ACCREDITATION
AGRÉMENT
CANADA
Qmentum

Accreditation Report

Toronto East Health Network

Toronto, ON

On-site survey dates: June 12, 2016 - June 16, 2016

Report issued: June 29, 2016

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 June 2016. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

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

Confidentiality

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

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

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

A Message from Accreditation Canada

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

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

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

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

We look forward to our continued partnership.

Sincerely,

Leslee Thompson
Chief Executive Officer

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Executive Summary

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: June 12, 2016 to June 16, 2016**

- **Locations**

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

  1. Community Outreach Services
  2. Toronto East General Hospital
  3. Withdrawal Management Services

- **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. Ambulatory Systemic Cancer Therapy Services - Service Excellence Standards
  7. Biomedical Laboratory Services - Service Excellence Standards
  8. Critical Care - Service Excellence Standards
  9. Diagnostic Imaging Services - Service Excellence Standards
  10. Emergency Department - Service Excellence Standards
  11. Hospice, Palliative, End-of-Life Services - Service Excellence Standards
  12. Long-Term Care Services - Service Excellence Standards
  13. Medicine Services - Service Excellence Standards
  14. Mental Health Services - Service Excellence Standards
  15. Obstetrics Services - Service Excellence Standards
  16. Organ and Tissue Donation Standards for Deceased Donors - Service Excellence Standards
  17. Perioperative Services and Invasive Procedures - Service Excellence Standards
  18. Point-of-Care Testing - Service Excellence Standards

19. Reprocessing and Sterilization of Reusable Medical Devices - Service Excellence Standards
20. Substance Abuse and Problem Gambling - Service Excellence Standards
21. Transfusion Services - Service Excellence Standards

- **Instruments**

The organization administered:

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

Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
Population Focus (Work with my community to anticipate and meet our needs)	61	0	0	61
Accessibility (Give me timely and equitable services)	118	0	0	118
Safety (Keep me safe)	735	3	17	755
Worklife (Take care of those who take care of me)	163	0	1	164
Client-centred Services (Partner with me and my family in our care)	525	3	1	529
Continuity of Services (Coordinate my care across the continuum)	96	0	2	98
Appropriateness (Do the right thing to achieve the best results)	1255	4	3	1262
Efficiency (Make the best use of resources)	66	1	0	67
Total	**3019**	**11**	**24**	**3054**

Overview by Standards

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

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

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

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

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	50 (100.0%)	0 (0.0%)	0	36 (100.0%)	0 (0.0%)	0	86 (100.0%)	0 (0.0%)	0
Leadership	49 (100.0%)	0 (0.0%)	0	96 (100.0%)	0 (0.0%)	0	145 (100.0%)	0 (0.0%)	0
Infection Prevention and Control Standards	39 (100.0%)	0 (0.0%)	2	29 (100.0%)	0 (0.0%)	2	68 (100.0%)	0 (0.0%)	4
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	44 (100.0%)	0 (0.0%)	2	78 (100.0%)	0 (0.0%)	0	122 (100.0%)	0 (0.0%)	2
Ambulatory Systemic Cancer Therapy Services	64 (97.0%)	2 (3.0%)	0	92 (100.0%)	0 (0.0%)	0	156 (98.7%)	2 (1.3%)	0
Biomedical Laboratory Services **	71 (100.0%)	0 (0.0%)	0	105 (100.0%)	0 (0.0%)	0	176 (100.0%)	0 (0.0%)	0
Critical Care	50 (100.0%)	0 (0.0%)	0	115 (100.0%)	0 (0.0%)	0	165 (100.0%)	0 (0.0%)	0

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Diagnostic Imaging Services	64 (95.5%)	3 (4.5%)	0	64 (97.0%)	2 (3.0%)	3	128 (96.2%)	5 (3.8%)	3
Emergency Department	71 (100.0%)	0 (0.0%)	0	107 (100.0%)	0 (0.0%)	0	178 (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
Long-Term Care Services	54 (100.0%)	0 (0.0%)	0	99 (100.0%)	0 (0.0%)	0	153 (100.0%)	0 (0.0%)	0
Medicine Services	45 (100.0%)	0 (0.0%)	0	77 (100.0%)	0 (0.0%)	0	122 (100.0%)	0 (0.0%)	0
Mental Health Services	50 (100.0%)	0 (0.0%)	0	91 (98.9%)	1 (1.1%)	0	141 (99.3%)	1 (0.7%)	0
Obstetrics Services	70 (98.6%)	1 (1.4%)	2	88 (100.0%)	0 (0.0%)	0	158 (99.4%)	1 (0.6%)	2
Organ and Tissue Donation Standards for Deceased Donors	52 (100.0%)	0 (0.0%)	2	96 (100.0%)	0 (0.0%)	0	148 (100.0%)	0 (0.0%)	2
Perioperative Services and Invasive Procedures	114 (99.1%)	1 (0.9%)	0	108 (99.1%)	1 (0.9%)	0	222 (99.1%)	2 (0.9%)	0
Point-of-Care Testing **	38 (100.0%)	0 (0.0%)	0	48 (100.0%)	0 (0.0%)	0	86 (100.0%)	0 (0.0%)	0
Reprocessing and Sterilization of Reusable Medical Devices	50 (100.0%)	0 (0.0%)	3	61 (100.0%)	0 (0.0%)	2	111 (100.0%)	0 (0.0%)	5
Substance Abuse and Problem Gambling	45 (100.0%)	0 (0.0%)	0	82 (100.0%)	0 (0.0%)	0	127 (100.0%)	0 (0.0%)	0

Transfusion Services **	70 (100.0%)	0 (0.0%)	5	68 (100.0%)	0 (0.0%)	1	138 (100.0%)	0 (0.0%)	6
Total	**1213 (99.4%)**	7 (0.6%)	16	1712 (99.8%)	4 (0.2%)	8	2925 (99.6%)	11 (0.4%)	24

