Obstetrics Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Perioperative Services and Invasive Procedures)	Met	4 of 4	1 of 1
Medication reconciliation as a strategic priority (Leadership)	Met	3 of 3	2 of 2
Medication reconciliation at care transitions (Critical Care Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Emergency Department)	Met	1 of 1	0 of 0
Medication reconciliation at care transitions (Hospice, Palliative, End-of-Life Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Inpatient Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Mental Health Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures)	Met	4 of 4	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Safe Surgery Checklist (Obstetrics Services)	Met	3 of 3	2 of 2
Safe Surgery Checklist (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
The "Do Not Use" list of abbreviations (Medication Management Standards)	Met	4 of 4	3 of 3
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management Standards)	Met	4 of 4	1 of 1
Concentrated Electrolytes (Medication Management Standards)	Met	3 of 3	0 of 0
Heparin Safety (Medication Management Standards)	Met	4 of 4	0 of 0
High-Alert Medications (Medication Management Standards)	Met	5 of 5	3 of 3
Infusion Pumps Training (Ambulatory Care Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Critical Care Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Emergency Department)	Met	4 of 4	2 of 2
Infusion Pumps Training (Hospice, Palliative, End-of-Life Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Inpatient Services)	Met	4 of 4	2 of 2

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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Infection Control			
Infection Rates (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Critical Care Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Hospice, Palliative, End-of-Life Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Inpatient Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Mental Health Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Obstetrics Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Perioperative Services and Invasive Procedures)	Met	2 of 2	1 of 1
Pressure Ulcer Prevention (Critical Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Hospice, Palliative, End-of-Life Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Inpatient Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Suicide Prevention (Emergency Department)	Met	5 of 5	0 of 0
Suicide Prevention (Mental Health Services)	Met	5 of 5	0 of 0
Venous Thromboembolism Prophylaxis (Critical Care Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Inpatient Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2

Summary of Surveyor Team Observations

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

Michael Garron Hospital is situated in the Toronto East Health Network. It serves over 400,000 people in 22 distinct neighbourhoods in east Toronto and is identified as one of the most culturally diverse areas in the city. This community has many families of low income with over 40% of the residents being immigrants who speak over 50 distinct languages. The population in this area has large proportions of children and youth and a growing proportion of seniors and elderly. Elevated rates of chronic disease, premature mortality and mental health and addiction concerns are common in many local neighbourhoods.

The Board of Directors has a good mix of talent- expertise and competencies. They understand their roles and responsibilities as a governing body and are aware that oversight for patient safety, risk management and quality improvement are fundamental roles of governance. The Board takes ownership for board accountability, strategic and fiscal oversight. In speaking to staff, a comment was made that is noteworthy for the Board to hear as stated “the Board keeps all aspects of the organization in its line of site, and they provide strong leadership in governance”.

Michael Garron is currently undergoing a redevelopment project that involves the construction of a new eight story patient care tower which will add up to 550,000 square feet to the existing hospital. As well approximately 100,000 square feet of the existing hospital will be renovated. There has been community engagement throughout the planning and development of this project – including the indigenous population who have performed smudging ceremonies for the new build. The redevelopment project is designed to deliver efficient, accessible, and high-quality patient care. Eighty-eight percent of the patient rooms are private with healing and family spaces included in the design.

The concept of integrating and partnering is not new to MGH. For over 25 years, health and social service organizations in East Toronto have collaborated to improve the health of its community. In 2017, they launched the East Toronto Health Partners (ETHP) – a network of key partners working together to create an integrated system across the community. In December 2019, Ontario’s Ministry of Health named the East Toronto Health Partners as one of the first Ontario Health Teams. MGH’s working relationships have strengthened with East Toronto Family Practice Network, Providence Healthcare, South Riverdale Community Health Centre, WoodGreen Community Services, VHA Home Healthcare, Patients, families, and caregivers and over 50 other engaged partner organizations. This existing partnership proved beneficial as a platform for a collaborative, rapid response to the pandemic.

The current Strategic Plan was launched in the fall of 2016 and was closely tied to the renaming and rebranding of the organization. At this time, the vision, mission, and values were also revised. The values were developed directly from the story of a patient and family experience with the hospital. Input into the strategic plan and the rebranding of the organization was provided by the Patient Experience Panel, Community Advisory Council, hospital leaders, community leaders, elected officials and front-line staff. It is evident the strategic plan provides a strong framework to support the operational and strategic decisions of Michael Garron Hospital (MGH) from the Board to the clinical areas.

The Leadership team is comprised of expert to novice members. New members to the team feel supported, respected, and valued, and are mentored and coached until they settle into their job roles and responsibilities. The MGH philosophy noted was "when we add a new member, we create a new team". Teamwork and collaboration are key leadership components at MGH, internally and externally to the organization. In asking what leaders and staff felt most proud of in the organizations the top five most common responses were: community, nimble, partnerships, patient centered approach and innovative.

Communications at the TEHN are identified as a priority both internal and external to the organization. There is a robust communications plan in place that was developed in partnership with the hospital foundation. Stakeholders are regularly consulted, and communication techniques and needs are regularly reviewed and updated frequently. There are robust policies and procedures regarding privacy and confidentiality and the Privacy Officer is regularly consulted when research projects or new initiatives are planned to ensure ongoing compliance to privacy legislation. A new privacy audit tool has been recently implemented and provides a daily dashboard of access to health records. The Information Management (IM) team operate with a "protect and enable" approach to information access.

The organization is commended for their community advocacy and leadership within the community, especially during COVID-19. The organization implemented several communication strategies in response to the pandemic that have been well received by staff and community. One of these strategies included 5 – Questions which is a process by which questions (hot topics) sent in via social media, patients, family, staff, or community members are researched and responded to by the CEO and/or subject matter experts on a regular bi-weekly schedule. The organization set up several COVID-19 pop-up assessment centers across their catchment area and worked collaboratively with community leaders to develop, translate, and distribute communication material.

The Community was well represented by Partners who deliver and refer clients for critical health and social services within Toronto East. Amongst the group providing key insights to the patient experience were providers for mental health, addictions, long term care providers and homecare, EMS, Family Health Clinics, Children's Mental Health, rehabilitation services, police, hospital partners and patient and family representatives from community (CAC), (OHT) and Patient Experience Partners (MGH).

An overall statement that was enthusiastically supported by health and social service providers reflected the view that MGH considers the patient and family at the centre of care. They join in partnership with other health and community providers as collaborators in meeting the needs of the community. Community providers emphasized that they felt valued and respected in their interactions with MGH in senior and frontline interactions. Several medical professionals indicated that a referral to MGH meant that patients would receive a streamlined transition to and from hospital care. They cited communication as a strength supporting ease of transitions that clearly benefit patients and their families. Police and EMS representatives remarked on the efficient reception and management of patients requiring emergency care with the added benefit of reducing wait times for these professionals to return to their urgent duties. Paramedics meet monthly to review the effectiveness of the service relationship and efficiency of processes between MGH and their service.

MGH shares service arrangement with St Michael's renal program and has a shared program for cancer care with Sunnybrook Hospital. Representatives spoke about the ongoing coordination and leveraging of scarce resources to provide a full range of services and to ensure that patients received critical care closer to home. Both areas of medical care are in high demands, requiring all to be proactively planning for expanding needs and sufficiently nimble to respond to the future planning needs of the community. MGH is a teaching hospital and is affiliated with the University of Toronto School of Medicine and Nursing. This collaboration provides for a significant number of students practicing at MGH throughout the year.

Toronto East encompasses many diverse communities with a growing immigrant population and a higher birthrate than other areas in the province. Concurrently the area is home to many seniors aging at home and in care settings. Community Health Centers work closely with MGH to address the changing profile of the community. The relationship with the homecare and long-term care resources is well developed and supports not only patients but also the needs of caregivers providing support to vulnerable and fragile seniors. The history of collaboration between the hospital and its community partners positions the group well to establish an early Ontario Health Team that has begun the work of developing a collaborative Quality Improvement Plan which focuses on what the partners have in common and how to target improvements across the spectrum of community care programs.

MGH's deep commitment to the community is best exemplified by their proactive response to the current Covid 19 pandemic. Staff from MGH reached out to the community to determine their needs and jointly developed plans with the community health centres to meet the exceptional needs for families and children. Many people in the area live in multi -generational homes, with high density housing and social economic challenges. To respond MGH set up eight pop up clinics in high needs areas, provided PPE to nursing homes prior to the Ministry's request to do so and provided designated staff assigned to nursing homes to educate and support nursing care staff on infection control practices. These collective actions demonstrate MGH's ability to respond in a timely manner and to pivot to the emerging community needs thus ensuring greater health and safety for those in the community, in effect, living their mission and values. This ability to respond in breadth and depth was highly praised and will continue to support the future work of the Ontario Health Team partners.

Two areas that community partners identified for ongoing development with the hospital would be to continue to develop the ability for patients and families to receive care in the language they best understand. A significant challenge given the array of languages spoken in this area. And secondly the mental health response and specifically the response to opioid use with expansion of harm reduction programs. These are ongoing challenges that partners acknowledge will require the participation of the full community to address.

Community partners identify MGH as a genuine community hospital with many expressions of gratitude and appreciation for the contribution they make each day. Many partners and patient/family representatives expressed pride in the quality of care that they receive within their local neighbourhood.

Detailed On-site Survey Results

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

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

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

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

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

See Appendix B for a list of priority processes.

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

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

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

Priority Process Results for System-wide Standards

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

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

Priority Process: Governance

Meeting the demands for excellence in governance practice.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

It has been a busy and challenging year for the Board of Directors of Michael Garron Hospital (MGH); responding internally and externally with community partners to the global pandemic, the ongoing work of the Ontario Health Team, the redevelopment project, recruiting new Board of Director members and fiscal accountabilities.

The Board of Directors has a good mix of talent- expertise and competencies. They understand their roles and responsibilities as a governing body and are aware that oversight for patient safety, risk management and quality improvement are fundamental roles of governance. The Board takes ownership for board accountability, strategic planning and fiscal oversight. The Board is regularly briefed on quality and safety incidents, data, cause and effect analysis and clinical outcomes. Regular reporting to the Board of Directors through aligned committee structure ensures the organizations priorities related to quality and safety are accessible and addressed. The Board is proud of its efforts and that of the organization in driving quality from the boardroom to the bedside.

In speaking to staff, a comment was made that is noteworthy for the Board to hear as stated “the Board keeps all aspects of the organization in its line of site, and they provide strong leadership in governance”. MGH has nominated and appointed three new board members to its board. Each new member receives a robust orientation to the organization and to the board. Ongoing board education, learning opportunities, retreats and tours of the hospital were viewed as positive components and tools that provided the Board with necessary information to effectively govern. The Board identified the need and is working toward a more diversified and inclusive Board. The Board is focused on ensuring services that meet the healthcare needs of the community are accessible. The Board receives frequent updates on the Covid status of the community and within the hospital (patient and staff). There are by-laws which address the term lengths and attendance requirement for board members.

There are processes in place to monitor the performance of the CEO and the Chief of Staff. There appears to be a good working relationship between the Board and Leadership at MGH. The CEO and management group report regularly to the Board. Succession plans are in place for members of the Senior Executive Team. There are processes in place to evaluate the effectiveness and functioning of the Board meetings and the performance of board members. By-laws are reviewed periodically.

Medical issues come to the Board through the Medical Advisory Committee. The Board understands its accountability regarding medical staff credentialing. The Board is familiar with the ethics framework and provided examples of how it used the framework to guide Board decisions.

Michael Garron Hospital has a strong Patient Experience Partnership program, and the organization is commended for the leadership exhibited in this area. Patients are members of the Performance Management Quality Committee. Patient feedback information is presented at the Quality meeting and to the Board on a regular basis. The board is encouraged to consider placing a patient on the Board of Directors as it is the patient experience, lens and voice that will bring insight, perspective and balance to the board discussions and decisions making processes.

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)

Michael Garron Hospital (MGH) is undergoing a huge redevelopment project with the hospital needing to raise $125 million and the Foundation needing to raise $76 million. It is the hopes of the organization that the keys to the new build will be handed over in October 2021 and occupancy will occur in late 2022. The newly developed building will provide state of the art IT technology and private patient rooms that meet current Infection and Prevention Control Standards as well as Patient and Family Centered care needs.

There are concise processes in place to support Capital budgets and purchases. A robust priority setting is established at the program level and chosen items are moved to a combined capital criteria list. Clicker technology is used for voting by the Directors of the programs in determining the priority of the clinical equipment, renovation need or informatics technology. Purchases over one million dollars requires the approval of the board. There is an appeal process which can be used by staff members should questions arise as to the priority rating and need for a piece of equipment. There is a contingency fund available should the need arise. The organization is grateful to the Michael Garron donation which provides approximately 2 ½ million dollars for equipment purchases per year.

Program Directors and Managers are supported by members of the Financial team. A financial software program permits real time viewing of operating budgets for program leaders. Financial education is provided to all leaders who are accountable for budget variances and financial targets. There are processes and criteria in place for resource allocation.

Michael Garron Hospital is commended for the integrity of its financial controls from an operating and capital viewpoint. A Resource Management Committee meets monthly, and an external auditor is used to assess and monitor financial resources and reporting. These audited financial statements are available on iCare and the public website.

Covid-19 has had a huge impact on the long-standing financial stability of MGH. Approximately 1 ½ million dollars has been used to support the community needs during the pandemic to assist with e.g., the establishment of seven Covid community assessment centers, support LTC facilities with PPE supplies and IPC staff, community flu vaccine outreach programs, school programs and homecare support to the elderly. This organization demonstrates the meaning of community and partnerships and is highly commended for the integrated work they perform in and outside the walls of MGH.

The current Strategic Plan was launched in the fall of 2016 and was closely tied to the renaming and rebranding of the organization. At this time, the vision, mission, and values were also revised. The values were developed directly from the story of a patient and family experience within the hospital. Input into the strategic plan and the rebranding of the organization was provided by the Patient Experience Panel, Community Advisory Council, hospital leaders, community leaders, elected officials and front-line staff. It is evident the strategic plan provides a strong framework to support the operational and strategic decisions of Michael Garron Hospital (MGH) from the Board to the clinical areas.

Michael Garron Hospital is one of the six anchor partners in the newly formed East Toronto Health Partners (ETHP) Ontario Health Team. ETHP is accountable for providing services and care to 300,000 people who live in the East Toronto community as well as an additional 75,000 clients who choose to receive healthcare in the local areas. ETHP is committed to create an integrated model of services that places the client and family in the center of care. The COVID-19 pandemic has caused ETHP to focus on four key strategic priorities; infection prevention and control and support; engagement and co-design with clients and caregivers; accelerated integrated care and advancing equity, diversity, and inclusion.

Michael Garron is currently undergoing a redevelopment project that involves the construction of a new eight story patient care tower and will add up to 550,000 square feet to the existing hospital. As well approximately 100,000 square feet of the existing hospital will be renovated. There has been community engagement throughout the planning and development of this project – including the indigenous population who have performed smudging ceremonies for the new building. The redevelopment project is designed to deliver efficient, accessible, and high-quality patient care. Eighty-eight percent of the patient rooms are private with healing and family spaces included in the design.

Community demographics and needs assessments are gathered using a community and services report. As well internal utilization data, data from community partners and information from the city of Toronto and Statistics Canada are collected to identify trends and areas for service needs. Michael Garron Hospital has formed numerous community partnerships including ten long term care facilities, East Toronto Family Practice Network, the Regional Renal Program, local schools, Toronto Paramedic and Police services. It was noted that the Covid pandemic has strengthens these relationships and MGH has provided ongoing support to their external partners. MGH identified there is service gap for youth mental wellness and adult substance needs.

The pandemic has caused consults, ongoing care, and clinics to be completed virtually and approximately 65% of clinics visits are performed virtually.

Priority Process: Resource Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Michael Garron Hospital (MGH) is undergoing a huge redevelopment project with the hospital needing to raise $125 million and the Foundation needing to raise $76 million. It is the hopes of the organization that the keys to the new build will be handed over in October 2021 and occupancy will occur in late 2022. The newly developed building will provide state of the art IT technology and private patient rooms that meet current Infection and Prevention Control Standards as well as Patient and Family Centered care needs.

There are concise processes in place to support Capital budgets and purchases. A robust priority setting is established at the program level and chosen items are moved to a combined capital criteria list. Clicker technology is used for voting by the Directors of the programs in determining the priority of the clinical equipment, renovation need or informatics technology. Purchases over one million dollars requires the approval of the board. There is an appeal process which can be used by staff members should questions arise as to the priority rating and need for a piece of equipment. There is a contingency fund available should the need arise. The organization is grateful to the Michael Garron donation which provides approximately 2 ½ million dollars for equipment purchases per year.

Program Directors and Managers are supported by members of the Financial team. A financial software program permits real time viewing of operating budgets for program leaders. Financial education is provided to all leaders who are accountable for budget variances and financial targets. There are processes and criteria in place for resource allocation.

Michael Garron Hospital is commended for the integrity of its financial controls from an operating and capital viewpoint. A Resource Management Committee meets monthly, and an external auditor is used to assess and monitor financial resources and reporting. These audited financial statements are available on iCare and the public website.

Covid-19 has had a huge impact on the long-standing financial stability of MGH. Approximately 1 ½ million dollars has been used to support the community needs during the pandemic to assist with e.g., the establishment of seven Covid community assessment centers, support LTC facilities with PPE supplies and IPC staff, community flu vaccine outreach programs, school programs and homecare support to the elderly. This organization demonstrates the meaning of community and partnerships and is highly commended for the integrated work they perform in and outside the walls of MGH.

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 Department of Human Resources provides support to approximately 2,600 staff of which approximately 82% are unionized. There are 11 bargaining units. Michael Garron Hospital (MGH) has approximately 500 volunteers and 450 physicians.

This department has developed a Wellness Strategic plan which focuses on the positive states of being with programming designed to reduce and minimize the risk of illness, disease, and injury, and maximize personal and professional potential. There are four HR Strategic plan priority pillars; Build a Respectful, Inclusive and Safe culture, Strengthen Leadership Capacity, Lead with our Values and Encourage Health and Wellbeing. Employee surveys are used to collect information in each of these pillars. The data is analysed, and the results are used to assist with the development of supportive employee programs that meet staff wellbeing needs. The 2019 data scores have improved from the 2017 scores. This Wellness program assists staff with their financial concerns and has won the Excellence Canada Financial Wellness Pioneer Award. Mental Health and Wellbeing and Physical Wellness are also included in the strategy plan.

It was noted that there is a great deal of human capital competition between the numerous Toronto hospital sites and often location is a factor when recruiting staff. This is an ongoing worry for the leaders of MGH. This organization is affiliated with numerous education institutions including the University of Toronto and welcomes residence and students from most professional affiliations. There are robust processes in place for the recruitment and selection of staff. The organization attempts to hire staff whose talents reflect their core values. Patients from the Patient Experience Panel are used to assist with hiring specific groups of professionals e.g., nurses. Patient Partners may be asked to be part of the interview panel, assist with the development of interview questions or role play during a simulation laboratory exercise to assess the caring aspect verses task focus aspect of the possible hirer. The organization has a comprehensive orientation program for new hirers.

Approximately 70% of the staff have had a recent performance appraisal and with the current pandemic in place the completion rate is lower than the organization would like to see. Staff have received education on how to file a complaint and submit a Whistle Blower form. Mandatory learning curriculums are provided to staff through e-learning and the completion rates are monitored by HR and the Directors.

There are numerous retention strategies provide for staff by MGH such as long service awards, gifts, and meals. In person or online exit interviews are provided for staff leaving the organization.

MGH is commended for its innovative human resource team and for the ongoing work this team provides to improve the quality of its employees personal and work life. The HR staff appear to have “tentacles” into numerous programs and projects that involves staff, safety, work-life balance, wellness etcetera. It is evident in speaking to the team that they are “in the know” and aware of happenings associated with the organization. It is recommended that the organization put forward their HR model of service for the organization as a Leading Practice to Accreditation Canada.

Priority Process: Integrated Quality Management

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
3.4 There are clear, documented processes shared with clients and families about how to file a complaint about the organization or their care or to report a violation of their rights.	!

Surveyor comments on the priority process(es)

Michael Garron Hospital (MGH) is commended for its overall focus on Integrated Quality Management. MGH has a very dedicated team of professionals: committed leaders, staff and physicians who are clearly focused on providing quality, safe care and minimizing risk across the organization and into the community.

The organizations 2020-2021 Quality Improvement Plan includes a collaborative quality improvement initiative with several of the East Toronto Health Partners (ETHP) in the Ontario Health Team. MGH's Quality Improvement Plan is aligned with and supports the priorities, commitments, and behaviours of the Quality & Patient Safety Plan, which in turn is aligned with MGH's Strategic Plan.

There have been numerous safety initiatives introduced into the practices of the Michael Garron which involve the participation of leadership, physicians, and staff. Leadership Safety Walkarounds are scheduled, and the expectation is for leadership to be visible and present in clinical areas. Daily Safety Checks are performed to review recent safety issues across the organization. All department leads (including HR, Pharmacy and Engineering Services) participate and discuss topics such as falls, sick calls, slippery surfaces in the parking garage, patient monitoring concerns, near misses' etcetera. Investigative and follow-up tasks were assigned to the most relevant person. The organization's Daily Safety Check has been recognized as a Leading Practice through Accreditation Canada.

Quality Huddles Board are situated in the service areas. Numerous quality improvement activities and initiatives specific to the program and aligned with the strategic direction of the organization were noted. It is recommended that a repository that houses all corporate and service quality initiatives be housed and managed by the Quality team. This would help staff, who are considering a quality initiative, to determine if similar work has been done prior in the organization. It would also provide the Quality team information regarding outcomes and sustainability of quality initiatives.

Bedside report and daily rounding huddles occur in clinical programs. It is unclear if the patient can provide input into either of these activities and if not, consideration should be given to formalizing a process for patient input. This may mean a redesign of the communication or transfer of accountability tool. As well, there seems to be no formalizes process for a patient or family to submit a complaint. Consider providing bedside information and include the Patient Relations contact information. Education on how to formalize a complaint should be part of the admission protocol and documented in the patient health record.

Situated on each unit is a poster with the Managers name, picture, and contact information. The poster is entitled “Tell Us How We are Doing?” and patients and families are encouraged to contact the Manager with comments or feedback.

One of Michael Garron Hospitals greatest quality improvements achievements over the last year has been the implementation of a deprescribing pilot program which is directly associated with improving patient outcomes and saving hospital and system resources.

There are clear processes in place for reporting, recording, investigating, and closing incidents. A couple of safety programs entitled “Good Catch Program” and “Learning from Incidents” encourages staff to identify, report and learn from incidents or near misses. There is a documented and coordinated approach to disclose patient safety incidents to patients and families. Designated staff receive formal training on how to approach the topic, patient, and family. The organization is encouraged to submit this Disclosure process to Accreditation Canada as a Leading Practice.

Other Quality and Patient Safety Programs include Team Agreements, Positive Patient Identification, I-Pass, Just Culture principles through standardized practice and Concern, Uncomfortable and Stop (CUS). The organization is commended for its many safety initiatives which align with the safety pillars of High Performing Teams, Early Warning Systems and Speak up for Safety.

There is an emphasis on best practice; order sets and evidence-based guidelines have been adopted and the teams are commended for their work toward a standardized approach to patient care. In 2019, ETHP signed a four-year agreement with the RNAO around implementation of Best Practice Guidelines within and across organizations. The implementation of the Person and Family Centered Care Guideline in 2020 has generated change ideas to improve patient and family with their participation in care planning and treatment choices.

The governing body receives regular reports on all indicators through the various subcommittees of the Board, with roll-up reports shared with the full Board.

Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Michael Garron Hospital (MGH) has three Bioethicist each having a varied professional background as a nurse, physician, and lawyer. Although all three have other role responsibilities, the three ethicists are accountable for fostering ethics expertise and capacity across the organization. They are accessible to staff around the clock and if not available, MGH has a contract with Sunnybrook Hospital who has a program called Health Ethics Alliance and a group of accessible ethicists.

MGH does not have an Ethics Committee. They believe that all staff, from the Board to the front line, play a key role in delivering ethical health care. The current ethics framework has been in place since the early 2000's. It is not one of the more commonly used frameworks across the province, however it was noted that it meets MGH's criteria of an ethical framework and is particularly useful when determining resource allocation and supporting the justification of a decision. The MGH Ethics Framework is reviewed annually with key stakeholders such as Leaders, Medical Advisory Committee, Nursing, Interprofessional Practice and Patient Experience Partners.

New staff are introduced to the bioethics resources during orientation. A Bioethics page is located on both the external webpage and iCare with resources linked to MGH's Ethics Framework. Staff have access to ongoing ethical discussions and learnings at Lunch and Learn events, in-services, I-learn modules and Zoom presentations. Staff noted the processes of how to contact the ethicists should an ethical situation arise in the clinical areas. The organization is encouraged to continue its journey of building capacity with all members of the healthcare team. In reviewing the ethics framework, consideration might be given to survey staff regarding the ease of use of the current, multi-sided ethical framework.

Medical Assistance in Dying (MAID) is performed at this organization. A MAID committee has been formed and staff who feel they are able to assist with the tasks of MAID are aligned with the program. The organization carefully monitors the activities around MAID, updates policies and processes to meet legislative changes and supports healthcare providers, patients and families with ongoing consultation and moral support. Debriefs occur as necessary.

The Research Ethics Board oversees all research involving participants conducted under the auspices of MGH to ensure that the research study meets the highest scientific and ethical standards. During the pandemic, nonessential research studies were suspended. Research studies which align with MGH's community needs, mission, vision, values, and strategic direction are chosen. An Innovation fair is held annually with the focus on; improving current processes, moving the dial on patient care and new avenues which have yet to be discovered. Dragon's Den panels have also been used to choose relevant research studies.

Priority Process: Communication

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Communications at MGH is identified as a priority both internal and external to the organization. There is a robust communications plan in place that was developed in partnership with the hospital foundation. Stakeholders are regularly consulted, and communication techniques and needs are reviewed and updated frequently. There are robust policies and procedures regarding privacy and confidentiality. The Privacy Officer is regularly consulted when research projects or new initiatives are planned to ensure ongoing compliance to privacy legislation. A new privacy audit tool has been recently implemented and provides a daily dashboard of access to health records. The Information Management (IM) team operate with a “protect and enable” approach to information access.

The organization is commended for their community advocacy and leadership within the community, especially during COVID-19. The organization has implemented several communication strategies in response to the pandemic that have been well received by staff and community. One of these strategies included 5 – Questions which is a process by which questions (hot topics) are sent in via social media, patients, family, staff, or community members. These topics are researched and responded to by the CEO and/or subject matter experts on a regular bi-weekly schedule. The organization has set up several COVID-19 pop-up assessment centers across their catchment area and worked collaboratively with community leaders to develop, translate, and distribute communication material to promote these centres and share up-to-date information about COVID-19.

Other examples of both cross-department collaboration and communication innovation includes the development of a virtual open forum, the use of storytelling through staff and patient video production, close to 500 COVID-19 related communication/IT request tickets resolved, a daily safety check, My Safety Champion Checklist, and a critical care remote monitoring pilot project. These initiatives showcase the commitment and support to promoting health and well-being in their community.

Another communication success is the My Chart portal providing patient access to their health record. Currently the hospital reports having approximately 4500 patients accessing their information via My Chart.

Another successful initiative reported by the team was the implementation of the Hypercare App. Hypercare has reportedly improved access to specialists and reduced the numbers of pages and delays in specialist consultations. The App is used by physicians within the organization and used by many physicians in the surrounding MGH community. The organization is encouraged to consider extending this app to Nurse Practitioners and Midwives and to develop metrics for this initiative. The organization is commended for their innovation efforts.

The organization reports experiencing a Cyber incident that resulted in activating a Code Grey and the Incident Management System. The organization responded quickly and have since taken significant steps to learn and embrace identified opportunities to improve because of this experience. The organization is commended for their willingness to share their experience broadly with others so others can learn from the MGH experience.

The IT plan is currently being refreshed as part of this refresh the organization is encouraged to keep line of sight on maintaining a strong IT systems foundation that will support redevelopment and enable expanding existing IT infrastructure to both utilize and stretch resources.

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)

The team underpinning the physical supports of the organization has strong leadership, a true sense of accountability and quality, and extremely proud of the work that they do to support the organization.

In a period of the pandemic and an onsite transformation project, the team has taken the time and expertise to transform many pieces of ER and ICU into negative pressure rooms. This change clearly set the stage for success during COV ID as it would be recognized as leading the organization towards building a safe environment for care providers. Safe care providers provide safe care and the impact of there work cannot be underestimated.

The team takes safety and quality seriously. One clear quality improvement of importance was the acknowledgement that the hospital supply of oxygen may be at risk during COVID because of increasing demand. The team took immediate measures to find a safe back up supply for the organization.

The team regularly reviews codes and drills appropriately.

The new facility was an obvious source of pride for the team. Special note that there was clear disappointed with the virtual survey pivot because of COVID. We are all looking forward to meeting the team that deserves significant credit for the innovations to provide for a safe environment during COVID.