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

Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Safety Culture			
Accountability for quality (Governance)	Met	4 of 4	2 of 2
Patient safety incident disclosure (Leadership)	Met	4 of 4	2 of 2
Patient safety incident management (Leadership)	Met	6 of 6	1 of 1
Patient safety quarterly reports (Leadership)	Met	1 of 1	2 of 2
Patient safety-related prospective analysis (Leadership)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Communication			
Client Identification (Ambulatory Care Services)	Met	1 of 1	0 of 0
Client Identification (Ambulatory Systemic Cancer Therapy Services)	Met	1 of 1	0 of 0
Client Identification (Biomedical Laboratory Services)	Met	1 of 1	0 of 0
Client Identification (Critical Care)	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 (Diagnostic Imaging Services)	Met	1 of 1	0 of 0
Client Identification (Emergency Department)	Met	1 of 1	0 of 0
Client Identification (Hospice, Palliative, End-of-Life Services)	Met	1 of 1	0 of 0
Client Identification (Long-Term Care Services)	Met	1 of 1	0 of 0
Client Identification (Medicine Services)	Met	1 of 1	0 of 0
Client Identification (Mental Health Services)	Met	1 of 1	0 of 0
Client Identification (Obstetrics Services)	Met	1 of 1	0 of 0
Client Identification (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 (Substance Abuse and Problem Gambling)	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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information transfer at care transitions (Ambulatory Systemic Cancer Therapy Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Critical Care)	Met	4 of 4	1 of 1
Information transfer at care transitions (Emergency Department)	Met	4 of 4	1 of 1
Information transfer at care transitions (Hospice, Palliative, End-of-Life Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Long-Term Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Medicine Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Mental Health Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Obstetrics Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Perioperative Services and Invasive Procedures)	Met	4 of 4	1 of 1
Information transfer at care transitions (Substance Abuse and Problem Gambling)	Met	4 of 4	1 of 1
Medication reconciliation as a strategic priority (Leadership)	Met	4 of 4	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Ambulatory Care Services)	Met	7 of 7	0 of 0
Medication reconciliation at care transitions (Ambulatory Systemic Cancer Therapy Services)	Met	7 of 7	0 of 0
Medication reconciliation at care transitions (Critical Care)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Emergency Department)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Hospice, Palliative, End-of-Life Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Long-Term Care Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Medicine Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Mental Health Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Met	5 of 5	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures)	Met	8 of 8	0 of 0
Medication reconciliation at care transitions (Substance Abuse and Problem Gambling)	Met	3 of 3	2 of 2
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 pump safety (Ambulatory Care Services)	Met	4 of 4	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Infusion pump safety (Ambulatory Systemic Cancer Therapy Services)	Met	4 of 4	2 of 2
Infusion pump safety (Critical Care)	Met	4 of 4	2 of 2
Infusion pump safety (Emergency Department)	Met	4 of 4	2 of 2
Infusion pump safety (Hospice, Palliative, End-of-Life Services)	Met	4 of 4	2 of 2
Infusion pump safety (Long-Term Care Services)	Met	4 of 4	2 of 2
Infusion pump safety (Medicine Services)	Met	4 of 4	2 of 2
Infusion pump safety (Mental Health Services)	Met	4 of 4	2 of 2
Infusion pump safety (Obstetrics Services)	Met	4 of 4	2 of 2
Infusion pump safety (Perioperative Services and Invasive Procedures)	Met	4 of 4	2 of 2
Narcotics safety (Medication Management Standards)	Met	3 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Client Flow (Leadership)	Met	7 of 7	1 of 1
Patient safety plan (Leadership)	Met	2 of 2	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Worklife/Workforce			
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
Infection rates (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Pneumococcal vaccine (Long-Term Care Services)	Met	2 of 2	0 of 0
Patient Safety Goal Area: Risk Assessment			
Falls prevention (Ambulatory Care Services)	Met	3 of 3	2 of 2
Falls prevention (Ambulatory Systemic Cancer Therapy Services)	Met	3 of 3	2 of 2
Falls prevention (Critical Care)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Falls prevention (Diagnostic Imaging Services)	Met	3 of 3	2 of 2
Falls prevention (Emergency Department)	Met	3 of 3	2 of 2
Falls prevention (Hospice, Palliative, End-of-Life Services)	Met	3 of 3	2 of 2
Falls prevention (Long-Term Care Services)	Met	3 of 3	2 of 2
Falls prevention (Medicine Services)	Met	3 of 3	2 of 2
Falls prevention (Mental Health Services)	Met	3 of 3	2 of 2
Falls prevention (Obstetrics Services)	Met	3 of 3	2 of 2
Falls prevention (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
Pressure ulcer prevention (Critical Care)	Met	3 of 3	2 of 2
Pressure ulcer prevention (Hospice, Palliative, End-of-Life Services)	Met	3 of 3	2 of 2
Pressure ulcer prevention (Long-Term Care Services)	Met	3 of 3	2 of 2
Pressure ulcer prevention (Medicine Services)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Pressure ulcer prevention (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
Suicide prevention (Emergency Department)	Met	5 of 5	0 of 0
Suicide prevention (Long-Term Care Services)	Met	5 of 5	0 of 0
Suicide prevention (Mental Health Services)	Met	5 of 5	0 of 0
Suicide prevention (Substance Abuse and Problem Gambling)	Met	5 of 5	0 of 0
Venous thromboembolism prophylaxis (Critical Care)	Met	3 of 3	2 of 2
Venous thromboembolism prophylaxis (Medicine Services)	Met	3 of 3	2 of 2
Venous thromboembolism prophylaxis (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.

Toronto East Health Network has as strong a connection with the community. These relationships have developed over the years and are a reflection of the fact that the organization is viewed as the community's hospital, and the hospital sees its role as supporting the community. Strengthening this bond are the numerous staff that have "grown up" both in the community and at the hospital.

The hospital makes regular efforts to reach out to the community. The Community Advisory Panel is one such example. This is a group of community members who meet approximately five times a year and who are consulted on issues that affect or could potentially affect the community. Community engagement will need to ramp up over the next number of months, not only due to the strategic planning process but also in light of the redevelopment project that is planned to commence roughly in 2018. While the long-term impacts of the project will be far reaching and positive, in the short term the community can expect potential disruption which will require ongoing and clear communication.

The surveyors met with a number of local health care providers, including representatives from area hospitals, primary care centres, community health centres, public health, the Community Care Access Centre (CCAC), and the Thorncliffe neighbourhood office. All spoke glowingly of the organization's commitment to partnering with other providers and working together to meet the health needs of their shared populations. Examples were provided regarding community clinics being established, proactive CCAC relationships that facilitate patient flow, being present at the community level, and developing proactive relationships with public health (i.e., Baby Friendly Initiative designation, and local health links).

The organization has a reputation for being easy to work with, and is just as happy seeing a community partner coordinate/run a service as it is running it itself. As such, community agencies want to partner with MGH due to this philosophy. As the Patients First agenda continues to roll out across the province, this attitude and mindset will put the organization in a strong position and validate the move toward the Toronto East Health Network.

Toronto East Health Network (TEHN) is governed by a very strong volunteer board of directors. The board is well structured around governance accountabilities and provides the appropriate level of strategic guidance and direction to allow leadership to effectively manage the operation.

The board is involved in a number of key strategic initiatives, most notably the development of a new, five-year strategic plan to be completed in 2016. Five task forces support the development of the new plan: innovation, education, funding, networks, and care. All task forces address specific questions with feedback provided to form a key part of the planning process.

The board has a very clear commitment to listening to its internal and external communities in developing the plan. Reaffirming the vision, mission, and values will be a key component of the refresh. The timing, given external developments in the system, is very appropriate. Relationships between the organization and its community are excellent, in no small part due to the board’s commitment to reach out not only directly but through a Community Advisory Panel.

Board functioning is very high level, with a clear emphasis on strategic planning as well as quality, safety, risk mitigation, and fiscal stewardship. Systems and processes are well developed and as a result the board is able to meet its responsibilities on behalf of the community and the organization.
Looking ahead, a tremendous emphasis will be placed on the redevelopment project which has the potential to consume significant governance time. Having structures in place to ensure the board is able to provide appropriate oversight to the project and maintain its accountabilities in relation to the ongoing operation of the organization will be important.
The board has a very good skill mix. As the network further develops it will need to ensure its membership continues to reflect the diverse community served by the organization.
Leadership is remarkably passionate about the organization, the care it provides, and the role it plays in the community and in the broader health care system in supporting staff, physicians, and volunteers to ensure that only the highest quality, evidenced-based care is provided to all patients. Significant efforts have been made to develop leaders throughout the hospital, and exceptional tools are available to assist in this area. Many staff have advanced in the organization, including one who started as a porter and is now director of emergency and diagnostic imaging.
The visibility of the leadership team throughout the organization is noted by all and it sets a very clear expectation around the organization's priorities. Setting a course for the organization is one thing; advancing it by being present is another and this team does that very well.
While expectations are high, the environment is designed to allow those with energy, passion, and commitment to thrive and excel. This philosophy creates a high-performing organization in every sense of the word.
Like all hospitals, staff are under significant pressure to meet expectations, not only on the patient care side but also on the business side through efforts to maximize quality-based procedures and quality improvement efforts. As such, performance expectations placed on individual staff members and physicians are high. With these expectations, however, comes a very strong support network with MGH. The organization has a wellness strategic plan that articulates the efforts it will make to foster a healthy work environment. Embedded in this is the development of a comprehensive mental health strategic plan, enhanced work-life balance programming, and introducing a gym and fitness studio to support the team. TheTEHN was the first hospital in Canada to receive the Mental Health at Work Platinum Level Award of Excellence from Excellence Canada is a reflection of this commitment.
Introducing a second victim program, developing a world-class workplace violence prevention program, and continually looking at strengthening support for everyone associated with the organization contributes significantly to the fabric of the organization. The survey team noted that staff and physicians were remarkably committed to the organization and trusting of the directions being pursued. This trust in no small part stems from the organization's commitment to support its people.

The survey team visited most clinical areas of the organization and was impressed with the level of care provided throughout. Facility limitations and the resulting crowding in some areas hindered staff to a degree; however, significant efforts were made on a daily basis to ensure these challenges did not impact direct patient care. All areas were focused on quality improvement, with commitments to ongoing quality improvement activities noted across the enterprise. Staff were very engaged, not only in care delivery in their immediate area but also in the organization as a whole. Discussions regularly reinforced a strong awareness of health and safety practices and a good understanding of the need to maintain education levels through the i-Learn system.

Commitments to processes such as Choosing Wisely Canada ensure the organization remains at the forefront of clinical delivery of services, and the relentless focus on quality and improvement will ensure the programs and services continue to follow best practice.

Like all hospitals, significant energy is expended on patient flow, ensuring that the right patient is in the right bed at the right time, and that where feasible, any patients not required to remain in the hospital are moved to the most appropriate locations. At multidisciplinary minute rounds, every patient is reviewed daily by all who are involved in the patient's care, including immediate care delivery and transition care.