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)

MGH has been in a command-and-control environment over the past 18 months with several emergency situations that have impacted the organization in ways that have demonstrated resilience, organizational agility, opportunities for leaders to grow, innovation and actively reflect on how to apply learnings in the re-development project. Organizationally, MGH follows an IMS format which has a clear command structure, roles and responsibilities that are clearly defined and built-in redundancies to allow for continuity of command. There is a central HEOC that is connected to the community and has a Patient Partner as a full member.

In 2019 the organization was challenged with a 'cyber attack' that rendered the organization in an emergency command mode for well over 3 months. The hospital's IMS format lent itself well that the EOC was up and operational within 3 hours with leaders, resource leads and executive across the program areas to ensure seamless care. They were able to determine the attack was progressive and proactively shut down other servers to protect the remaining integrity of information. The IMS structure, processes and people understanding their roles was critical in the identification and response of threat.

While downtime procedures have always been existent in areas with local 'downtime boxes' they were not planned for extended periods of time beyond 4 - 6 hours. Additionally, with 'downtime' procedures primarily being paper based, there was a generational divide with providers who had not used paper, carbon copy or other modes of sharing information. Clinical Resource Leads (CRL's) provided support to each of the areas during the period of impact, as well in the transition back from paper to electronic platform. Communication during the Code was highlighted by the team and validated in other episodes of care whereby front-line staff was aware of what was happening, what processes were implemented and impromptu education/support when required. Externally the communications team leveraged social media, central call line to provide information, social interactions and rounding on an hourly basis with patients and families by clinical and leadership staff to ensure confidence in the care, protection of health information and support for staff.

As a downtown hospital, MGH participates in the GTA Emergency Management Network which is a compilation of all the TAHSN and partially affiliated hospitals to conduct large regional events, share learnings & resources and assist one another in events. This network conducted a Code Orange drill in the fall of 2019 and leveraged video technology, shared lists, and focused on family reunification as part of a key objective if patients were diverted to multiple sites.

The organization has a regular schedule of codes/drills, as well as an online learning module with mandatory learning modules for staff to ensure codes are reviewed. During COVID, many of the drills have gone virtual in partnership with local fire departments and other agencies to ensure preparedness.

MGH has been a leader in Code White and reducing the number of events and workplace violence. They have won several awards for their approach and leverage Gentle Persuasion as an approach for de-escalation within their key areas of the Emergency Department or Complex Continuing Care where patients with dementia may be the aggressor due to disease progression. This approach to managing patient to patient or patient to staff violence speaks to the values of compassion the organization has.

COVID has been the most recent challenge the IMS system and EOC has faced with a community that has higher risk factors based on the socioeconomic, health and demographic disadvantages. Throughout the journey, MGH has been a leader in COVID management with the communication within/outside of the organization, mobile assessment centres, pop-up clinics in schools and novel ways in managing the 'ramping down' of services through virtual care. COVID, the cyberattack, code orange (Yonge street attacks) and recent code acqua has served to assist in informing the new redevelopment with the advancement of fire/security, silent alarms being on separate servers/cloud, redundant security systems, redundant generators for power, communications/IT within and outside of the hospital to allow for screening, repurposed zones for clinics, HVAC systems to be nimble, furniture selection to allow for physical space & IPAC standards and redundancy in power grid access to mention a few lessons applied to the future site. MGH will serve as a leader in future events and a key partner for other hospitals redeveloping.

The EOC in full partnership with IPAC has also ensured staff safety is of paramount importance with the introduction of 'protected' code blue or 'protected' code white where security dons/doffs personal protective equipment to reduce or eliminate exposure risk. The Emergency Management Committee has an active voice on the Joint Health and Safety Committee to understand the concerns of staff and translate the information into processes that protect staff/patients.

While the pandemic plan is robust and provides action, plans related to the pandemic, where the organization has opportunity for growth are clear business continuity plans that would identify co-dependencies within/outside the organization. While the business continuity plans are specific to COVID they may not have the applicability to other types of emergencies (e.g., full power failure, ice storm). As well, there is no central location for the continuity plans to be regularly reassessed and managed.

What was clear from the team was extreme pride in the breaking down of silos across areas to augment emergency preparedness, humility, and the willingness to learn, culture of safety, community 'proud' in providing support and keeping staff safe in the prevention of workplace violence.

Priority Process: People-Centred Care

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

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

Surveyor comments on the priority process(es)

The Organization has embedded key principles that support a People Centred Care approach in their Mission, Vision and Values. MGH has demonstrated their great respect for Patient and Family engagement by formally adopting the values of Compassion, Accountability, Integrity and Courage. These four foundational values were presented to MHG by a family member bringing forward recommendations for improvements in the quality of service to patients and their families. Their Vision is Create Health. Build Community is well reflected in the development of the Community Advisory Council and the extensive outreach the hospital has undertaken to ensure the safety and reduce risk of COVID-19 for children in local school areas through to seniors being supported at home and in local term care.

Communication materials, leadership messaging and staff interactions reflect a common understanding of this vision and the application of the values of the organization.

There is clear evidence and multiple examples of services that are co-designed with patients and family partners, best evidenced in the co development of the Patient Orientated Discharge Summary(PODS), Patient Experience Panels and Patient Experience Partners(PEP) engaged with several units, PEP members on hiring teams and facility/room design consultations, the annual Quality Improvement Plan(QIP) development, Hospital Emergency Operations Committee (HOEC) briefings, and the involvement of Community Advisory Council members in current and future development plans for the hospital extension and involvement of youth in the planning for transition to home or adult services. There was active engagement of patient and family advisors in five panel which include: MGH General, Mental Health, Hemodialysis, Maternal Newborn and Emergency Services.

The organization involves PEP members in the orientation of new staff members and simulated situational learning opportunities to address professional practice with a goal to increasing sensitivity to needs of patients and family and the impact of positive and negative communication. Patient's stories and Patient Story videos are used extensively throughout MGH including at the governance level as ongoing teaching tools and to stimulate organization wide change and development. PEP have also been involved in an ongoing consultation process on visitor access that has been significantly limited by the COVID-19 pandemic infection control measures. This is an area of great concern for patients and their family and was a central theme raised during the Experienced Based Co Design (EBCD) sessions where MGH partnered with the Change Foundation. An action plan was developed from these sessions and learnings will be incorporated in the ongoing adjustment to access by family caregivers and essential visitors. MGH has an appeal process that patients and family members can utilize to increase their time together with staff in units reporting a committed effort to expand options if possible, keeping the safety of all in mind when developing options.

A very impressive feature of this organization is consideration by environmental services, communication, and technology department of the importance of providing and adapting their services to meet the needs of patients. In the context of a major build along side the existing hospital, efforts have been made to reduce the noise and disruption for inpatient units where at all possible.

Recommendations for future would include a consideration of more formal linkages between the Patient Engagement Partners and the Board governance as it is the patient experience, voice and lens that will bring insight, perspective and balance to the board discussions and decision-making process. The Patient Experience Panel could also consider a targeted recruitment strategy to increase the diversity of this group like the diverse population in the community and represented on the Community Advisory Council. And finally, the information provided to patients and family with the link to the Patient Relations Office could be reviewed for consistency across all units.

MGH has a breadth and depth of patient and family engagement strategies that is exceptional with many tools and processes that could be modeled in other organizations.

Staff are performing change of shift reports at the bedside and actively include patients in the exchange of information. Family members are encouraged to participate in caring for hospitalized loved ones. Patient and family consultation meetings are scheduled to plan for transitions of care.

At the clinical unit level, Patients & Family Council members have input into education materials and space design. The surveyor was informed that PFC members will be engaged in the interview process for new staff (e.g., Cardiac unit).

Program quality boards with key indicator finding are visible to patients and families and located in the halls of clinical programs. White e-boards are in several waiting rooms and used to inform patients waiting for a procedure of the volumes of patients preceding them and possible wait times.

The organization is encouraged to continue to include the voice of the patient in decision making.

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)

There are many exceptional examples of how the organization coordinates flow and care of patients both internally and between organizations.

1. During COVID the organization employs clear admission avoidance strategies working closely with community physicians to Care for COVID appropriately in the community.
2. The organization utilized a redeployment strategy to facilitate the care of patients out of hospital to protect its acute care responsibilities.
3. The organization created safe capacity in ER and ICU in very short order to facilitate care of COVID patients.
4. A clear collaboration between Anesthesia and surgical programs with Barrie Thoracic cases facilitates efficient use of capacity and is clearly patient oriented.
5. Strong relationships exist with tertiary care centers for cardiac interventions.
6. The Dashboard used for bed management meetings is extremely well organized and understandable to foreign eyes. It also highlights staffing capacity and potential threats to capacity from community outbreaks of COVID.

The implementation of a Patient flow coordinator is seen as a clear success by all staff.

Other highlights include a robust hospitalist service and overnight consistent Internal Medicine availability.

Hypercare was celebrated. "Communication between teams is allowing us to better inform our patients" Dr. Katherine Stanley. Internal Medicine
.

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		
8.7	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.	!
8.10	The team stores clean diagnostic devices and equipment according to manufacturer's instructions and separate from soiled equipment and waste.	
Standards Set: Perioperative Services and Invasive Procedures		
4.8	Contaminated items are appropriately contained and transported to the reprocessing unit or area.	!
4.9	Contaminated items are transported separately from clean or sterilized items, and away from client service and high-traffic areas.	!
4.10	When transporting contaminated equipment and devices, applicable regulations are followed; environmental conditions are controlled; and clean and appropriate bins, boxes, bags, and transport vehicles are used.	!
Standards Set: Reprocessing of Reusable Medical Devices		
11.3	All flexible endoscopic reprocessing areas are equipped with separate clean and contaminated/dirty work areas as well as storage, dedicated plumbing and drains, and proper air ventilation.	
11.8	Flexible endoscopic devices are appropriately stored following manufacturers' instructions in a manner that minimizes contamination and damage.	!

Surveyor comments on the priority process(es)

There is an interdisciplinary team approach to medical device management in the hospital. Staff responsible for reprocessing have completed an accredited education program in reprocessing. There are standardized policies and procedures in place regarding the cleaning and reprocessing of medical equipment used within the organization. The team report that flash sterilization is not done in the organization. However, flash sterilization continues to be a standing agenda item on the program leadership agenda.

Manufacturer recommendations, as well as infection prevention and control best-practices, are incorporated into policy and procedure development. There is a manual documentation system used to document reprocessing quality control records. Although the manual system allows for tracking recalled equipment or instruments, the organization is encouraged to invest in an automated system for recording quality control and tracking data.

Reprocessing is primarily centralized except for endoscopes that are being reprocessed in the OR and B6 and ultra probes are reprocessed in DI. The organization is encouraged to consider further consolidation/ centralization of scope reprocessing. The organization has recently invested in new sterilizer units and are commended for their collaborative efforts to coordinate the installation during a pandemic.

The MDRD team reports being challenged by its current physical space restrictions. A business case is being prepared with recommendations to renovate the existing space to enable improved department flow and reduce the risk of cross-contamination. The organization is recommended to invest in a review of existing space to support improved department flow and best practices in reprocessing.

There is a dedicated team of interdisciplinary maintenance/trades who provide 24/7 coverage across the organization.

There is a robust automated preventative maintenance program in place that has been recognized as a leading practice. The team report a PM compliance rate 96%. The team acknowledge that a process is in place to manage incidents involving equipment. The leadership is strongly encouraged to review the current policy and practice regarding the management of incidents involving equipment to ensure all required steps in risk mitigation and incident investigation are taken.
The main reprocessing department has a separate area for decontamination and distinct workflows to separate clean and sterile areas. IPAC staff are engaged in monitoring compliance to IPAC standards. Soiled devices and equipment are transported to the reprocessing department using patient and/or staff elevators. Soiled equipment is transported on carts and covered by a towel. The organization is encouraged to review this practice and transport contaminated equipment using enclosed bins and less high-traffic elevators whenever possible.

Endoscopy reprocessing is performed in a separate room located within the endoscopy suite. The endoscopy reprocessing room is a small room without physical separation between contaminated, clean, and sterile areas. Workflows have been developed to help minimize potential for cross-contamination. Endoscopes are transported for reprocessing between towels. Most scopes are stored after reprocessing in enclosed cabinets. However, some scopes are stored on open wall hooks creating a risk of damage and contamination. The organization is recommended to review workflows and ensure all reasonable IPAC measures are implemented. It is recommended that signage be posted, and the reprocessing room door be closed to restrict access during reprocessing. It is recommended that contaminated scopes are transported to reprocessing area using clearly labelled enclosed bins. It is further recommended that the organization store all scopes in enclosed cabinets.

In Diagnostic Imaging some equipment is stored in corrugated open shelves. It is recommended that reprocessed equipment and/or devices are stored enclosed/covered.

Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Point-of-care Testing Services

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

Clinical Leadership

- Providing leadership and direction to teams providing services.

Competency

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

Episode of Care

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

Decision Support

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

Impact on Outcomes

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

Medication Management

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

Organ and Tissue Donation

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

Infection Prevention and Control

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

Diagnostic Services: Imaging

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

Diagnostic Services: Laboratory

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

Transfusion Services

- Transfusion Services

Standards Set: Ambulatory Care Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The ambulatory care leadership team is strong, committed and very patient centred in ensuring high quality safe care. The goals and objectives are developed in concert with local Patient Experience Programs (PEP) and feedback is actively sought from the community regarding their needs and concerns to better programming. The direction of the team(s) is to strive to achieve 'Care Closer to Home'. Each program while looking to expand services (e.g., angioplasty) to achieve this goal, leverage the strength in robust partnerships with academic centres such as Sunnybrook, Mount Sinai, and St. Mike's to ensure advanced care is near to communities.

MGH has several unique partnerships with Sunnybrook, Princess Margaret, St. Mike’s, and Mount Sinai to deliver radiation therapy, becoming satellite care hubs for angioplasty, ISAAC program to mention a few. Each of the partnerships have strong Memorandum's of Understanding (MOU's) and the team is well connected with various platforms including Systems Pro, Connect2Care, MyChart, Connecting Ontario. The physicians and programs have formed tightly knit teams within and outside of MGH that ensures seamless, timely and high-quality care for the residents of the community.

Over the past 4 years some of the innovations that have been introduced successfully have been the following:

1. Rapid Assessment Clinic (RAC) within the orthopaedic hub that has introduced advanced physiotherapy practice to reduce the wait times for initial assessment, provide options for a conservative approach to patients who are not meeting the criteria for surgery from a pathology perspective or patients who are not ready yet. This implementation has occurred in the past two years with markers for success on patient, staff, physician satisfaction as well as allocating precious physician resources to patients needing surgery. Shared was while the change in practice was a shift from historical practice, quickly realized was the benefit of this novel model where 50% of patients often did not require surgery and surgeons were able to focus on patients with need.