A multidisciplinary, highly motivated team is responsible for patient flow. The team has had considerable success in establishing effective relationships across multiple departments and service areas. Targets are established, regularly reviewed, and often exceeded. MGH is among the highest performer in the province with regard to meeting provincial targets. Of note, the week the survey team was on-site, the Local Health Integration Network (LHIN) was experiencing some of its highest alternate level of care rates, whereas MGH was experiencing some of its lowest. This is a direct testament to the organization's discharge philosophy.

The team is acutely aware that success may bring further demands and pressures on an already stretched system and is approaching the future with confidence. The team is highly proactive, with protocols for managing surges and bottlenecks in the system. Establishing the medical short stay unit has been a major benefit. As in many areas across the organization, the use of quality boards and regular team huddles is a key part of working life.

The ongoing evolution of patient advisors is an initiative that plays a significant role in the organization. A Patient Experience Panel (PEP) has been in operation for a number of years and the organization is engaging their expertise more and more around the table. Their involvement in policy review, publication reviews, hiring panels, and plan development, to name a few, ensures the patient voice is front and centre. As this engagement continues to evolve, rounding with patient advisors may provide some interesting insights into how the facilities, including signage and accessibility, are viewed by patients.

The organization is commended for its approach to collecting, reporting, and following up on client satisfaction data. The importance MGH places on this is reflected in the fact that patient satisfaction is included as one its quality improvement plan indicators and forms a significant part of its operations. Patient feedback is sought in a number of ways, with all feedback reviewed by the Patient Relations Office. Feedback complies with provincial legislation requiring follow up within five days and the level of detail of the follow up with patients and families is commensurate with the concern raised and the wishes of the complainant. That the organization has decided not to follow the Quality of Care Information Protection Act by treating all incidents in a "non-protected" manner reinforces this.

The most impactful part of the on-site survey was viewing videos made by the organization of patients and family members talking about their care. The stories were compelling and were clear reminders of why, as healthcare providers, ensuring a patient- and family-centred care model is fundamentally important.

The organization is clearly a leader in the delivery of innovative, evidence-based care. It has a strong focus on the future through research and learning and is well positioned to grow as a sub-region hub as health care delivery in Ontario continues to evolve. This enviable position stems from a dedicated, focused leadership team and a passionate, caring organization.

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)

Organizational excellence starts with the board of directors. For an organization to truly advance, its leadership needs to set clear direction, implement a strong accountability framework, and then hold the organization responsible for delivering results.

The on-site survey began with a meeting of the governors of the organization, including board members from all relevant subcommittees. The board's overall structure was noted with approval. It has a clear balance in focus between board accountability, strategic planning, and quality and fiscal oversight.

TEHN is dealing with a number of key issues that require strong governance attention. First, the organization is developing a new strategic plan, aimed for release late in 2016. The board has established a thorough process aimed at securing internal and external input. It has also appropriately analyzed its environment and is very aware of the demographic profile it supports. Five task groups have been established to inform the plan's development and all, when complete, will ensure a strong, balanced approach. The organization is commended for stretching its plan window from three to five years as this will provide stability as it moves forward.

The emphasis on quality and safety at the board level is noted with approval. There is no area of more importance to an organization than committing itself to providing the highest quality care possible to all who walk through its doors. The quality framework, with direction and support from the board, ensures this focus. Regular reporting to the board of directors through an aligned committee structure ensures the organizational priorities related to quality are addressed. The approach taken by the board in credentialing professional staff members, specifically in establishing a special credentials committee that included two voting members of the board, meant these members were then able to insulate the full board from being removed from potential hearings should a credentialing challenge arise.

In advancing the quality agenda, the board will need to ensure the organization remains focused, as it is easy to cast too wide a net when addressing quality initiatives and not have the operational capacity to support the efforts.

From a resource oversight perspective, the board has strong processes and sets clear expectations around performance. For the first time in recent history, the organization is facing an operating deficit which changes the focus somewhat at the governance level. However, principles remain the same and that is the resolve to set clear direction and hold the organization responsible to deliver. The operating plan framework does this appropriately, and plans are in place to ensure a balanced operation by year end.

The organization is moving closer to a major capital expansion of approximately $450 million, with a significant local share required. Maintaining operational fiscal integrity will be key as this project moves closer to fruition. The board will also need to ensure the capacity and controls necessary to support such a large initiative are in place.

The board is commended for how it functions. It has a thorough recruitment process aimed at ensuring the right skill mix around the table, and a strong internal accountability framework. A commitment to ongoing education, development, and evaluation is noted with approval and the organization's emphasis on governance versus management is a significant enabler as it moves forward.

The board is commended for the relationships it has developed and continues to grow with its local community and various health care partners. Its commitment to healthy partnerships, as reflected in the recent name change of the hospital and the introduction of the Toronto East Health Network, is a strong reflection of this.

The board should be proud of the leadership role it has played in bringing the organization to where it is today, and equally proud of the steps it is now taking toward ensuring the organization continues to thrive and, more importantly, continues to exceed the health care needs of the population it serves.

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)

MGH is commended for its strategic plan that is currently being used to direct the organization. It clearly articulates the vision, mission, and values and promotes direction and alignment through the success factors of encouraging people, cultivating collaboration, inspiring people, ensuring value, and being patient centred. In reviewing documentation and in discussions with members of the MGH team, it was evident that the plan provided the framework against which decisions were made for the organization operationally, tactically, and strategically.

The organization is commended for its efforts in the area of patient and family engagement through its PEP. Surveyors met with representatives of this panel, volunteers from the Research Ethics Board, and the chair of the Community Advisory Panel. In all discussions, it was clear that the voices they brought to the table were heard and that there was an enthusiasm, on behalf of the volunteers and the organization, to broaden the engagement. To date, by providing its perspective on signs and policies (e.g., vaccinate or mask, family presence, patient publications, wayfinding, health equity, the quality improvement plan, and being involved in hiring panels), the PEP has had a very positive effect on care delivery across the organization. The organization has also recently introduced a Hemodialysis PEP that will bring the same focus to the patient journey as has the "parent" PEP since 2012. There are efforts to incrementally increase the voice of the patient at various committees and tables and the organization is urged to continue to focus on this important area.

The organization is in the early days of a refreshing its strategic plan, aiming to develop a new, five-year plan. The process is called Voyage 2021. Five task forces have been engaged around innovation, education, care, networks, and funding. Through an appreciative enquiry process, these task forces will inform the broader process with the goal being to hold a board summit in the fall, preparatory to a pre-Christmas launch of the new plan. Supporting the process are comprehensive environmental scans, population demographics and projections, and health system intelligence. In the end, the organization will have a new plan that includes a re-affirmed/re-crafted vision, mission, and values as well as a re-energized brand and identity. The organization is commended for the process it is following and for the extent to which it is involving its customers, community, stakeholders, and teams in the process.

The organization is commended for its planning processes and how it ensures good alignment across the organization. Planning is comprehensive, clear, and concise. The operational planning process is sound and involves all programs and services in establishing clear goals and objectives, with strong metrics.

The organization is commended for establishing a Community Advisory Panel and has put in place a healthy agenda process to ensure strong input. Engagement around external relationships and partnerships, redevelopment, rebranding, and community connectedness have all helped strengthen the organization.

The organization has a remarkably strong planning environment and is commended for its leadership.

Priority Process: Resource Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization is commended for the integrity of its financial controls, both from an operating and a capital perspective. Review of documentation highlighted a robust process for setting annual plans and a clear commitment to full organizational engagement in fiscal planning. Annual process assumptions are confirmed by the board of directors and then rolled out to the organization in a structured manner.

The organization is facing, for the first time in some time, the need to address an operating deficit. The team is commended for the focus it is bringing to this reality, and its clear understanding and commitment toward ensuring efficient and effective delivery of care. The Performance Improvement Committee (PIC) provides operational direction in this area and it was noted that the ethical framework is brought into the discussion regularly. As such, discussions are open and frank, and always focused on doing what is right. While people may not always be happy with directions chosen, they all respect the integrity of the process and hence the outcomes.

The processes to ensure managers and directors have access to real-time data are very strong. The ability to review information daily and the structure of accountability ensures the organization is able to manage variances in real time, thereby helping significantly to track progress against specific financial targets.

The focus on quality-based procedures management is noted with approval. PIC is multidisciplinary and has ensured a high degree of financial literacy across the organization. The paired leadership model between clinical and administrative team members helps ensure all aspects of the funding model are understood and addressed.

The processes to determine capital investments, whether clinical equipment, information technology, and/or renovations, are strong. Robust priority setting at the departmental/program level rolls up to a process where all items are reviewed against clear criteria and then ranked together. Once approved, strong processes are in place from a purchasing as well as an "accountability to complete" perspective.

The 12-year cash flow projections are noted with approval, particularly in light of the extensive redevelopment plans in the organization's future. The "own share" requirement is significant; however, the organization's internal integrity, strong Foundation, and tremendous relationship with the community will position it for success.

The ability to generate information necessary for managers and directors to manage and lead their respective portfolios is noted with approval. The relationships between decision support, health records coding, and clinical informatics is strong and is being leveraged by the organization. The entire team is

commended for its commitment to ensuring the right information is available at the right time for the right individuals.

The fiscal reality in health care in Ontario is a challenge for all. The ability to address this varies across organizations and the processes at MGH put it in a strong position to navigate the ongoing fiscal pressures. The team is commended for its commitment to excellence in all that it does and, most notably, for the capacity it has developed across the organization and the resulting financial literacy that exists.

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 organization is commended for its dynamic human resources team and for the support it provides to all staff, volunteers, and physicians associated with the organization.

There is a clear commitment to excellence and an awareness that providing programs that advocate for wellbeing needs to be a priority. The organization's workplace violence prevention program is very strong, with all staff appropriately trained and aware of the supports provided through the policy. The strength of the program is reflected in the fact that it is viewed as a best practice by other organizations and is being highlighted by Health Quality Ontario.

This commitment to wellbeing is present through other avenues, including the second victim program, which provides strong support to individuals who have experienced traumatic situations, and a strong focus on building a mentally healthy workplace. This latter program is redefining organizational supports in this area and sets out clear strategies on how the organization plans to achieve strong results for its team. The external recognition reinforces this and the "go-forward" focus on mental health education and awareness, prevention, management, and positive workplace culture has the potential to set the organization apart.

Safety is clearly a strategic priority, with strong investments in a number of areas, including personal protective equipment, personal safety devices such as Vocera, and the importance of crucial conversations in engaging fellow staff and patients.

The strategic plan, which includes developing exceptional leaders, cultivating a healthy work environment, driving performance and accountability, promoting healthy bodies and healthy minds, fostering staff safety, and inspiring innovation, is alive across the organization. Surveyors noted the positive culture, the very engaged team, and the strong commitment to innovation. It was also noted that a number of staff in managerial/leadership positions had been developed internally through program supports across the organization. This develops a tremendous level of commitment and expertise within and across the organization.

The organization is commended for its efforts in the area of talent management and more specifically for the framework advocated in the talent management discussion guide released in May 2016. The commitment to and recognition of the inter-connectivity of workforce planning, talent acquisition, learning and development, performance management, and career progression is noted with approval. With the roll-out planned for the next two fiscal years, emphasis on this will be key. Of note, the organization has a very committed and long-standing workforce which will result in an ever-increasing

need to identify new talent from within and outside the organization. This program will help significantly with stablilization.

The organization is commended for undertaking employee opinion surveys and more so for developing a clear engagement strategy through thoughtful analysis of the results. Of note, efforts to ensure a culture that fosters LGBTQ inclusiveness are noted with approval. Internal discussions and discussions with external partners reinforced the importance of this, and also the esteem in which the organization is held for its leadership.

The organization's onboarding programs and commitment to continuous learning were noted with approval. While these were typically focused on staff, it was noted how well supported and engaged volunteers were across the organization. In discussions with volunteers, the commitment to ensuring they had the tools necessary to support their roles was clear. The volunteer program, with close to 500 members, is one of the cornerstones of the care provided to the community and for that, all should be remarkably proud.

The organization's efforts in staff retention are also noted with approval. Significant energy is spent recognizing performance and commitment with celebrations and events. At a more granular level, supports like the staff-in-need fund reflect a caring culture that is the envy of many.

The tone of the organization is very much set by the commitment to excellence across the human resources program, and the team is commended for the tremendous impact it has on the provision of high-quality and accessible care.

Priority Process: Integrated Quality Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

MGH is commended for the commitment it brings to quality management.

A culture of quality improvement appears to be embedded across the organization. All areas visited had a clear understanding and appreciation of the importance of quality improvement and had the tools to identify opportunities and advance them accordingly. Regular huddles have been introduced incrementally over the past number of years. They occur across the organization and cover program-specific and corporate topics.

The organization is commended for the 400 Good Catches program and congratulated for celebrating its 100th catch while the survey team was on-site. This innovative way of promoting and advocating for a culture that celebrates risk identification and avoidance is a testament to the passion everyone at the organization brings to improving the patient and staff journey.

The organization is commended for its approach to disclosure, specifically the open and professional manner with which it responds to concerns raised by patients and/or families, and by the process to initiate an investigation. It was clear, from examples presented, that the rights of the patient are the number one priority. That the organization has decided not to follow the Quality of Care Information Protection Act by treating all incidents in a "non-protected" manner reinforces this.

Of note, the organization has a very impactful video program where patients and family members are interviewed about the care they received. These stories are remarkably moving and provide powerful teaching moments. Videos are played ahead of most meetings and provide great context for the discussions ahead.

The hallmark of the organization's focus on quality improvement is the development of the annual quality improvement plan. While this is required to be submitted to Heath Quality Ontario and can be somewhat prescriptive in nature, MGH sees the process as way to annually re-calibrate its quality focus. The plan is developed from the bottom up. There is a call to staff identifying potential areas of focus, followed by identification of measurement plans, priority setting, and finally confirmation of methods and measures. The cycle allows for appropriate governance engagement and sets the tone for all quality improvement activities across the organization.

The organization identifies priority areas: smoking cessation, total margin, C-section rate, workplace violence prevention, patient experience, Clostridium difficile (C. difficile), medication reconciliation at

discharge, emergency department (ED) wait times, alternate level of care, rescue from danger, and quality-based procedures 30-day readmission rate. The impressive point to note from the indicators in the plan is that they cross many areas and reflect a strong balance of the overall priorities of the organization.

Supporting the quality improvement plan is the organization's quality and safety plan that addresses topics such as the organization's framework, including monitoring and accountability, risk management, and resource requirements. Driven by the MGH success factors (encourage people, cultivate collaboration, inspire innovation, ensure value, and patient centred), the plan is the foundation for safe, high-quality care through balancing quality improvement, risk management, organizational safety, and measurement and monitoring as well as the added focus on Health Quality Ontario's six dimensions of quality (patient-centred, safe, efficient, effective, timely, and equitable)

The team is commended for the prospective analyses undertaken over the past couple of years, including continuous electrocardiogram monitoring in the cardiology inpatient unit and lab specimen transportation from the outpatient department. This commitment to reviewing processes is supported by a wealth of information that is provided to programs and services to help them review their respective indicators. All areas of the organization track specific metrics and all are aligned with the broader corporate objectives. The balanced scorecard reviewed by the board summarizes ongoing quality activities and reflects the commitment of the board in this important area.

Despite the major ongoing initiatives around quality improvement, the organization is always looking for new and different ways to deliver service. Whether through the six hospitals in the Joint Centres for Transformative Health Care Innovation, Think Differently meetings, operations huddles, or the formal senior leadership team social media strategy, everything is focused on improving care and access for the patient.

The MGH team should be rightly proud of its advances in quality management. All are to be congratulated.

Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization is commended for its frameworks for ethics-based research, ethics decision making, and overall corporate ethics decision making.

A comprehensive discussion was held with members of the Research Ethics Board and the hospital ethicist to understand and appreciate the breadth and depth of the efforts in these areas. The organization is commended for its commitment to "research ethics by design," which in essence promotes ethics as a part of the research initiative as opposed to oversight. This shift in emphasis has been received remarkably well by those requesting research approval as it creates much more of a partnership culture. The culture that has developed is one of the Research Ethics Board being an enabler to good strong research, and the ethics framework as adopted and followed has clearly been embraced by those working in the research space. The organization is also commended for its overall commitment to research, the success of which is in no small part due to the approach taken in assessing the ethical implications of the work undertaken.

In discussions with clients and patients, as well as through feedback from various committees and groups, it became clear that attention to the level of understanding of substitute decision making is needed. Given the incidence of chronic disease and the importance of end-of-life care, ensuring sound, clear information and communication in this area is necessary. The various tools developed and efforts in play were commendable.