2. MGH is the only baby friendly accredited hospital in all of Ontario which is a proud moment for the team. COVID has made this challenging to continue the models of care with physical distancing IPAC measures for the breastfeeding program. The team has developed novel ways to stay connected and still provide support to a community demographic that has high birth rates, lower socioeconomic status and who are culturally diverse.

3. Nocturnal Program in Hemodialysis is novel where the needs of the community were met to provide dialysis at different times and overnight for more complex patients. The process for implementation was heavily anchored in partnerships across the organization to understand the health outcome for the community. The outcome of the program has been quite positive with a total of 24 dedicated beds.

4. Pulmonology Program is actively working on a 'Home Spirometry Program' coupled with virtual care to provide care closer to home, but also addressing the COVID environment. As a high-risk group, the team developed a program that is close to completion to allow for kits to be delivered to patients' homes and gather the information that will allow respirologists to discuss treatment options through virtual care. This ensure patients are safe, maximizes resources and reduces the flow in the hospital.

5. Virtual programming ~ many of the ambulatory care clinics have pivoted to virtual care to ensure that programming continues, while safeguarding the community from COVID. Discussed were many programs likely to remain virtual as they have been effective, patients are quite happy to receive care at home and the model allows for efficient care.

The teams conduct their morning huddles which are very well received, focused, and discuss the day's work, challenges, and opportunities for quality improvement. Many quality improvement initiatives are identified and follow-up with clear accountability. Staff indicate that the huddle is where they feel connected with their leadership team, their voices are heard and sense of purpose. MGH should be very proud of the work of these teams as they drive many improvement initiatives.

MGH has been under tremendous stress from an emergency management perspective over the past 2 years with a prolonged Code Grey (cyber-attack), Code Orange (Yonge Street Van Attack), Code Acqua (Flood) and more recently COVID. This organization's leadership has been nimble, committed, and resolute in supporting their teams. Staff highlight in all interactions of how much it mattered to them to have leadership on the floors, cancelling all meetings to be present with their teams, providing them moral/emotional support during difficult days and most importantly embodying the meaning of community'. Staff expressed their love of the organization, the community with many having worked over 30+ years at MGH.

When asked what the hopes of each respective programs were the responses were unique yet common, they included:

1. Continued integration of different aspects of care into programs
2. Continued sense of community above all else
3. Families to feel their care providers are part of their journey
4. Delivering high quality care for the local community
5. Continued enhance strategic partnerships and 'share care models' to be advanced
6. Regional expansions

Encouraged would be for MGH to continue their journey in quality with a more centralized approach and to harvest all the quality improvement initiatives to catalogue the challenges, successes and incorporate into a more central strategy.

Priority Process: Competency

MGH has an inter-professional practice model with each area having Clinical Resource Leader to drive and integrate education locally within clinical care areas. Organizationally there is a clinical practice and education committee that reviews, discusses, and endorses evidence-based guidelines. Patient partners sit at the program level and provide feedback on evidence guidelines and ways that make sense for patients and families. During COVID where information was rapidly changing and the committee would send out daily or weekly 'Practice Bulletins' in a one-page SBAR format to be shared at huddles, distribution lists or when leaders rounded. This was critical in ensuring the highest quality care for patients, but it also provided staff with the tools to feel safe, effective, and efficient.

The impact of patients and their feedback was very clearly articulated by a physician who talked about 'Kyle's Story' which focused on pain management and the challenges the team had in ensuring competency of staff in CAD pumps. While the situation occurred years ago with the patient passing, the story and the lessons learned remains very vivid in the minds and hearts of clinicians to ensure that this type of situation does not occur again.

MGH has strong partnerships with other organizations and implements evidence-based guidelines for care pathways. They are aligned with regional entities such as Cancer Care Ontario and the Ontario Renal Network to ensure standardization of service across the system.

Priority Process: Episode of Care

MGH prides itself in creating a high reliable organization through the consistent use of standardized order sets, evidence-based care guidelines, standardized tools for assessing risks (e.g., Morse Tool, Braeden Scale) and leveraging quality initiatives to improve access and flow. Staff could clearly articulate tools used for clinical care and the benefit of having consistency in the ways care is provided.

Front line staff were also able to echo all the educational support provided to them to provide high quality safe care in times of normalcy and times of crisis. Shared was the 'just in time' information during the COVID response when information was changing daily. Ways in which staff received timely information included bullet rounds, huddles, practice change 'blasts', email, leadership rounding. What resonated with most staff was the leadership presence that provided education, general support, emerging information and instilled a sense of camaraderie. Infection prevention and control was also noted to be pivotal during the pandemic in sharing information on transmission guidelines, best practices that would keep not only patients safe but staff as well. Early in the pandemic there was a heightened sense of fear amongst staff, however the presence of leadership and transparency of information ensured that there was confidence in the ability to provide care while being safe. An example shared was in the haemodialysis unit which provided care to 3 COVID positive patients and there was no transmission or spread. The team, in partnership with IPAC proactively tested all patients within the unit when cases became known, tested staff, and heightened protocols for cleaning. Several members of the front-line staff indicated that there was no perceived fear providing care because they were confident in their IPAC team, leadership, and each other in maintaining practices. There was a strong sense of accountability amongst staff and ensuring they held others accountable as it pertained to personal protective equipment.

MGH has very strategic partnerships with large academic centres that enables patients to seamlessly be enrolled in Clinical Trials. A coordinator within the cancer program provides current information of all trials that enables physicians or nurse practitioners to facilitate discussions for options. While typical within the oncology department, all of outpatient services are connected to their respective agencies (e.g., kidney network, pulmonology) that provide opportunities for patients.

MGH is also actively changing practice of providers through patient bedside rounding, advanced roles for professional health disciplines, having patients embedded within committees to make effective change. What is clear is the desire to integrate the voice and perspective of patients and families in the care provided to ensure the community is receiving what they need in care.

There is a very clear process for patient complaints and compliments. While the information is immediately brought back to the manager/leadership, opportunities exist to create stronger bonds with patient relations to further understand hospital trends of concerns. As well, quality improvement should be captured centrally to better understand where natural synergies may exist across the system and fully evaluate the impact.

The strongest asset that MGH has is their people. Repeatedly staff shared their joy working at MGH as it was their family and community. Staff shared their pride in being associated with the hospital and attributed this to the strong leadership, the close bonds to the community and the sense of family with one another. Another sentiment staff shared was their tangible feeling of impact on the lives of patients. Patients remember kindness in times of stress and this story was shared through the eyes of a staff person who recalled a former patient approaching her and saying "Do you remember me? You made such a difference in my life when I first received my diagnosis. You gave me a glass of water, a box of tissue, held my hand and told me things would be okay and that we would take the journey together step by step". While the staff didn't immediately remember the former client, the words have stuck with her over the past few years in reminding her of the commitment she has made to the community.

The surveyor visited the Ambulatory Fracture Clinic and an Outpatient Paediatric, Eating Disorder and Pre/ Post Natal Clinic.

There were clear referral processes in place. Patients were registered at a central registration desk and identification bracelets were applied to all patients.

The Fracture clinic was a Monday to Friday operation for outpatients and was supported by qualified registered casting staff and orthopaedic physicians. The space has numerous assessment rooms. The fracture clinic staff will go to the inpatient units to provide essential services as the need arises for admitted patients.

The Outpatient Paediatric clinic had several offices and assessment spaces. Support was being provided to breast feeding moms and a Lactation Consultant was accessible. This clinic is seeing a rise in eating disorders in adolescents and provides essential resources and supports to this population and family members. The clinic space is used for infant hearing assessment on the weekends.
There were no medications administered in the clinics.

Referring physicians are provided with reports from both ambulatory clinics to ensure transitioning of information occurs. Both clinic spaces were clean, well organized, and conducive to patient care needs.

Priority Process: Decision Support

MGH has a very clear and robust process for release of information, health data records and storage. While the Code Grey impacted the processes for chart retrieval, storage, and documentation there was no perceivable impacts from staff.

Release of information is very standardized, and the organization was able to develop alternative methods to ensuring patients and families appropriately accessed their health records while maintaining COVID restrictions.

As the organization has several partnerships across the system (e.g., MSH, Unity Health, PMH, Sunnybrook) they have service level agreements and data transfer agreements that allow for the sharing of information freely between the organizations. This arrangement allows for MGH to access tertiary and quaternary care for the community nearby while having instantaneous access to health information to manage care close to home. Strategically the organization has positioned itself well in being able to tap into specialized care, immediate consultation, and rapid follow up for patients.

The recent cyber-attack did not impact the relationships or access to information. While partner organizations immediately and proactively shut down connection points with MGH to ensure the integrity of computer servers, it did not impact the flow or access to information for clinicians. The organizations leadership was effective in ensuring minimal impact at the level of the patient and provider.

MGH uses RL6 solutions for their incident reporting system. There is a clear process for incident submission, review, management, and resolution. A multi-pronged approach is used with staff notifying their immediate supervisor, entering the system, thorough investigation and leveraging the information for quality improvement. Critical incidents are more robustly discussed and addressed with senior leadership.

While there is clarity in the structure and process, what wasn't clearly shared was a broader analysis of incidents across the organization and the pressure points those areas should focus on based on trending. This may be an opportunity for MGH to focus on.

Standards Set: Biomedical Laboratory Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Episode of Care

Priority Process: Diagnostic Services: Laboratory

The Department of Laboratory Medicine provides a full suite of diagnostic laboratory services within the hospital. The laboratory team consists of pathologists, a clinical a clinical chemistry consultant, approximately 40 medical laboratory technologists and approximately 25 laboratory technicians as well as six Registered Practical Nurses and five administrative/management staff. The laboratory was Accredited by IQMH and ISO 15189 and in November 2020 underwent their mid-cycle assessment of 66 assessment criteria (Sections 1 and 2). They reportedly received only one criteria of non-conformance regarding quantitative calculations in POCT testing. The lab has 90 days with which to comply with this standard.

The laboratory is part of a shared lab system for microbiology and molecular biology with four hospitals that was established close to seventeen years ago. Member agreements are in place to support this shared lab service. This shared arrangement has been helpful in supporting increased lab demands related to COVID-19 swab processing. The lab was able to reallocate staff to support increased COVID-19 assessments and enable label printing at pop-up assessment centres.

The laboratory services engage in regularly quality control and quality improvement monitoring. The department has recently implemented a new quality control IT system (Soft total QC). This QC technology as helped the team closely monitor processes by which specimens are ordered, collected, processed, and reported. Any discrepancies are investigated, and improvement actions taken promptly. Specimens are triaged to help achieve targeted result and reporting turn-around-times. Approved SOPs are utilized consistently across the department. The team participate in safety huddles Monday through Friday. The team are encouraged to report incidents, near misses, and opportunities for improvement.

Clinical unit staff print STAT labels at the point of order. Additional front-end automation provides alerts within the system to the STAT specimen. Lab staff have recently implemented a new patient ID system (Soft ID) and handheld device that is compatible with both the lab system and Cerner documentation system. Soft ID is used by the blood procurement team and replaces the need for printed labels. The technology scans a patients' ID wristband, connects to requisition, and provides lab staff with the verification along with the colour tube needed for blood draw and requires a final identification and specimen verification. The team also report continued investment in technology that has helped them improve testing efficiency and meet increasing service volumes.

Standards Set: Critical Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
7.17	A process to investigate and respond to claims that clients' rights have been violated is developed and implemented with input from clients and families.	!
10.5	The cultural practices and spiritual beliefs of clients and families in regard to death and dying are respected.	
11.4	Appropriate follow-up services for the client, where applicable, are coordinated in collaboration with the client, family, other teams, and organizations.	
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

There is clear infrastructure in place to support and manage the complexity of a Critical Care Unit to meet the needs off the community. The physician staffing model is lean with a small group covering both the Intensive Care Unit and a Rapid response team. Physicians take call for 3-5 days at a time before signing off to other physicians. In house night coverage is provided by the on call Internal Medicine Physician. These models may require re-evaluation as their acuity and growth of the organization continues to expand including the recent additional Cath lab responsibilities and growing referral base for thoracic and bariatric cases.

During COVID the leadership team managed through surges in patients by training and changing care models to meet the complex needs of COVID patients. Multiple physicians from a multidisciplinary background were identified and trained to help provide clinical coverage in a team-based care model.

Prior to COVID, nursing team-based models of carer were developed and implemented to maintain all clinical services. The Intensivist Physician group recruited throughout the organization and trained multiple physician groups to be integrated into a 24-hour care model during peaks of COVID.

Front line staff are well trained in conflict management and the process of de-escalation in emotionally charged situations. There appears to be some disconnect between Medical leadership and the number and significance of ethical issues identified by front line staff and in conversation with families. The ICU social worker is recognized by front line staff and families as incredibly supportive and personally notes that with COVID it has been the most challenging time of her career. It is not clear if the amount of support required for all the complexity of patients and community is being met with internal resources.

Quality is managed through daily huddles and is inclusive of all specialties.

There is its significant recognition of the program Hypercare as a recent addition to facilitate communication between medical teams. There is well established paper process for communication between teams because of transferring cases.

Feedback from families regarding communication was generally positive. In one case the family felt that exemplary care was provided as multiple members were permitted to visit a sick patient during COVID and felt staff had gone the extra mile to facilitate the needs of the family.

Priority Process: Episode of Care

I had the privilege to meet with two different family members who had many very good experiences in the organization however felt the need to raise concerns with Critical Care Leadership. It was very clear that in both cases the family were concerned that they had not received adequate acknowledgment and follow up to their concerns.

The Infection Prevention & Control staff are highly involved in patient and practices in this unit. A Pharmacist is assigned to work with this department daily. Staff note that the BPMH is completed by the ER physician prior to the patient's admission to the Critical Care Unit, and pharmacy verifies this medication information.

Interdisciplinary rounds occur. Social workers are team members and there is familiarity with the ethics framework and accessibility to an ethicist. End of life and withdrawal of services processes are in place. Medical Assistance in Dying is provided in this organization by a qualified team. Spiritual support is available, and a non-denominational space is located within the hospital. Respiratory Technologists support this program.

A Bedside Safety Checklist is used by staff which includes patient identification and assessment of restraint use. Staff complete their documentation in the patient's room and change of shift report is completed at the bedside. As much as possible and in conjunction with COVID-19 restrictions, this program found innovative ways to include family members in patient care. As an example, Facetime was used to allow family members to be present during the death of their loved one.