The ethics framework was also very much in play across the organization. Recent discussions around medical assistance in dying, the organization's name change, and ongoing budget deliberations reinforced not only the commitment of the organization in applying the framework but, more importantly, the value it brings to grounding discussions around what is important.

One area of focus during the discussion was the organizational capacity around ethics, specifically with staff and physicians being comfortable identifying and participating in ethical discussions at the front line. There have been clear and ongoing efforts to provide the support necessary to train staff, and this is commended. Of note, very few documented situations have arisen on the front lines where specific ethics consultations with the ethicist were required, which reinforces a comfort level in dealing with situations in the moment.

The MGH members who are involved in and support the principle-based care and decision-making processes and philosophy are commended for their leadership.

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)

The communications team consisted of representatives from information management, information technology, corporate communications, business intelligence and special projects, and privacy and freedom of information. The collegiality and collaboration among these individuals was evident, as was their individual and collective support for the MGH strategy. Their focus on and support for patient- and family-centred care and engagement is noteworthy, particularly recognizing that their involvement may be somewhat more indirect relative to their clinical counterparts.

The team profiled their role in the development of the patient videos used to advance patient- and family-centred care. They also modelled the practice of patient storytelling with a video that illustrated an aspect of their unique role in support of patient- and family-centred care, specifically the implementation approximately two years ago of a program that gives patients and families computer access and access to Skype to connect to family or businesses in remote locations. The support for this service is based on the importance of communication and connectivity to the quality of patient experience, satisfaction, and safety.

The 2014-2017 communications strategy emanates from the MGH strategy, and includes ambitious tactics and targets. The plan is to refresh the communications strategy as soon as the corporate strategy is refreshed. The process will include and be informed by an update of the 2013 communications survey. The team describes using a multi-pronged approach to gaining input from internal and external stakeholders through face-to-face encounters, soliciting feedback through email and social media, and mining available data on satisfaction with communication through patient relations and engagement surveys. With each update of the plan, the team is encouraged to ensure the new version is dated and all content changes are highlighted to help those referencing the documents to understand the changes.

The communications team is a small, dedicated team that supports the executive and board as well as front-line managers and staff. The team has been very proactive and creative in its support and advancement of social media. There are processes to ensure capture and timely response to feedback and comments using plain language.

As part of a deliberate approach to profiling and celebrating the accomplishments and successes of teams and the organization in general, there is a very thoughtful approach to when, where, and how to frame messages. For example, the recent acknowledgement for MGH's engagement and integration of midwifery will be framed from the perspective and with the voice of midwives, staff, and most importantly, patients.

Recognizing that all staff play a critical role in communications and profiling the organization, staff have been educated about the value of storytelling. There is a tool kit for managers on how to facilitate effective communication, support for the implementation of engagement strategies such as huddles and leadership rounds, and the communications team is readily available to support leaders and staff with messaging. Given the limitations in communication resources, there has been a focus on building capacity in the organization for all staff and leaders to enable communication. This ensures communications team members are available to be involved and plan effective communication for high-profile issues, such as renaming/rebranding, and for corporate projects, such as the launch of MyChart. This ensures communication becomes part of effective change management.

There is excellent support for electronic documentation, with the majority of inpatient documentation being electronic. Access to results and documentation by patients will be enabled by the launch of MyChart in July, following a year of detailed planning. In the interim, there are effective processes to facilitate access to information in a timely fashion, with support from clinical team members as appropriate for interpretation.

A successful business case was made to prioritize capital funding for information technology infrastructure and connectivity to overcome dead spots in operational/clinical areas, based on patient/staff satisfaction and care/quality risks associated with Vocera and input of vital signs monitor data. The focus on patient care quality and safety is also evident in the ability to provide e-discharge communication to continuing care providers typically within 24 hours. The organization is recognized as a leader with notification of admission/discharge and ED visits, and has been engaged to support other hospitals in the LHIN with this leading practice.

The teams describe constructive collaboration and support with operational and clinical teams. The constructive approach taken by the physicians and Medical Advisory Committee in reframing chart deficiencies from provider-centric with a negative emphasis to a quality of care process supporting continuity of patient care is an excellent illustration of support for the corporate mandate of quality, safety, and integration.

Clinical and operational support teams describe the value they place on decision support in helping with mining, presenting, and analyzing data, to support an understanding of population needs as well as decision making and performance oversight.

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)

This is an impressive, multi-skilled team that exhibits a high level of collaboration and cooperation.

The team recently received an award for the major improvement in risk reduction, for which they are justifiably proud.

The response rates to disasters, both flooding and ice storms, have been exemplary.

The team conducts preventive maintenance programs and regular fire drills.

The team is dealing with an aging building and infrastructure and is to be commended for the maintenance of these. Planning for the new wing is well advanced and includes internal and external stakeholders.

Quality boards are evident in both the food services area and the hospital basement, and huddles are held regularly. The cleanliness and tidiness of the basement is a credit to the staff who work there.

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 emergency preparedness plans are up to date and extremely well developed. The plans are updated as a point of good practice, and the content continues to evolve to reflect the current environmental context and the engagement of internal and external partners, including patients (i.e., the development of a code silver, meaning an active attacker).

Education around preparedness is enabled through a number of avenues, including the intranet learning management system; education sessions facilitated by unit-based educators and/or content experts such as fire safety, infection prevention and control (IPC), and mental health; and conducting mock codes with feedback.

In the event of codes or infectious outbreaks, the protocols are described as effectively describing roles and accountabilities. In the current infection outbreak, the contribution and value of having a patient advisor engaged in the process to provide ideas for communication was observed. Debriefings occur to capture lessons learned and share opportunities for improvement.

All codes are captured at a corporate level, and the information is collated and correlated with reported security, patient care, and staff safety incidents. Status and trend reports are shared at corporate-level quality, safety, occupational health, and workplace violence meetings. Those generating and receiving the data are encouraged to consider if there are others who would benefit from receiving the information, to influence improvement at the unit and patient care levels (i.e., code whites). Some aspects of the reporting of codes and incidents remain paper based and manually collating them is resource intensive. Information technology infrastructure and support could be considered to help speed up the availability of assessment and decision making information.

At the system level, MGH is very engaged at the regional (LHIN-level emergency planning), provincial (Provincial Infectious Diseases Advisory Committee), and national (Hospital Emergency Preparedness Association) levels. An emergency management communication tool, in the form of an electronic board that supports information exchange between hospitals and agencies in the LHIN, enables timely communication and engagement of support and response in the Toronto area. There is a coordinated approach to preparing for events that could impact the system (i.e., the Pan Am games in 2015, the Paralympics in 2017) which entails planning with internal and external stakeholders.

In 2015, MGH received a Risk Improvement Award from FM Global and the Healthcare Insurance Reciprocal of Canada (HIROC), recognizing a significant improvement, from the 40th to the 91st percentile in five years, in its risk score. This achievement is a credit to the obvious collaboration of

leaders and teams throughout the hospital, and the focus on proactive planning and responsiveness to patient, staff, and environmental safety and risk issues.

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)

An interdisciplinary, highly motivated team is responsible for patient flow. The team has had considerable success in establishing effective relationships across multiple departments and service areas. The team is highly proactive. Targets are established, regularly reviewed, and often exceeded.

MGH is among the highest performers in the province with regard to meeting provincial targets. The team is acutely aware that success may bring further demands and pressures on an already stretched system and is approaching the future with confidence.

The protocols for managing surge and bottlenecks in the system were particularly impressive.

The establishment of the medical short stay unit has been a major benefit.

As in many areas across the organization, the use of quality boards and regular team huddles is a key part of working life.

Priority Process: Medical Devices and Equipment

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

There is a strong team managing the medical device reprocessing area. All staff working in the reprocessing area are appropriately trained with a certificate program as the minimum requirement for employment. Annual reviews and re-certifications are completed for all staff. The department manager is extremely proud of his team.

Staff responsible for environmental upgrades work closely with IPC when renovations occur to ensure there is no threat to the public, patients, staff, and physicians.

There is an excellent preventive maintenance program, and a great partnership with GE Healthcare who are on-site performing preventive maintenance and repairs as required.

There is a well-developed procurement policy and process. There is a transparent capital approval process that requires approvals for all equipment over $1,500. Better long-term planning for equipment review and renewal to ensure the equipment is always up to date and in good working order. Replacement is planned and completed in a timely fashion.

Staff satisfaction is high, as evidenced by the low turnover among those working in the reprocessing areas and in the maintenance department.

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

A needs assessment of the community served and patient populations are used by the hospital to assist in the development of specific ambulatory care clinics.

There are formal partnerships with The Hospital for Sick Children to share care for particular paediatric patients, to ensure the best possible care is provided.

Space is a challenge for many of the clinics. The plan with the new build is to co-locate clinics to enhance collaboration and patient and family satisfaction.

Priority Process: Competency

Staff in the ambulatory care clinics have the appropriate education, background, and credentials to provide the care patients need. For example, infusion pump training and information on preventing and managing workplace violence is done at orientation and annually. Team members have regular performance reviews.

Leadership at the clinics is commended for seeing the advantage of cross training staff to better manage clinic staffing needs and provide safe, competent care to patients. There is a collaborative, team approach to care provision in these clinics.

Priority Process: Episode of Care

Referrals primarily come from primary care physicians and the ED for most of the ambulatory care clinics.

Visits are prioritized so those requiring the most urgent follow up are seen in a timely fashion. Staff accommodate patient needs to ensure they can be seen when necessary (i.e., appointment times outside of regular clinic hours). In addition, also to ensure patients are cared for and improve the rate of no shows, pre-appointment reminder calls are made. No show rates are routinely monitored and reviewed to look for ways to reduce the number of no shows.

A patient information handbook is provided to patients and their families for certain ambulatory care clinics, to help them understand what to expect and the care to be provided. A language line is used to assist patients when they cannot understand or respond to physicians and staff in English.

Priority Process: Decision Support

Record keeping in the ambulatory care clinics can be a challenge as there is a mix of paper and electronic charting systems. Patient privacy and confidentiality is maintained using these charts.

Multidisciplinary teams working in the clinics document in the patient files, leading to appropriate information sharing. This is important for good patient care and outcomes.

Priority Process: Impact on Outcomes

The ambulatory care clinics serve a very diverse population and are physically spread out throughout the hospital. Staff and physicians are engaged in many formal research endeavours. There are also a number of quality smaller improvement initiatives, including plan-do-study-act (PDSA) studies.

Staff and physicians are very involved and continuously trying to improve the care and outcomes for their patients. This is an excellent quality portrayed by the staff working in these areas.

Standards Set: Ambulatory Systemic Cancer Therapy 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		
10.9	The client's informed consent is obtained and documented before providing services.	!
10.10	When clients are incapable of giving informed consent, consent is obtained from a substitute decision maker.	!
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 ambulatory cancer care service is growing at a rate consistent with the aging population and the national cancer incidence rate. As with other teams in the hospital, the oncology team is a broad-based, multidisciplinary team.

Referrals can be either those with a cancer diagnosis or a strong suspicion of cancer.

Especially noteworthy is the lung cancer pathway with strong evidence of reduced wait times for patients.

Tumour boards (multidisciplinary team [MDT] review) are well established. Not every patient is reviewed at MDT. This is potentially an opportunity not just to ensure the medical needs of the patient are met and meet standards of care, but also to identify potential non-medical needs of patients.

The Cancer Care Committee is in the process of recruiting a patient representative.

Telephone follow up with patients is an outstanding practice and has been shown to be very valuable.

The team is closely connected to Cancer Care Ontario programs and has a very strong and positive relationship with Sunnybrook Cancer Centre.

The team regularly monitors its performance and regularly exceeds wait time targets. All patients are seen within two weeks of referral, an outstanding accomplishment.

The team should be applauded for its use of computerized physician order entry (CPOE) and standardized treatment regimens.

The team would benefit from the addition of a dietitian to its staffing component, as well as additional psycho-social resources. The latter is a nation-wide issue in oncology and is regularly identified in patient surveys across the country as a service shortcoming.

Priority Process: Competency

This is a highly motivated team with a strong patient focus.

All team members are fully engaged in the quality improvement program.

Priority Process: Episode of Care

During the on-site survey, a group of highly motivated patients expressed a high degree of satisfaction with services received.

Patients and families are well engaged with service planning and design.

There is an implied consent process for chemotherapy administration. Review of patient records found wide variation in documentation about the consent process. Patients, staff, physicians, and the organization would be well served by the introduction of a standardized, written, signed consent form.

Nursing staff expressed a high degree of confidence in and showed excellent relationships with the medical staff.

Priority Process: Decision Support

The team is well connected to community resources and partner facilities.

Treatment regimens are standardized.

Priority Process: Impact on Outcomes

Outcomes are regularly monitored by the oncology team.

Huddles are held regularly.

The use of quality boards is widespread.

Priority Process: Medication Management

The team is applauded for its approach to the safe handling of chemotherapy agents.

Standards Set: Biomedical Laboratory Services - Direct Service Provision

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

The organization has met all criteria for this priority process.

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

In 2016, the laboratory participated in the Ontario Laboratory Accreditation program conducted by the Institute for Quality Management in Healthcare (IQMH).

The laboratory has excellent leadership and a strong management team with a skilled, competent interprofessional team. Multiple methods of education are used such as education rounds, annual skill and quality assessment of staff, lunch and learns, and webinars. Education is also provided to students working in the laboratory.

Microbiology is performed off-site as this testing is not available at the hospital. This works well for getting quick results.

The laboratory is to be commended for the expert quality assurance program led by pathologists to review all first-time malignancies. All discrepancies in the pathologists' opinions are resolved or the specimen is sent out for further review. This is an excellent practice that would be appropriate to share with the public to improve their confidence in the hospital's ability to identify and respond to tumours.

The laboratory management described this team as an amazing team who feel empowered to make improvements. There is confidence in the quality of laboratory results.

Standards Set: Critical Care - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Leadership on the critical care unit is very astute with regard to the staff and their needs. Staff longevity has been addressed with succession planning. A new nursing grad initiative financially supported by the critical care unit education, and in conjunction with George Brown College, is being used to prepare staff to replace those nearing retirement.

A dedicated team of physicians provides care on the unit.

The Code Blue Committee developed and tested an improved response to code blues in the hospital, with great success.

Staff are recognized for their good work on the huddle boards and newsletters, often as a team rather than as individuals.

Priority Process: Competency

Staff on the critical care unit have the appropriate credentials and are prepared for the care that they are expected to provide. An extensive orientation program is delivered at the time of hire. Annual re-certifications are done as needed.

Competency assessments are performed for particular procedures.

IV pump training and re-certification is mandatory.

Education and training for agency staff is exceptional, to ensure patients are provided with the same outstanding care that they receive from all the staff on the unit.

Priority Process: Episode of Care

The critical care unit provides tremendous patient care to a very sick population, paying particular attention to continuity of care using a multidisciplinary team approach. There is a defined process for the on-call physician handover to ensure continuity as well.

Minute rounds are impressive in providing a wealth of information to a variety of individuals in a very short time frame. Bedside rounds allow for the family, and the patient if possible, to be involved.

Information at transition points is handled well with appropriate follow-up documentation.

The unit is applauded for incorporating a daily bedside safety check to improve patient, family, and staff safety.

The physicians are remarkably proactive in their care provision when the family is invited to be present for procedures, up to and including resuscitation, in the critical care unit. This has increased the families' trust in the care provided while creating a therapeutic alliance between physician, patient, and family.

Priority Process: Decision Support

Patient records are accurate and up to date. The collection of patient information is commendable.

Flow of information is appropriate to the needs of the staff providing care.

Disclosure of information is done as required. Patients may access their records.

Priority Process: Impact on Outcomes

The critical care unit follows the hospital's direction for adverse event reporting, incident reporting, and the disclosure process. When an incident occurs, physicians are involved with disclosure to patients and their families, following appropriate fact finding to ensure the right information is provided.

Reporting on adverse events, incidents, and near misses is driven by the hospital in order to learn and improve the care provided to patients. A just culture is evident in the hospital, allowing staff to feel comfortable disclosing such events and using them as learning opportunities. This leads to many quality improvement initiatives of which the unit and hospital should be very proud.

Priority Process: Organ and Tissue Donation

Organ and tissue donation is well managed by the hospital, in particular by the critical care unit. There is a defined policy involving two physicians for neurological determination of death.

Minute rounds identify those where imminent death is likely.

The Trillium Gift of Life Network works closely with the organization when the possibility of tissue or organ donation is identified. The hospital performs tests and laboratory work as directed by the team at Trillium prior to the recovery of organs and tissue.