Daily huddles occur and the quality board had relevant indicator information. The program plays a key role with the Trillium Gift of Life Network as was evident by a recent letter received from TGLN and displayed on the quality board.

A Rover crash cart with essential supplies and a critical care staff attend all Code Blues within the hospital. An IPASS document is used by frontline staff to support transition of information for patients transferring between units.

Priority Process: Decision Support

The organization is encouraged to consider enhancements to their BPMH and medication reconciliation processes and flow. Essential BPMH and Medication reconciliation pieces are in place, however, the flow of information is not easy to access or interpret from an external lens. Computerize provider order entry is going to be provided soon.

The Health Record is currently part paper and part computer. The hospital is slowing moving toward a fully computerized health record.

Standards Set: Diagnostic Imaging Services - Direct Service Provision

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

The organization has met all criteria for this priority process.

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

This program provides a comprehensive array of services including Radiography, Mammography, Diagnostic Ultrasound, CT, MRI, Nuclear Medicine, BDM and non-invasive vascular Laboratory services. In 2020, cardiac and respiratory diagnostics, joined the Diagnostic Imaging Portfolio which includes Echocardiography, Exercise lab, Holter Lab, ECG, Pulmonary Function Lab and Sleep Lab. The department has approximately 150 full time and part time staff and 19 radiologists. In 2019-2020, 150,000 examinations were performed on 125,000 patients. The staff noted that joining the two programs together has had a positive effect on teamwork, collaboration and efficiencies for the organization and patients.

Staff felt they had sufficient equipment and had this not been the case, there would have been numerous occurrence events during the global pandemic. A CT scan, which was recently purchased and situated in the Emergency Department ensures patient safety and patient flow, particularly during this Covid-19 period. Staff are pleased with recent capital purchases of new equipment and technology. Performance maintenance is completed on equipment on a scheduled basis and necessary documentation is maintained.

Frontline staff validated that when new equipment is purchased an education component is provided by the vendor or by “train the trainer” methodology. There are concise processes in place for cleaning the equipment and furniture between patients. Several of the main pieces of equipment are connected to a back-up generator should the hydro go out, however with the new redevelopment build, the intent is that all major pieces of DI equipment will be connected to a generator.

To keep wait times and patient satisfaction on target during the pandemic, the DI program expanded their hours of operation for Ultrasound, CT, MRI and Vascular. It was noted that many of the essential changes to practices that were introduced due to the pandemic, have increased efficiencies in the department and the intent is that these practices will continue post Covid. Staff noted they feel safe working into the evenings and nights in this department and security is available should a situation arise. Staff wear the Vocera badge when working and there are alarm buttons in the radiology rooms. PPE has been readily accessible to staff.

The DI program has recently developed a process whereby patients may book their own screening mammography online. In doing this, patients may book a time convenient to them and the DI department mammography online. In doing this, patients may book a time convenient to them and the DI department has identified resource efficiencies. This department is encouraged to submit this work to Accreditation Canada as a Leading Practice and are encouraged to continue their work on this project to include additional DI services.

Policies are reviewed and revised once every two years. Staff have access to these on the computer as well as I learning modules. Performance appraisals are completed, and staff noted the feedback received from leadership was valuable to their professional growth. Staff receive ongoing education and learning opportunities. Staff have been encouraged to take vacation and time off to stay healthy during the pandemic. The DI program is commended for ensuring their staff are supported during these trying times.

This program was diligent in working on the unmet high priority standards from the 2016 accreditation survey. Areas corrected were colour-coded signage, wheelchair access and separated waiting rooms. A Peer Review radiology software program was purchased and installed to validate accuracy of readings.

Ultrasound probes are being disinfected in the DI department and without being onsite to visualize the flow of the probes it is difficult to determine if the soiled to clean direction is maintained. The DI leaders are encouraged to consider having the probes cleaned in the Medical Device Reprocessing Department (MDRD) where high level disinfectant protocols and equipment flow is a skill set and practice of MDRD staff and the environment is conducive to cleaning soiled equipment.

The equipment in the Diagnostic Department is current with new technology. This department has ample space to house its large equipment and supplies. Waiting rooms have been reconstructed to support safe COVID-19 practices. Washrooms and change rooms are wheelchair accessible.

The Nuclear Medicine Department is supervised by an employee who is certified as a Safety Officer. Relevant safety measure has been put into place to ensure the safety of the patients and the employees to include signage, disposal of waste products, hot and cold waiting rooms, and personal protective equipment. The department is compliant with the Canadian Nuclear Safety Commission guidelines.

In speaking to DI staff, they are proud of the services they provide to the community and highlighted the hours of accessibility. Patients are registered at a central registration centre; however, DI has the capability to register a patient if the need arises. The quality Board and patient information boards were visible. Daily huddles occur.

The Ultrasound program will be moving into a newly redeveloped section of the new hospital. At this time, a new soiled and clean space will be provided for ultrasound probes. Until this new space is available, the leaders of the ultrasound program are encouraged to work with Infection and Prevention staff to ensure current cleaning practices meet CSA standards for reprocessing ultrasound probes. Cardboard boxes should be removed from all clinical spaces.

Standards Set: Emergency Department - Direct Service Provision

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

Emergency services does an exceptional job in supporting the multicultural needs of the community and creating a work environment that is safe at a time of uncertainty. Much credit goes to the collaborative efforts of the ER and IPAC in the education and support of the medical teams.

The organizational responded to the needs of staff during COVID to enhance space in the ER and provide negative pressure isolation rooms. Modifications to setting arrangements enabled the patients to be visible for triage in case of change in medical condition.

There are quality initiatives generated by the team including changes in process to reduce blood culture contamination.

There is clear evidence of strong team culture and support in cases where ethically challenging issues regarding end-of-life care are presented. There has been education directed towards bioethics to help the team manage difficult cases.

A focus on wellness including a survey of staff has been implemented. Enhanced communication strategies are thoughtful and allow staff to check online for new information relevant to there own department.

The ER team is recognized for its outreach programs during COVID as they facilitated the testing of patients in the community.

"The culture in our Emergency Department is to step out and help others in need"
The ER department has the essential equipment and supplies to support pediatric services.

A space was recently recreated for Outpatient pediatrics and was designed with community and patient input. The organization is commended for creating this beautifully decorated space to ensure privacy and safety for this population.

The medication rooms are considered the safe rooms for staff.

Priority Process: Competency

An educator works in this department to ensure staff education and competency packages are completed. The educator supports the orientation of new staff to the department and ensured mentorship is in place.

Staff performance appraisals are completed every two years. For new staff there is a 30-60-90 day follow up meeting followed by a one-year performance review. Learning plans are accessible and additional shifts are provided for staff who require further educational opportunities. The hospital provides education resources to support staff learning.

Staff are familiar with incident reporting and filing. Patient/family complaints and investigation of occurrences are completed by leadership, and findings shared with staff.

Priority Process: Episode of Care

The community "H" markers and ER entrance markers are established. The Emergency Department is divided into zones and patient healthcare needs are categorized and provided according to the zone. Patient Navigators are in place to help identify and support patient needs.

This department is well equipped. Security is in this department and provides support on an as need basis. Patients with Mental Health concerns has a private space located away from the general population. There are processes in place to identify those at risk of suicide. Outpatient pediatric patients have a separate entry point. There are several negative pressure rooms and individualized care spaces.

This department is encouraged to formalize a process and accountability to ensure carts such as the Braslow cart are checked according to departmental policies. Refrigerators are monitored daily, and findings recorded.

BPMH is completed on patients who are admitted to the hospital.

Priority Process: Decision Support

There are processes in place for patients if they desire to review their Health Records. Patients have access on MyChart.

Staff sign privacy and confidentiality forms on an annual basis.

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

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

MGH has a strong Hospice and Palliative care program for the community. They are partnered with the Tammy Latner Centre for Palliative care that provides physician homes services and pain management. The team is quite attuned to the community needs and understands the broad cultural, socioeconomic, and vulnerable aspects of their population. Pre-pandemic the program offered on-site tours and face-to-face conversations with patients and families to assess fit. However, with COVID, over the past 9 months the program has ceased all onsite visits and is currently in the process of developing a virtual tour that will be part of the program. The virtual tour will be narrated by a former family member to provide first person perspective and incorporate the benefits for patient/family. Additionally, the program has developed comprehensive welcome packages that have been reviewed by Patient Partners for health literacy and applicability.

Organizationally, there is a strong embracing of culture and religion whereby patients and families have their care plans tailored to their preferences (e.g., how to handle the body immediately after death, who can touch the body, smudging). The team is attuned to the needs of the community and incorporate traditions into their model of care.

The principles of palliation (autonomy, transparency, communication, and honesty of disease process) are adhered to ensure patients and families can transition together. During COVID, the program has ensured to create other ways to ensure connection and meaningful interaction including numerous zoom calls, tablets by the bedside and increased family meetings to ensure communication.

The team has a strong psychosocial aspect to support not only the patient but the family as well during the death process. Spiritual care is made available before, during and after the patient's death and there is a close monitoring of behaviour to ensure psychological safety.

Leadership ensures there is a strong focus on staff wellness and touch base frequently with the team daily to ensure there is support. Daily huddles occur at 1130 am for a purposeful pause and discussion of challenging cases. A wellness specialist is available for all staff, and this ensures no burnout.

While there are local quality improvement initiatives or complaints that are resolved, organizationally there appears not a well-developed connection of system analysis or larger scale QI that can impact across the system.

Priority Process: Competency

The team is a specialized and highly functioning team who has clear scope of practice, roles, and responsibilities. Their services are available across the organization and easily accessible through direct order entry. Most recently the Emergency Department has instituted a 'Palliative Order Set' to address the community needs as many residents were not coming into hospital for fear of contracting COVID. As a result, patients arrived near end of life and in significant physical, emotional, and mental pain with little time to be addressed appropriately. This was a fully collaborative initiative with the ED identifying the challenge and reaching out to colleagues to address.

The program uses, monitors, and educates on CAD pumps. The clinical resource lead provides the expertise in ensuring all new hires are provided 2 full days of education, a checklist for safe practice and re-evaluated every two years. Fail safe redundancy is built into the process to ensure that staff who are not comfortable have 'just in time' education to safely provide pain management.

The palliative care physicians are available on a 24/7 schedule and provide urgent consults, opioid management (continuous, breakthrough and timing) and ensure nursing staff is supported. Lessons were applied and learned through past events surrounding pain management (Kyle's story) and the need to ensure continuity and standardization of practice/care.

Priority Process: Episode of Care

The program has a clear structure, strong processes and is patient and family focused. All advance directives are discussed with patients and families on admission and throughout the course of care (modified when appropriate). The team wraps care around the patient and the family to share the journey until death occurs, providing support along the way. Psychosocial readiness assessments are conducted early on to ensure that appropriate resources are attached to the family including social work, spiritual care, cultural needs, and anything else that will allow the patient/family to prepare for the journey.

The team does draw upon the bioethicist and leverages the ethical framework when family crisis is presented, and the focus has shifted away from the care/needs of the client. The team is clear in their mandate of upholding Quality of Life in final days and makes every effort to achieve this in a culturally sensitive way. An example includes using the 'roof top garden' for elders in the indigenous community to smudge and provide final rites to the patient.

Conversations of end-of-life occurs very early on in the admission process and ensure there is clarity for advance directives and resuscitation status. The team uses these touch points to not only education the family but to ensure the patient is active in the care planning and assist in family dynamics.

During COVID, partnerships with IPAC ensued to allow for home meals to be delivered patients. This is often very important for the culturally diverse community where food and eating are closely connected. While MGH attempts through their central food services to provide nutrient dense food with selection, it often becomes a barrier for patients. A process was developed to allow for food to be delivered by families in single container use, wipeable containers and to remain in the room until removed by family/ staff. This has assisted in quality of life for patients.

The program does exceptional work and is focused on patient and families during difficult transitions. While there is a strong focus on wellness, encouraged is to continue to focus on staff to reduce burnout in the COVID environment.

The Hospice team are commended for their skills and passionate commitment to person and family centred care and creating the positive "spirit of the unit". The team use their Huddle Board to monitor and share quality and performance metrics. The department has implemented the AHEART program as part of EQ training and promote a "speak your smile" approach to care and communication. Since the programs implementation the team report a proactive response to patients and a decrease in complaints. The team are aware of the organization's ethics framework and access the ethicist when faced with ethical dilemmas. The team are encouraged to use the ethics decision support tools to help the staff build further capacity and confidence in principle-based decision-making. The department report participation in quality improvement and research projects. The department leadership are encouraged to continue to build strategic research partnerships and opportunities to engage in applied research.

The components of medication reconciliation are in place. The pharmacist completes a medication reconciliation note that is included in the electronic health record. At time of onsite review, it was difficult to identify/locate the Best Possible Medication History and medication reconciliation. The organization is strongly recommended to review the documentation and implement a clearly defined process of BPMH and medication reconciliation.

Priority Process: Decision Support

Organizationally there is a strong policy and procedure framework that catalogues, itemizes, sunsets, revises and notifies leaders of policy requirements. The platform is easily searchable and provides staff an ability to use key words/terms to access information quickly.

The team uses evidence-based guidelines and ensures there is a standard approach to intake. The Palliative Prognostic Scale (PPS) is the primary tool to assess patients entering the program (score is 40 or below). This tool provides the team an ability to educate families on what to expect over the next weeks to months in terms of deterioration. This ongoing education allows families to understand the physiological and cognitive decline and prepare themselves as best possible. The team primarily uses patient experience as shared by the family as a tool to drive change and improve quality of life.

An opportunity may be to develop both outcome and process metrics to assist in a more robust evaluation of how others access services, how education on pain management has been effective and compare patient experience measures on other floors regarding pain management and end of life care.

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

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

Surveyor comments on the priority process(es)

Priority Process: Infection Prevention and Control

The infection prevention and control team is commended for their exemplary efforts to quickly respond to COVID-19 and to take efforts to manage the pandemic within the organization and their surrounding community. The shared information about COVID-19 epidemiology and the ways in which to protect staff and patients has helped show systems thinking and working together as a system saves lives.

The team shared how they quickly established structures and processes through which they were able to connect with regional infectious disease clinicians, monitor, communicate, and establish both an internal PPE stewardship program as well as several screening and assessment pop-up centers. The organizations' leadership approved additional resources towards a pandemic response. The organization has developed a Covid-19 dashboard that provides daily metrics related to the pandemic that is shared with staff and community partners. The infectious disease medical Director along with ICP team members have partnered with community health organizations including, Long Term Care facilities and schools to support and communicate pandemic information with clients and families. The collaboration with schools is an important step towards helping to de-stigmatize testing. Again, the organization and the ICP team is commended for their leadership for “realizing this community and partnership approach benefits the hospital, mitigates inequities through a purposeful response. This helps both our own organization and staff and our community to stay well ... and that benefits everyone.”