Standards Set: Diagnostic Imaging Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Diagnostic Services: Imaging		
4.1	The physical environment has clear signage in place to direct clients to the imaging service.	
4.2	The team has a separate service area that includes space for clients to wait and space for conducting diagnostic imaging procedures.	
4.3	For nuclear medicine, the team designates separate waiting areas to segregate clients who have been injected with radioactive substances from other clients.	!
4.8	The client service area is accessible to clients using mobility equipment such as wheelchairs, walkers and crutches.	!
17.5	The team collects, analyzes, and interprets data on the appropriateness of examinations, the accuracy of the interpretations, and the incidence of complications and adverse events.	!

Surveyor comments on the priority process(es)

Priority Process: Competency

The organization provides strong spiritual care as required.

Priority Process: Diagnostic Services: Imaging

The program is a progressive service providing a comprehensive array of services including general x-ray, bone mineral density, mammography, ultrasound, CT, MRI, nuclear medicine, and non-invasive vascular. Equipment in the program is a mix of new and old technology. Recent investments in mammography, including migrating to digital, pursuing Canadian Association of Radiologists accreditation to apply to become an Ontario Breast Screening Program site, and vascular and CT, combined with strong technology in all modalities places the organization in a good place to support the community it serves. As with most programs, reducing wait times is a major focus and efforts to address this through process improvement initiatives are ongoing.

Hours of operation have recently been reviewed, including increasing support to the ED to assist with patient flow.

The program's commitment to patient safety and quality improvement is noted with approval. Topics covered in a huddle that occurred during the on-site survey reinforced this commitment. Recent updates to the website are also a strong reflection of the Patients First culture promoted across the program. In addition, increasing the information available will greatly assist patients to navigate the system and result in a much better experience for patients and families alike. This focus on patients is also reflected through efforts to coordinate tests across modalities.

The surveyor team was impressed with the organization's overall commitment to quality improvement, particularly with the alignment and focus on achieving results. Current initiatives highlight an overall commitment to improvement in all aspects of the program and all align appropriately with the organization's overall strategic plan. Initiatives ranging from improved report turnaround time to patient satisfaction survey action plans to the new CT scan implementation reflect a program committed to advancing support for patient needs and expectations.

The tenor of the department was extremely positive. Members of the team who were interviewed reported that they feel supported by the organization and program. Furthermore, all felt that their voice is heard, something that was confirmed through staff involvement in equipment acquisition and overall priority setting. The tone created by the staff and volunteers promoted a welcoming environment with patients feeling supported and aware of ongoing activities.

The team is commended for its efforts to engage referring physicians to ensure the mix of services, in so much as possible, supports needs across the broader community. The action plan worksheet that was developed following a review of the diagnostic imaging physician survey conveys a keen interest in listening to referral partners.

Patient safety materials were noted with approval. Material for all modalities was readily available and easy to understand. The falls prevention policy included in the materials was approved two weeks prior to the survey. While this Required Organizational Practice has been rated as met, the program needs to ensure all aspects of the policy are appropriately implemented and followed by staff.

Waiting space for patients brought down to imaging from the floors is not appropriate. The program knows this is a challenge and ongoing efforts are being made to find solutions. With the planned increase in space as a result of the redevelopment project, the department and the organization are urged to address this situation.

Support for staff education and training was noted with approval and the program's commitment to effective radiation safety was evident throughout. All equipment is appropriately maintained through strong vendor relationships, with manuals available and updated as required. Policies and procedures are current and all staff are made aware of changes as necessary.

The diagnostic imaging program is a core service to the hospital. It is very well run and supported by an extremely positive, engaged, and well-trained team.

Standards Set: Emergency Department - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The ED team is a group of energetic, creative individuals who share a commitment to exploring and implementing ways of supporting access to services.

Program leaders have been very proactive and supportive of engaging patients as partners on teams and with informing improvement initiatives. For example, two patient advisors are now part of the program's Quality Improvement Committee and there is active recruitment to include an advisor as part of the interprofessional unit-based council. There has been long-standing engagement with and respect for the perspective of the Patient Experience Panel. The team described how patient input directly influenced such things as the design of the ED space and the triage process.

The team described the value placed on relationship building with internal and external partners.

Priority Process: Competency

Respectful collaboration among all team members is evident and is modelled by leaders in the program.

Staff scheduling for nursing reflects staggered shifts to support the predicted flow of visits to the ED. Staff generally work in all areas to ensure capacity and capability to respond to changes in volumes or staff availability.

Staff describe an orientation that supports gaining skills and competencies to work in each area of the department. When new equipment or systems are introduced, such as the Omnicell drug cabinet, education to support safe use and successful implementation of change is provided.

The educator facilitates a very robust education program for the interprofessional team members, in collaboration with educators from other clinical programs such as mental health, paediatric, and cardiac programs, or those supporting corporate-wide initiatives such as falls prevention and mock codes. Staff have access to i-Learn for online education and to track their completion of mandatory and elective educational offerings. Professional and leadership development is also supported with attendance at conferences, involvement in corporate initiatives, and pursuit of certifications/academic programs.

Leaders and staff are sensitive to the importance of self-care for staff wellbeing. In instances of high volume, traumatic clinical outcomes, critical incidents, or personal need, there are opportunities to modify assignments. There is also support for debriefing (second victim support).

Priority Process: Episode of Care

Although the ED might appear somewhat sprawling, the team, with input from patients, has designed care areas, traffic flow, and signage that make it a safe and welcoming environment and one that is reasonably easy to navigate.

Tools and processes have been established to support communication from the point of presentation in the ED to transfer/discharge from the ED. The Canadian Triage and Acuity Scale (CTAS) is used and triage and assessment/documentation tools have been standardized, including general ED assessment as well as falls and suicide risk, among others. Accountabilities are clear for specific assessment and documentation processes, such as medication reconciliation by the pharmacist for admitted patients in the ED.

Staff work closely with patients and families to understand patient needs, goals, and care plans. Printed materials are available to augment verbal information. All observations of encounters between staff and patients in the ED were respectful, professional, and supported direct participation of the patient and family.

There are great supports and resources for specific patient populations with care planning and support in the ED setting. The immediate availability and access to designated mental health crisis workers and psychiatrists are believed to have contributed to improved care and patient flow for this population.

The ED collaborates with other programs to ensure safe, quality patient care at transition points. Close monitoring of wait times and examining these relative to clinical areas and services has helped focus attention on opportunities for improvement. The reduced wait time for transfer of patients to critical care is an excellent illustration of teams collaborating in the interests of patient safety and patient flow. Similarly, a quality improvement project that involves identifying patients who are scheduled to leave the ED but appear to be at risk for deterioration has resulted in a pause to reconsider the appropriateness of the timing of the transfer and/or the destination unit. This is believed to be having an impact on the rates of unexpected inpatient deterioration on inpatient units.

Priority Process: Decision Support

The ED does not as yet have an electronic medical record comparable to what exists in the inpatient units. The majority of documentation in the ED is paper based and is scanned into an electronic record on discharge. This requires the ED to have additional and sometimes unique processes to ensure timely access to care information and to safeguard privacy. The goal of eventual total electronic medical records is supported. It is noted that the department appears to have adequate computers and information technology support to ensure timely access to the component of the patient record/diagnostics that make up part of the electronic medical record.

In terms of evidence-based protocols, staff describe how Choosing Wisely Canada has influenced some of the ED admission order sets and care protocols. Similarly, revised protocols and collaboration between diagnostic imaging and the ED have reduced specific diagnostic imaging requests, with the benefit of reduced patient exposure to radiation.

Priority Process: Impact on Outcomes

Huddle boards and rounds are used to support communication and engagement of staff in quality improvement and understanding of performance. The ED teams explained that the unit-based council and the ED Quality Risk and Safety Committee receive program level data and performance and benchmarking reports, and help identify the information, such as issues of concern or worrisome trends, that should be prioritized for communication on the boards and during rounds.

Priority Process: Organ and Tissue Donation

The Trillium Gift of Life Network provides information about referral processes and is a resource to the staff when appropriate. Because the hospital is not a trauma centre, there are limited volumes.

Data regarding referrals and tissue donations are received regularly from Trillium and sharing is overseen by program leaders.

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

This is a highly motivated, strong, multidisciplinary team with a strong patient focus. The team has developed a suite of goals and objectives.

Patients and families are well engaged in the planning of services and families are regular visitors to the staff and the unit. A patient who was interviewed was loud in his praise of the services received.