There are several specific activities established over the course of the pandemic that have demonstrated the organizations values in action and commitment to keeping their patients, staff, and community informed and safe. The organization established several community assessment pop-up centres and worked with local community COVID-19 Champion to adjust the outreach approach, develop, and translate communication (when indicated).

The community response to the organizations’ PPE drive showed the community’s strong connection by the large donation of PPE received. The organization initiated a sewing mask challenge that resulted in more than 100,000 masks being donated, laundered, and distributed to some of the local vulnerable populations (i.e., homeless).

A PPE stewardship program is in place and supply levels are monitored frequently with information shared with staff. There is a staff N95 fit testing system in place. Occupational health and safety staff are alerted when staff are due for N95 retesting. Occupational health has a robust process in place to provide support to staff and physicians who have tested positive for Covid-19, awaiting test results, and/or are returning to work after being positive/tested. Environmental services have also responded by providing enhanced cleaning measures and education to their staff.

Engineering services have undertaken enhanced duct cleaning and additional cleaning in all hospital mechanical rooms. Engineering services have increased the negative air draw in several rooms in the hospital.

The organization is recognized for prioritizing the need to support staff and physicians' mental health and well-being throughout the pandemic. Icare phone support program was established to provide access to a therapist, and a multitude of resources. The team reported they shared a common sense of responsibility to humanize and support each other. There is a wall of inspiration in the organization that displays messages and stories of gratitude and overcoming challenge. The ICP team and organizations leadership meet regularly and discuss ways in which to enhance information, education, and their support to their internal team, patients, and families, as well as their surrounding community.

The ICP team consists of 2 infectious disease physicians with a third ID physicians providing clinical patient care. There are 4 ICPs who have clinical and non-clinical assigned areas of responsibilities and project leadership. The ICP committee includes a patient representative and adjustments to isolation signage and other decisions are made with patient and family input.

The ICP team experienced a recent staffing challenge and have been able to recruit new team members who are pursuing specialist credentials. The organization is encouraged to include succession planning as part of their ongoing work to ensure adequate access to certified ICP support.
The team works collaboratively with Occupational Health. Policies are in place outlining required immunizations as well as work restrictions necessary to reduce transmission of infectious illness. There is a robust flu program supported across the organization.

The team shared research regarding hand hygiene (HH) rates and innovative electronic HH monitoring that is being conducted as a multi-centre research initiative. Hand sanitizers across nine units in the hospital automatically record each dispensed event. Real-time data from each event and the hospital census data is reported and available. The team is using this data to identify practice, outbreaks and track and promote HH compliance.

The organization has a robust anti-microbial stewardship program that was recognized as a leading practice.

An interdisciplinary team approach is taken in the selection of equipment. Manufacturing guidelines are used to establish cleaning procedures. Staff in each area are reportedly provided with education regarding equipment cleaning measures. The ICP team report a recent QI initiative undertaken that has resulted in a new ultrasound probe cleaning device that reduces the need for chemicals and electronically monitors cleaning quality assurance data.

The ICP team continues to sport monitor AROs across the organization. However, because of the pandemic the team utilized the ethical framework and decision-making process to redirect resources towards pandemic management and The Infection Prevention and Control team is commended for their continued organizational and community COVID-19 response and system leadership. The team continue to build a hub and spoke IPAC model and have implemented a community of practice to provide support to 10 long-term care homes in the region. The team also provides support to schools and a local shelter. Point of care IPAC risk assessments are completed. Established cleaning levels and schedules are in place and evaluated. Hand hygiene audits continue to be tracked using 'real data' that reflect what is reportedly more accurate audit rates. The team continues to reflect and evaluate their pandemic response and incorporate learnings into practice. The organization and IPAC team are commended for their upstream IPAC and pandemic practice. The organization and IPAC team are commended for their upstream IPAC and pandemic investment and are encouraged to share their experience and participate in research to help build IPAC and pandemic knowledge, skills, and capacity broadly.

Standards Set: Inpatient Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Clinical leadership was clearly able to articulate the process for developing goals & objectives on an annual basis. Programs utilize a dyad model of leadership with division chiefs & managers/directors in a unified process to develop objectives and share the responsibility for implementation. The goals are fully aligned with each pillar of the strategic plan and developed with multiple inputs including data, staff engagement, community needs, Community Health Centre, and patients. Understood by the leadership team is the community demographic with a large, marginalized population, one in ten who are admitted having addiction issues, low income and the diversity in culture/religion. This anchors the development of programming and meeting the needs of those accessing services.

The organization has a well-established Ontario Health Team (OHT) with more than 50 organizations embedded and partnering to support the community. Key pressure points continue to be managing ALC in times of crisis, decanting patients to allow for the influx of COVID patients and ensuring care is closer to home. In response to COVID the organization has successfully pivoted 'in person' services to 'virtual' care to meet the needs of people despite the ramping down of services in the spring of 2020.

Within paediatrics there is an excitement of growth of the program. The hospital is part of the Kids Health Alliance since 2018 which is a provincial entity that shares information, metrics, and knowledge across specialized, academic and community hospitals in the treatment of paediatric disease. MGH paediatric program has also most recently become an accredited paediatric teaching site and designated for PGY-I and PGY-IV residents. The growth of the program is especially important for a community that has a high growth rate of children and potentially paediatric disease. The program is closely linked to SickKids and this partnership continues to growth to form greater bandwidth across the city.

Leaders leverage the daily huddles, the 'Safety Call' and other modes of communication to connect with staff. When reaching out with pulmonary team 'front line staff' clearly articulated was their appreciation for their leadership team and the authentic commitment felt for their physical and psychological well-being. This was reiterated across other areas as well, especially during COVID.

Across the multiple sessions with staff what resonated loudly were the following words:

1. Proud to work here
2. Sense of community and family ~ we hold each other accountable to ensure each others safety
3. Incredibly strong culture with great relationships
4. Respect and collegiality amongst the team
5. We come together as a team
6. Our leaders listen to us and are very present and committed to keeping us safe
7. Our organization has kept us informed and our transparent. They acknowledge our commitment to care with meals and gifts
8. Compassionate care
9. Caring about each other on a personal level

Staff are connected to their leaders, organization, executive and want to continue to contribute for the betterment of the community. Examples of physicians returning early from maternity leave to assist programs and their colleagues, staff volunteering to Long Term Care facilities, Retirement Homes and other areas is common and what was clear is that everyone is interconnected. The better the community is supported, the better the organization is and the better that staff mentally/physically are. The commitment to community is an area that other hospitals should model after.

Where there is opportunity for growth is a continued focus on patient partnership in goal setting of programs, and a greater awareness of the patient relations program where families can turn to when there are concerns.

Priority Process: Competency

The teams utilize standardized orders sets, standardized handover tools (e.g., IPASS), standardized transitions tools (e.g., Patient Oriented Discharge Summary ~ PODS) and other evidence-based guidelines. Programs models are developed alongside other hospitals with content expertise or evaluated programs (e.g., SickKids eating disorders) at times, however the organization also develops novel programming anchored in evidence. One such example is the Smoking Cessation program which is evidence based, innovative, virtually provided and aims to shift the conversation from 'quit smoking' to counselling to understanding the underlying factors resulting in addiction.

The organization also has a Clinical Practice and Education Committee (CPEC) that meets monthly, reviews evidence, research and guidelines and develops targeted approaches for implementation. An example would be the 'protected code blue' protocols which need very quick transition, but evidence based to ensure the safety and well-being of staff, especially within the COVID environment. Other examples of EBG's pertaining to COVID was a dedicated Clinical Resource Leader (CRL) that would provide real time information on how to care for patients with COVID with ever changing information.

Education appears to be the underpinning of all programming development and including the perspectives of patients and families were provided within examples when using satisfaction surveys, real-time feedback, and feedback from community.

MGH is on a journey of fully implementing PODS across the organization and has successfully implemented in cardiology, critical care, surgery and COVID units. While planned to be fully implemented by the end of 2020, the pandemic shifted resources and focus necessitating a slower implementation.

Encouraged is for the organization to continue to involve patients and families in more 'live' co-design events in programming as priorities shift when the pandemic resolves.

Priority Process: Episode of Care

Organizationally staff are knowledgeable to their respective programs regarding how clients enter into program, what elements are important (e.g., falls, pressure injuries, handovers) and how partnership with patients and families is critical in the development of positive outcomes. The huddles were identified as a key conduit for discussing goal & objectives for the day, focus on safety, concerns and a general 'check in' for staff with their respective leaders.

Each area has a Clinical Resource Leader (CRL) that assists in the clinical development of staff, ensuring education is provided in a timely way and ensure high quality safe care. The CRL's have been pivotal during COVID with the translation of changing practice requirements whereby staff feel safe and supporting despite daily shifts. Each area also has full access to Infection Prevention and Control (IPAC) which was noted to be invaluable from front line staffing. Having the expertise to assist in navigating PPE questions, isolation, transmission, and general elements of safe practice assisted in allaying fears and supported seamless care.

Staff were quite articulate in the saying 'nothing about me without me' as it related to partnerships with patients and families when developing care plans, care goals, transitions to other units/home or just supporting communication. What was expressed was the difficult and unique nature of COVID that has changed the course of partnership in ways that are deeper and more positive with families.

Patient partnership and innovation was also shared as an example whereby staff took 'real time' feedback and quickly integrated the information to ensure safe transitions home. Many patients while happy to return home, could not without support of home services. Yet many expressed their concern of having multiple providers entering their home during COVID as it was a real 'fear' of these vulnerable clients. Together a richer process of transition home with support was developed to ensure families felt safe, readmissions were minimized, and hospital flow supported.

Another Quality Improvement initiative within the Complex Continuing Care was the ‘4-P’ initiative which ensuring the 4 key elements patient positioning, patient pain, patient personal items and patient personal care. Through the survey feedback process the team was able to identify with hourly rounding and ensuring these key elements were addressing that all downstream challenges such as behaviour, restraints, falls could be mitigated. The program has also shifted focus to more ‘habilitation’ which requires patients to be more active, sitting for meals and where possible ambulating regularly. Every patient has a detailed care plan that is created with the patient and/or family to meet the needs, goals and wishes of the person receiving care. Across the organization Gentle Persuasion Approach (GPA) is taken to reduce the number of inadvertent code whites called, and the limit the need of using restraints. The program within complex care is quite compassionate and patient focused.

Ethics within the inpatient setting is understood and the process for consultation was clearly described. While access varies from program to program in areas such as Complex Continuing Care, or Hospice and Palliation the team is pulled in quite often to assist in difficult conversations and work towards ethical resolution.

The Cardiac Program is another exemplary area that continues to grow and expand to meet the needs of the community. With strong partnerships with Sunnybrook and St. Mike's they can provide urgent lifesaving procedures, with repatriation agreements that allow for care and rehabilitation closer to home. These relationships are cultivated and expanded to include Emergency Management Services (EMS) and ensure that the right care is provided timely.

Staff on multiple occasions could articulate the incident reporting system. Incidents are reported centrally and MGH has a process to discuss critical incidents as well incidents with lower levels of harm. The huddle boards are the general vehicle to discuss incidents when they occur from a systems lens and share the learnings which occur from the review process. Shared was the value in hearing improvements and that the organization really focused on process and systems.

Staff overall expressed their pride to be part of the MGH community and that it felt like family, where there was a strong sense of care and accountability.

Continued opportunities are regarding incident management and building quality improvement from incidents. While it is very clear that incidents are explored and discussed at the local level, there doesn't appear to be a centralized or thematic analysis that leads to broad scale quality improvement, or the information is not shared organizationally of thematic elements for improvement.

The surveyor visited the inpatient surgical unit and the airway inpatient unit. Staff on both units were extremely proud of their work, the team, and the departments that they worked in. They were familiar with quality and safety protocols including falls, infusion pump handling, restraint protocols and pressure with quality and safety protocols including falls, infusion pump handling, restraint protocols and pressure sore processes. An interdisciplinary team approach was visible in both units and staff understood the relevance of collaborating with fellow regulated health providers (e.g., dietician).

Leadership is accessible and visible. Staff needs are identified and supported by clinical educators, clinical team leads, supervisors and managers. A Nurse Practitioner was associated with the Airway inpatient unit and took an active role in all ventilating aspects of patient care. Staff feel empowered to recognize and assist with quality improvement initiatives such as e.g., patient discharge checklist, weaning chronically ventilated patients.

The organization is encouraged to consider enhancements to their BPMH and medication reconciliation processes and flow. Essential BPMH and Medication reconciliation pieces are in place, however, the flow of information is not easy to access or interpret from an external lens. Computerize provider order entry is going to be provided soon. The organization is encouraged to move forward with the COPE project.

Priority Process: Decision Support

The organization has a hybrid model of electronic and paper-based records. There is a clear release of information process and staff are aware how to assist patients and families accessing records. During the cyber attack the medical record did not become a casualty as there were very solid downtime procedures, organizational resource leads to assist with paper-based process and teams standardizing their approach of documentation while in this temporary situation.

Priority Process: Impact on Outcomes

MGH is strongly connected to research entities across the academic hospitals and vets all research through the REB. There is appetite to continue to partner with other organizations to advance the knowledge of care in emerging areas (e.g., COVID) as well as existing populations that will serve the community.

Standards Set: Medication Management Standards - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Medication Management	

The organization has met all criteria for this priority process.

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

Leadership: MGH pharmacy program is comprised of roughly 42 FTE that include pharmacists, pharmacy technicians, pharmacy assistants and clinical resource leads. The program annually undergoes a separate accreditation process through the Ontario College of Pharmacists and was last accredited September 2020. The pharmacy program has supported the growth and development of staff through the certification of pharmacy technicians and assistants in IV and aseptic techniques. This certification is conducted annually to meet new guidelines.

The pharmacy is structured to provide support in a 'business model' or 'primary clinical assignment' to allow for focused support and expertise within a program. Medication reconciliation is conducted on admission by the pharmacy team to ensure standardization and completeness. Ongoing metrics demonstrates the effectiveness of this model.

Evidence is a primary focus of the group with standardized orders sets, key committees (e.g., Pharmacy & Therapeutics, Drug Safety Committee) to discuss evidence, guidelines, and the best ways that medication/ drugs should be used. The pharmacy group is also part of many drug trials related to COVID and IPAC or Infectious Diseases. This natural desire to advance the knowledge and practice of pharmaceutics within MGH will only serve the community into the future.

MGH overall has strength in their ability to formalize partnerships across the GTA to share resources and garner expertise. They have a formalized partnership poison control and other hospitals within the GTA for antidote sharing when required. They are also part of a larger consortium of hospitals in constant discussion regarding medication shortages. A principled ethical framework and risk lens is utilized when evaluating the organizations' ability to share medication or personal protective equipment with others.

The pharmacy group has recently embarked upon a QI initiative to address polypharmacy and the impact on the chronically ill and aging population within the community. The goal is to review all the medications people enter the hospital with and commence 'de-prescribing' medications that no longer have impact or may cause more harm. This pilot initiative not only allows for safer care with reduced risk of medication error, but it also allows the patient to have less future risk of interactions, fiscally reduces the medication costs to the hospital and patient and enables a more streamline and evidence-based formulary. This will be an exciting initiative for the team to follow up with.

The pharmacy team in full partnership with the infection prevention and control (IPAC) team have had a robust Antimicrobial Stewardship Program (ASP) since 2009. There are two dedicated pharmacists across the organization and review antibiotic administration three times a week. The process involves chart review, in-person assessment and discussions with the prescriber for education purposes. The program has won several leading practices and have published findings on 'Point-of-Care ß-Lactam Allergy Skin Testing by Antimicrobial Stewardship Programs: A Pragmatic Multicenter Prospective Evaluation' in the journal of infectious diseases. The partnership continues to drive home the importance of the ASP and have experienced success with a 60% reduction in anti-pseudomonas and c-difficile virtually being eliminated. Recommended is that the team continues to share their success with other organizations on a provincial and national scale to share the learnings.

The program has also embarked upon the Penicillin Allergies initiative which is a testing program (first of its kind in Canada) to assess individuals if in fact they have allergies to penicillin. The importance of the initiative is the limitation of drug/treatment options for patients who believe they are allergic to the drug. This program will ensure allergy accuracy and potentially more care options. The program will be embarking upon a larger clinical trial across Canada soon.

Finally, the pharmacy program has a dedicated organization resource lead that is working with the redevelopment project and preparing the program to support the new tower and old building. The process flows, automated bar coding, IT platforms will all be integrated and ensure a safer process for drug procurement, storage, and administration.

The program has a very strong and integrated team working on focused initiatives that serve the patients, promote safety and support staff.
A review of medication management was undertaken during onsite survey. The pharmacy team participates in regular safety huddles and performance improvement activities. Since previously being designated as a Leading Practice, the antimicrobial stewardship program has expanded the program to include prospective analysis, different types of cultures, and is working advocate to de-label penicillin allergy alerts as much as safe to do so. The organization is encouraged to explore ways in which to share this work.

Hazardous medications are prepared in a separate room from other medications. The team report being constrained by their current space. The organization is commended for their work towards standardizing IV pumps and has recently rolled out 300 IV pumps across the organization. Soft and hard limits have been established and there is a process in place for regular updates to IV pump medication library.

The pharmacy team has contributed to the organizations' overall COVID response within the hospital and community. The team are keen to continue working towards expanding the scope of practice of all pharmacy team roles and to continue establishing strategic partnerships. The organization is encouraged to consider additional ways in which they can engage patients and families in pharmacy projects and decision-making.

Standards Set: Mental Health Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Mental health and Addiction Services has a strong, committed, interprofessional team. The team has a recovery focused and inclusiveness approach to care. The clinical leadership engages patients and family, especially youth, in co-designing surfaces and comfort care plans. The clinical leadership is involved in several GTA, regional, provincial, and national specialist professional committees. Program leadership has implemented a shared Director of Mental Health role with a community partner organization. This operational leadership model further supports the organization and program staff to identify, co-develop, and implement programs that will meet the mental health and addictions current and anticipated needs in the foreseeable future. Program leadership is a well-established structure that provides specialized medical, nursing, and allied health guidance. This guidance has led to the implementation of in-patient and out-patient services as well as a community-based withdrawal management program that addresses mental health services that encompasses child, youth through to older adult services.

The leadership team is currently undergoing a service planning refresh. The team is engaging patients and family as well as their community partners in this planning process. A consistent theme shared by all members of the team was a commitment towards creating “synergies not silos” as they move forward with expanding existing programs and implementing new ones.

The team collects and monitors information about the communities with which they serve and use this information to plan and improve care. For example, they successfully advocated for separate space within the emergency department, increased security to 24/7 coverage, innovative resource navigation role, and an innovative transitional youth program

The pandemic reportedly presented a challenge for the mental health and addiction team to "think outside the box" and identify additional ways in which to collaborate with other clinical services and community partners. The team proudly shared stories of how they successfully rose to this challenge and worked with the pediatric team to utilize existing bed capacity in a different way that enabled improved bed capacity and patient flow for children and youth in need of inpatient intensive mental health care. Additionally, with support from hospital leadership and the infection prevention and control team, the MHS team was able to open a new mental health Covid-19 positive mental health inpatient unit. The team and organization are commended for their leadership and practice driven changes made to not only quickly create a new specialized unit but to enhance crisis team in reach capacity across the organization.

The mental health clinicians helped start the corporate wellness team and established a buddy system to support professionals providing psychiatrist access to staff in the hospital.

The clinical leadership team on both the adult and child services have developed operating plans and quality improvement initiatives that are monitored, reported, and shared with staff across the units by way of regular emails, huddle boards, unit-based councils, and informal communications.

Priority Process: Competency

Program and clinical leadership across the mental health and addictions services report having a focus towards ongoing education and professional development. For example, the teams engage in grand rounds, regular email updates, attendance at conferences, and when possible, invite experts to speak with the team on specific topics of interest. Additionally, regulated health professionals maintain required CME or college required education hours. Nursing staff receive a comprehensive orientation to the organization and to the mental health services area. This orientation includes violence prevention, falls prevention, protected code white, and mental health specific medication management.

The team report the ability to pursue additional education or added skills like CBT and mindfulness. The teams report that defined training and education for all staff is not yet in place across the program services. The program leadership is encouraged to formalize and define required training, qualifications, and competencies specific to the mental health and addictions program and services.

Program leaders and available frontline staff report being aware of the organizations ethical framework and supports available to assist with ethical decision-making.

The adult and the child and youth mental health teams have a strong focus towards safety and prevention and management of violent or aggressive behaviours. An alert system and a violence assessment tool have been adopted by the units. Both teams are commended for achieving a significant reduction in restraint use and the need for seclusion.

The teams utilize standardized communication tools and processes to share information at shift change and during patient transitions in care.

The teams spoke proudly about the strong interdisciplinary team approach that was consistent across all mental health and addiction services. The organization is encouraged to consider ways in which team effectiveness can be evaluated and strengthened. The teams noted some challenges in the recruitment of nursing and social workers, especially in the child and youth program areas. The organization is strongly encouraged to review existing roles, workload, and staffing needs.

Priority Process: Episode of Care

Organizationally staff are knowledgeable to their respective programs regarding how clients enter into program, what elements are important (e.g., falls, pressure injuries, handovers) and how partnership with patients and families is critical in the development of positive outcomes. The huddles were identified as a key conduit for discussing goal & objectives for the day, focus on safety, concerns and a general 'check in' for staff with their respective leaders.

Each area has a Clinical Resource Leader (CRL) that assists in the clinical development of staff, ensuring education is provided in a timely way and ensure high quality safe care. The ORL's have been pivotal during COVID with the translation of changing practice requirements whereby staff feel safe and supporting despite daily shifts. Each area also has full access to Infection Prevention and Control (IPAC) which was noted to be invaluable from front line staffing. Having the expertise to assist in navigating PPE questions, isolation, transmission, and general elements of safe practice assisted in allaying fears and supported seamless care.

Staff were quite articulate in the saying 'nothing about me without me' as it related to partnerships with patients and families when developing care plans, care goals, transitions to other units/home or just supporting communication. What was expressed was the difficult and unique nature of COVID that has changed the course of partnership in ways that are deeper and more positive with families.

Patient partnership and innovation was also shared as an example whereby staff took 'real time' feedback and quickly integrated the information to ensure safe transitions home. Many patients while happy to return home, could not without support of home services. Yet many expressed their concern of having multiple providers entering their home during COVID as it was a real 'fear' of these vulnerable clients. Together a richer process of transition home with support was developed to ensure families felt safe, readmissions were minimized, and hospital flow supported.

Another Quality Improvement initiative within the Complex Continuing Care was the ‘4-P’ initiative which ensuring the 4 key elements patient positioning, patient pain, patient personal items and patient personal care. Through the survey feedback process the team was able to identify with hourly rounding and ensuring these key elements were addressing that all downstream challenges such as behaviour, restraints, falls could be mitigated. The program has also shifted focus to more ‘habilitation’ which requires patients to be more active, sitting for meals and where possible ambulating regularly. Every patient has a detailed care plan that is created with the patient and/or family to meet the needs, goals patient has a detailed care plan that is created with the patient and/or family to meet the needs, goals and wishes of the person receiving care. Across the organization Gentle Persuasion Approach (GPA) is taken to reduce the number of inadvertent code whites called, and the limit the need of using restraints. The program within complex care is quite compassionate and patient focused.

Ethics within the inpatient setting is understood and the process for consultation was clearly described. While access varies from program to program in areas such as Complex Continuing Care, or Hospice and Palliation the team is pulled in quite often to assist in difficult conversations and work towards ethical resolution.

The Cardiac Program is another exemplary area that continues to grow and expand to meet the needs of the community. With strong partnerships with Sunnybrook and St. Mike's they can provide urgent lifesaving procedures, with repatriation agreements that allow for care and rehabilitation closer to home. These relationships are cultivated and expanded to include Emergency Management Services (EMS) and ensure that the right care is provided timely.

Staff on multiple occasions could articulate the incident reporting system. Incidents are reported centrally and MGH has a process to discuss critical incidents as well incidents with lower levels of harm. The huddle boards are the general vehicle to discuss incidents when they occur from a systems lens and share the learnings which occur from the review process. Shared was the value in hearing improvements and that the organization really focused on process and systems.

Staff overall expressed their pride to be part of the MGH community and that it felt like family, where there was a strong sense of care and accountability.

Continued opportunities are regarding incident management and building quality improvement from incidents. While it is very clear that incidents are explored and discussed at the local level, there doesn't appear to be a centralized or thematic analysis that leads to broad scale quality improvement, or the information is not shared organizationally of thematic elements for improvement.

The surveyor visited the inpatient surgical unit and the airway inpatient unit. Staff on both units were extremely proud of their work, the team, and the departments that they worked in. They were familiar with quality and safety protocols including falls, infusion pump handling, restraint protocols and pressure sore processes. An interdisciplinary team approach was visible in both units and staff understood the relevance of collaborating with fellow regulated health providers (e.g., dietician).

Leadership is accessible and visible. Staff needs are identified and supported by clinical educators, clinical team leads, supervisors and managers. A Nurse Practitioner was associated with the Airway inpatient unit and took an active role in all ventilating aspects of patient care. Staff feel empowered to recognize and assist with quality improvement initiatives such as e.g., patient discharge checklist, weaning chronically ventilated patients.

The organization is encouraged to consider enhancements to their BPMH and medication reconciliation processes and flow. Essential BPMH and Medication reconciliation pieces are in place, however, the flow of information is not easy to access or interpret from an external lens. Computerize provider order entry is going to be provided soon. The organization is encouraged to move forward with the COPE project.

Priority Process: Decision Support

The team utilizes the electronic health record for most of their clinical documentation. Comfort plans (aka care plans) have been built into the documentation platform. Both the adult and the child and youth services report having a consistent process by which they obtain and document client information. The team in both the adult and the child and youth services were aware of policies related to the collection, access, and privacy of client records. The team acknowledged that education about legislation to protect client privacy is provided regularly. Teams across all service areas have implemented IPASS to help standardize communication and the flow of information, especially during transitions of care. Further assessment and validation of compliance to legislation and policy will occur during the onsite component of the accreditation process.

Priority Process: Impact on Outcomes

The mental health team describe having a standardized procedure to select evidence informed- guidelines that are appropriate to the services offered. The clinical team are represented on several local, regional, provincial, and national specialist committees. These connections have enabled rapid access to best practice information that has reportedly helped reduce unnecessary variation in service delivery. Evidence-based tools are reviewed and updated regularly by subject matter experts. Patient and family feedback is incorporated into the review process.

The child and youth service actively engage their patients in the development of policies and in the codesign of program changes. The mental health leadership team is encouraged to further involved patients and family directly in their policy and procedure development process.

Client information, including behavioural triggers, is collected on admission, and following a behavioural related incident (i.e., seclusion) and incorporated into the clients' comfort plan. This information further helps towards mitigating the risk of harm to client and staff and towards improving patient safety. The teams report that post-incident debrief communication has provided a welcome opportunity for shared learning, consistent practice, and helped reduce the number of patients being restrained or requiring seclusion. Suicide prevention tools have been implemented to the adult service. A modified suicide prevention tool has been developed and implemented in the child and youth service.

Quality improvement activities are conducted, reported, and shared amongst the team on each unit as part of regular safety huddles. Mental health and addiction services report having the patient engagement panel. This panel provides an opportunity for input into program plans and improvement activities.

Standards Set: Obstetrics Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Obstetrics Services and Special Care Nursery (SCN) program leadership shared with pride and candor many of the program successes and opportunities for improvement. Annual program goals and objectives are in place and monitored regularly by the team. The team utilize data in their planning and service development. This year the goals were developed with input from front-line staff and patient/family feedback was also considered as much as possible. The team is encouraged to continued engaging front-line staff and to engage patients and families purposefully and directly in future program planning cycles.

The program administrative, medical, and nursing leadership are involved in several external committees and actively seek out opportunities for community partnership. The strong community presence and collaborative approach to care has resulted in several new or enhanced programs that are helping to meet the needs of patients and community. For example, the team has been involved in education regarding diversity and equity and are in the process of updating policies to reflect a more inclusive nomenclature. Examples of clinical programs being developed include, an interdisciplinary program providing medical and social support for patients with addictions, translated patient information resources, early pregnancy clinic, and parental support program (SCN) that is being transitioned to a virtual model.

The team report having a process to assess and request space, staffing, and equipment resources needed to deliver care across the program areas. The OBS and SCN engage in regular team meetings and huddles to monitor safety and progress in achieving objectives.

Priority Process: Competency

There is a strong focus on education and skills development in all areas of Obstetrics Services and Special Care Nursery (SCN). There is a robust orientation program provided on hire and when returning from an extended leave. Each area has identified mandatory education required for medical and nursing staff. Nursing have implemented a competency-based framework that helps support and monitor staff progress from novice to expert. Mandatory education is monitored via an LMS system. Annual infusion pump training is provided. New Smart Infusion pumps have been implemented in the clinical area. Staff report receiving infusion pump training annually and recent training on the use of the new infusion pumps.