The team demonstrated exceptional working relationships.

The unit has been recently painted but needs the return of the art work as soon as the frames can be adjusted to comply with occupational health and safety regulations.

Families are strongly encouraged to be part of the decision-making process

Priority Process: Competency

All staff, physicians, nurses, clerical, support, and volunteers demonstrated high levels of competency and commitment.

Exceptional teamwork was observed at a daily huddle.

Priority Process: Episode of Care

All standards were met by this high-performing team.

In the near future, this team will likely face some unique challenges regarding medical assistance in dying. This team will likely be a key part of developing appropriate policies and addressing the growing number of those who are aging in the population who will be seeking to use their services. Close attention will be needed in the coming months and years to meet these challenges and support the team.

Priority Process: Decision Support

Criteria for admission to palliative care are well established, and patient assessment is thorough.

Priority Process: Impact on Outcomes

This is a highly developed team with a strong evaluative focus. The development of new, academically robust, measurable outcome measures is a priority.

The team is seeking ways to build capacity and develop new models of 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 IPC works diligently throughout the organization to ensure infection rates are very low. Proactive steps as well as outbreak management when an infectious disease is present have helped contain infectious disease threats. The IPC team works collaboratively with public health and other external partners such as CCACs to monitor and handle potential and actual infectious disease outbreaks.

Staff immunization status is reviewed at time of hire and updated as needed. Annual flu immunization rates are monitored. There are good surveillance and screening practices.

There is a multidisciplinary approach to outbreak management to ensure all necessary individuals are part of the team.

The organization is commended for the Helping Hands Project, where volunteer high school students perform hand-hygiene audits and educate patients and families about hand hygiene. This project has been very successful.

Antimicrobial stewardship practices are well developed and led by passionate physicians. They have initiated a unique research project, using a dog who can sniff out C. difficile in patients.

IPC initiatives to prevent hospital-acquired infections have been very effective.

Staff education is important. It is done initially at orientation with subsequent regular updates. Education includes hand hygiene and the use of personal protective equipment. Hand-hygiene practices are audited in all areas of the hospital.

Standards Set: Long-Term 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

This is a strong multidisciplinary team that concentrates on the delivery of high-quality patient care and mutual support. The team works in a demanding and highly emotionally demanding area.

The introduction of the "I want to be called_____" is an excellent innovation.

The team has developed specific goals and objectives which are regularly reviewed.

The team makes full use of story boards and quality boards.

There is a high degree of patient and family engagement.

The team has been very successful in reducing the use of psychotic drugs in elderly populations.

Priority Process: Competency

All team members are highly qualified in their respective fields. Orientation is complete and comprehensive. A wide range of educational opportunities are available to all staff.

The longevity of service of many team members is a reflection of the terrific work environment.

Patients and families are well integrated into the care delivery model.

Priority Process: Episode of Care

Many patients and family members were strong in their praise of the care received. Care is comprehensive.

Priority Process: Decision Support

The team has access to a broad range of tools to enhance patient care, and tools are well utilized.

Priority Process: Impact on Outcomes

This is a strong team with strong goals and objectives and measurable outcomes.

The use of story boards and quality boards and the regular review of targets and achievements is exemplary.

Mutual support for team members is evident. There is an interest in a greater academic focus for the team which is encouraged.

Like palliative care, this team will potentially be highly impacted by legislation on medical assistance in dying, and support for team members as they work through policy and procedure development will be required.

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

With respect to interdisciplinary committees, there are two subcommittees that report to the Quality Management and Patient Safety Committee: the Pharmaceutical Committee and the Safe Medication Practices Committee.

The pharmacy team explained a nice example of ethics and prospective analysis when their patient-controlled analgesia pump vendor declared that there was a pump shortage. The team (pharmacy staff, nursing, ethics, and anesthesia) did a thorough failures modes effects analysis and determined the patient risk if the only epidural pump were to be used. Patient safety was top priority when planning for this potential event.

The hospital has a Level 6 medical health record which facilitates the pharmacy's operations. Prescriber entry is linked to the medical records system of the hospital and the pharmacists have access to the prescribed medications across the hospital. The list of medications in the pharmacy information system also shows the time that has passed since the prescription was written. Drug interactions are identified with a message.

The pharmacy team orders medication from the formulary and there is a process for adding and deleting medications. There is a process to order non-formulary medication. There is also a process for self-administration of medication and monitoring patients after medication has been administered.

The organization is encouraged to consider notifying the pharmacy when the medication has reached the destined unit and/or patient.

Standards Set: Medicine Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The medicine unit is appropriately staffed with the correct skill mix. Leadership has addressed some staff needs through, for instance, a wellness program. It is also important to keep staff safe through initiatives like the workplace violence prevention program.

There are good partnerships with family physicians and the community to improve engagement. Work with the LHINs occurs on a daily basis to help with enhanced patient care on discharge.

The medicine unit is recognized in the hospital for its sense of community and working to augment partnerships.

Priority Process: Competency

There are good educational opportunities for staff working on the unit, including well-established infusion pump training and online education through i-Learn training.

Workforce violence prevention training is provided at orientation and updated annually. Certification processes are in place for relevant staff.

The medicine unit is commended for its teamwork and support among staff members that was obvious during the on-site survey.

Priority Process: Episode of Care

The medicine unit provides first-rate patient care. Family involvement from admission through to discharge planning is evident. An electronic discharge summary is a superb tool allowing family physicians to be notifed of the patient's status in a timely fashion. Screening tools are used to keep patients from developing pressure ulcers, being injured in falls, or experiencing deep vein thrombosis, another other issues.

Patient and family engagement occus through their involvement in a variety of committees. Engagement also occurs through such avenues as post-discharge phone calls and rounding at the patient's bedside.

There are robust care plans for all patients admitted to the unit. Teamwork and continuity of staff for excellent patient care is identified.

Information sharing at transition points is well done and documentation is completed appropriately.

Staff are well educated at orientation and additionally as needed. Infusion pump education is one area in which the unit excels.

Patients identified with violent behaviors are flagged, to help with staff and patient safety.

Priority Process: Decision Support

Technology has allowed improved record keeping for patient information. It also allows timely access for those who are involved in providing care to the patient.

Patient information is protected to avoid breaches of privacy or confidentiality in the hospital. Privacy audits are completed regularly.

Priority Process: Impact on Outcomes

Well-developed formal research protocols and processes are in place. These are often developed in conjunction with the University of Toronto.

Quality improvement initiatives are evident throughout the department. A more informal process using PDSA cycles are initiated to look for unit-specific improvements. These multidimensional quality improvement programs reflect the hospital's desire to be a leader in the health care field.

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	
2.7 The physical environment is safe, comfortable, and promotes client recovery.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	
Surveyor comments on the priority process(es)	
Priority Process: Clinical Leadership	

The mental health department is an enthusiastic team supporting adult inpatients and outpatients, and child and adolescent inpatient and outpatient areas.

There is an emphasis on the patient getting better, goal setting for care, and a recovery focus right from admission. There is a strong working relationship between psychiatrists, psychologists, nurses, social workers, and different committees and panels. Patient and family feedback is gathered through various means. The mental health PEP, the discharge follow-up phone calls, and community meetings are some of the opportunities for patients to share their feedback.

Team huddles ensure the balanced scorecard and the associated and service-specific indicators are monitored and improved on an ongoing basis. The mental health department provides a wide breadth of services and new initiatives are constantly being added. The department reports on its achievements and several staff are presenting on those locally and internationally.

Priority Process: Competency

There is a wide range of opportunities for education and training in the mental health department. Staff use i-Learn as a source of education and are trained as needs arise (e.g., ethics framework). There are ample opportunities for staff to learn from each other (e.g., mindfulness). There have been many opportunities for learning regarding workplace violence prevention. Workplace violence incidents are monitored. Leaders are encouraged to share incident trends to ensure staff awareness and engagement with improvement tactics. There has been a mock drill on a code white and the team is commended for this.

The team has developed its own team agreement that all staff in the mental health department are encouraged to sign. The agreement describes why staff are there, stating the importance of respect and quality care for the patient and their family, and what they should expect from their workplace in terms of rights and responsibilities. There is a sense that silos have been dismantled and teams are now working together effectively. Team huddles and various multidisciplinary meetings have contributed to this.

Staff are recognized in team meetings and in writing (e.g., huddles, Friday Files) for their contributions to quality and patient safety. For instance, during a huddle a student was recognized for catching a near miss patient event involving medication and the