Program leadership, clinical leaders, and front-line staff (virtual meeting) report awareness of both the process and the supports available to assist with ethical dilemmas and decision-making. Across the program areas leaders and staff report a strong sense of collaboration, safety, and person-centered care. The teams utilize standardized communication tools (iPASS) to communicate during transitions in care and utilize SBAR to communicate situations requiring escalation (i.e., deteriorating patient condition).

The staff in both the Obstetrical units as well as the SCN report ongoing challenges with recruitment of staff. There is a process in place to support department cross-training and staff report being able to pull-in staff from within OBS units to assist during times of increased patient volumes. The organization is encouraged to develop staffing plans, surge, and acuity triggers within OBS and SCN units. There are several ways in which the OBS and SCN teams meet to discuss operational plans and quality improvement (huddles, UBC). The clinical leadership is encouraged to establish and implement a process to evaluate team effectiveness within each respective unit.

Priority Process: Episode of Care

The leadership and staff during this virtual survey consistently report a sense of pride in their practice and care provided to clients and families. Staff are commended for their ongoing commitment to maintaining essential 24/7 services across the Obstetric Service units as well as within the Special Care Nursing throughout the pandemic.

Prenatal information is sent by a patients' community provider via fax to the OBS area prior to delivery. The information received from the community provider is reviewed and assessed to identify potential increased risk. Where increased risk is identified prior to delivery a process is available to have additional staff and specialists attend the birth.

The clinical team in each clinical unit describe a robust process by which information about the client is gathered as part of the triage/admission process. The team report the use of standardized assessment tools and processes that were developed with input from patients.

There is a lactation consultant providing a breastfeeding clinic in Ambulatory care usually 3-4 days/week. On clinic days the lactation consultant will round on in-patients. All nursing staff working in each program unit complete a 21-hour breastfeeding training program.

Client information is shared with other members of the care team(s) in person during transitions in care using iPASS.

Staff receive training regarding fetal surveillance and policies are in place regarding fetal health assessments. Escalation processes and alerts are in place to respond to changes in maternal and/or fetal condition. The OBS team report following a standardized process to prioritize, and schedule planned C-sections that allows for the capacity to respond to emergency situations. The team report having 24/7 access to OBS and anesthetist. The team shared awareness of the consent policy. Staff also indicate they are aware of the process to obtain support with ethical decision-making.

The team receives information regarding community demographics and diversity and are encouraged to continue implementing education regarding culturally sensitive care and to develop translated patient education resources.

The SCN has defined admission criteria and access to the unit requires physician-to-physician dialogue and admission approval. The team report a consistent process is followed to obtain consent with efforts undertaken to enable time for discussions between co-parents as required during pandemic related visitor restrictions.

The program leadership are strongly urged to review practices and processes by which parent/visitor identification is checked on entry and exit to the unit to further protect children in their care (i.e., Code Amber).

Each unit across the program begin discharge planning on admission and report having a supportive process with a goal of a smooth and safe discharge home. There are several specialty clinics offered that help provide additional specialized support and follow up to newborns, expectant, and post-partum women and families.
The team are commended for their efforts to maintain Breast Feeding Friendly designation. The unit has recently completed a 'smile zone' project with input from patients and families. The unit is brightly coloured, filled with large pictures, and has a welcoming family kitchen area. There are way-finding signs on the floors that have reportedly helped people locate specific units.

The organization have begun to offer free on-line prenatal and breastfeeding classes. The team are encouraged to continue their work to build program Mental Health and Addiction linkages, knowledge, and skills.
A falls screening tool has been developed for use in the department. Falls assessment is completed at various times throughout the episode of care. The organization is encouraged to consider using a standardized falls risk assessment tool across the organization or consider validating tool currently used in the Obstetrics program. The organization is encouraged to review departmental security and access protocols.

The components of medication reconciliation are in place. The pharmacist completes a medication reconciliation note that is included in the electronic health record. At time of onsite review, it was difficult to identify/locate the Best Possible Medication History and medication reconciliation. The organization is strongly recommended to review the documentation and implement a clearly defined process of BPMH and medication reconciliation.

Priority Process: Decision Support

The OBS and SCN clinical leadership and staff available during the virtual survey report that documentation is completed primarily on the Cerner system. Education is provided on the documentation system and on documentation policies and practices within each specialty area.

Staff report feeling comfortable in being able to voice opportunities for improvement and generally are provided with a response when a request for resources is made. Clinical leadership and staff available during the virtual survey report that training and education about legislation to protect client privacy and information is conducted regularly. Staff in OBS and in SCN consistently reported awareness of a chart auditing process to ensure that client information is accessed appropriately. Staff are aware of the policy and procedure for patients to access their medical record including accessing information via the My Chart portal.

Priority Process: Impact on Outcomes

The specialized teams across the OBS units as well as the SCN follow established clinical guidelines. Additionally, teams consistently reported that a standardized process is in place to select and monitor compliance to evidence-informed guidelines appropriate for the services offered. Whilst the teams utilized some patient feedback in the development of standardized tools, they are encouraged to engage patients and families purposefully in the development of guidelines and best practices in future.

The teams each use their huddle boards and available data (ICP, COVID-19) to identify and respond to risks in both a proactive and responsive way. The team consistently reported awareness of the incident management and disclosure process. Also, the leadership and staff consistently reported feeling there is shared accountability for safety and a just culture. Quality improvement activities, indicators, and progress are displayed on each unit's quality boards and discussed during safety huddles.

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

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

The preoperative team is well coordinated and collaborative. There have been many challenges during COVID and the sound ethically driven and community engaged approach has driven a fair and transparent approach to the allocation of resources during COVID. Clear process and strong leadership from Anesthesia and Surgery are clearly a strong point of the organization. The leadership team responds appropriately to the needs of patients and providers are respected when advocating for the needs of the patients. “Three wise people" is an innovative approach.

There have been significant quality improvements because of clear collaboration between Surgery, Anesthesia, Nursing, and administration. Significant results include reduced length of stay in ortho and thoracic surgery, reduced blood transfusion, and reduction in opioid prescription through multi modal analgesia delivery.

The preoperative program has strong collaborations with Barrie and Sunnybrook and readily share information through trusted relationships and process. There is early success with virtual care and follow information through trusted relationships and process. There is early success with virtual care and follow up and remote monitoring of patients.

Significant changes in the process of prep assessment have reduced the length of stay significantly in the clinic. Opportunities to expand the virtual preoperative assessment program are ongoing.
The leadership is progressive, innovative, and diverse.

Priority Process: Episode of Care

The first surgical pause was completed with the inclusion of the patient. The patient was introduced to all surgical members that were present in the Operating Room. The patient was positioned by the surgeon with a focus on nerve and bone pressure points. The second pause occurred prior to the initial incision.

BPMH is collected for outpatients who have been interviewed during the Pre-Admit process. The surgical team have access to an electronic medication list on the computer. The Anaesthetist interviews the patients prior to the induction of the anaesthetic and is familiar with BPMH. The surgical pause was used to identify any concerns for questions including medications.

At transition from the OR to the PACU unit, a verbal handover is given by the anaesthetist and OR staff. A "PCU I-Pass" form is completed by the OR staff and given to the PACU staff to ensure a comprehensive list of information is provided at handoff to PACU staff. PACU staff receive physician orders for patients prior to their transfer to the inpatient unit or discharge.

It is suggested that all mattress and arm boards in the OR are inspected to ensure chipped or cracked items are replaced with new ones. MDRD currently uses the general population elevators for transporting case carts and other instruments. It is suggested the organization consider a dedicated service elevator for the MDRD department to reduce risk of contamination for sterile products. Michael Garron Hospital is currently in a redevelopment phase.

Laser processes and safety measures are in place. Staff and physicians receive mandatory education prior to using the laser machine and are re-certified as required.

The Operating Room has good work and product flow. It is clean, well lite and organized. Staff noted they have ample equipment and supplies. The anaesthetic medication carts are standardized, and the anaesthetists are accountable for signing out narcotics and wastage. The surgical team appears to work cohesively and collaboratively.

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

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

The organization has met all criteria for this priority process.

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

The organization utilizes several POCTs across the clinical areas. POCT is overseen by a duly qualified member of the laboratory service. Regular quality control (QC) of all POCT devices is completed and monitored. QC monitoring is supported with Ageis software that is linked to the laboratory system. Currently, devices are connected to the system when placed in the docking unit. However, the lab is planning to covert POCT devices to a wireless system enabling real-time data integration.

The team report having a robust point-of-care testing education program. Education is supported with the help of clinical resource leaders provide annual mandatory education, follow-up education, and proficiency testing to front-line clinical staff.

The Department of Laboratory medicine monitors quality control and quality assurance of point-of-care testing (POCT) conducted across the organization. The laboratory was Accredited by IQMH and in November 2020 received their mid-cycle virtual assessment. The assessment identified one area of POCT non-conformance. The nonconformance was identified as uncertainty of measure for quantitative POCT calculations. The team report at this specific requirement has recently been added to the IQMH standards. The organization has 90 days to comply with this nonconformance.
POCT policies and procedures are consistently followed. Compliance to POCT policies and quality controls are monitored by the laboratory staff routinely with appropriate follow up as required. Staff wear appropriate PPE. Specimens are labeled as per policy.

Standards Set: Transfusion Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Episode of Care

.

Priority Process: Transfusion Services

Transfusion services collect and report indicators during Monday-Friday huddles and report on monthly transfusion statistics. The transfusion services report having a transfusion committee that includes a patient representative and includes a member from the Jehovah's Witness faith who provides input to the transfusion programming. Transfusion education is provided to nursing staff during orientation and includes infusion reaction management. The team acknowledges collecting information about the demand for transfusion services regularly and reportedly adjusts service volumes based on clinical trends and changing service demand. The team have a robust document management system that alerts staff when new or revised SOPs are implemented. There is a policy in place regarding the management of any incidents of transfusion reaction.
The Transfusion team is a small team that is very committed to providing the best possible care for their patients. The team was also very proud to have recently presented at Sickle Cell Canada conference. There is a developing partnership with two large GTA hospitals and homecare to provide some home-based care. The organization is commended for their efforts to collaborate and integrate care and are encouraged to continue to develop evidence-based guidelines and training.

Instrument Results

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

Governance Functioning Tool (2016)

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

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

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

- **Data collection period: September 23, 2019 to September 26, 2019**
- **Number of responses: 14**

Governance Functioning Tool Results

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1. We regularly review and ensure compliance with applicable laws, legislation, and regulations.	0	0	100	93
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	0	0	100	97
3. Subcommittees need better defined roles and responsibilities.	79	14	7	66
4. As a governing body, we do not become directly involved in management issues.	21	0	79	85
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	93

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
6. Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	98
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	0	100	95
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	0	0	100	95
9. Our governance processes need to better ensure that everyone participates in decision making.	100	0	0	60
10. The composition of our governing body contributes to strong governance and leadership performance.	0	0	100	93
11. Individual members ask for and listen to one another's ideas and input.	0	0	100	96
12. Our ongoing education and professional development is encouraged.	0	0	100	91
13. Working relationships among individual members are positive.	0	0	100	95
14. We have a process to set bylaws and corporate policies.	0	0	100	92
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	98
16. We benchmark our performance against other similar organizations and/or national standards.	0	0	100	78
17. Contributions of individual members are reviewed regularly.	0	0	100	64
18. As a team, we regularly review how we function together and how our governance processes could be improved.	0	7	93	79
19. There is a process for improving individual effectiveness when non-performance is an issue.	0	0	100	61
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	0	0	100	84

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
21. As individual members, we need better feedback about our contribution to the governing body.	71	14	14	34
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	0	0	100	81
23. As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	95
24. As a governing body, we hear stories about clients who experienced harm during care.	0	0	100	80
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	0	0	100	92
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	0	0	100	86
27. We lack explicit criteria to recruit and select new members.	93	0	7	76
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	0	0	100	90
29. The composition of our governing body allows us to meet stakeholder and community needs.	0	0	100	93
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	94
31. We review our own structure, including size and subcommittee structure.	0	0	100	89
32. We have a process to elect or appoint our chair.	0	7	93	91

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2019 and agreed with the instrument items.

Overall, what is your assessment of the governing body's impact over the past 12 months, in terms of driving improvements to:	% Poor / Fair	% Good	% Very Good / Excellent	%Agree * Canadian Average
	Organization	Organization	Organization	
33. Patient safety	0	0	100	82
34. Quality of care	0	0	100	84

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2019 and agreed with the instrument items.

Worklife Pulse

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

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

Accreditation Canada provided the organization with detailed results from its Worklife Pulse 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:**
- **Minimum responses rate (based on the number of eligible employees): 336**
- **Number of responses: 0**

The organization used a substitute tool.

Client Experience Tool

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

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

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

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

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

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

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

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

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.

Appendix B - Priority Processes

Priority processes associated with system-wide standards

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

Priority processes associated with population-specific standards

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

Priority processes associated with service excellence standards

Priority Process	Description
Blood Services	Handling blood and blood components safely, including donor selection, blood collection, and transfusions
Clinical Leadership	Providing leadership and direction to teams providing services.
Competency	Developing a skilled, knowledgeable, interdisciplinary team that can manage and deliver effective programs and services.
Decision Support	Maintaining efficient, secure information systems to support effective service delivery.
Diagnostic Services: Imaging	Ensuring the availability of diagnostic imaging services to assist medical professionals in diagnosing and monitoring health conditions
Diagnostic Services: Laboratory	Ensuring the availability of laboratory services to assist medical professionals in diagnosing and monitoring health conditions
Episode of Care	Partnering with clients and families to provide client-centred services throughout the health care encounter.
Impact on Outcomes	Using evidence and quality improvement measures to evaluate and improve safety and quality of services.
Infection Prevention and Control	Implementing measures to prevent and reduce the acquisition and transmission of infection among staff, service providers, clients, and families
Living Organ Donation	Living organ donation services provided by supporting potential living donors in making informed decisions, to donor suitability testing, and carrying out living organ donation procedures.
Medication Management	Using interdisciplinary teams to manage the provision of medication to clients
Organ and Tissue Donation	Providing organ and/or tissue donation services, from identifying and managing potential donors to recovery.
Organ and Tissue Transplant	Providing organ and/or tissue transplant service from initial assessment to follow-up.
Point-of-care Testing Services	Using non-laboratory tests delivered at the point of care to determine the presence of health problems
Primary Care Clinical Encounter	Providing primary care in the clinical setting, including making primary care services accessible, completing the encounter, and coordinating services
Public Health	Maintaining and improving the health of the population by supporting and implementing policies and practices to prevent disease, and to assess, protect, and promote health.
Surgical Procedures	Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge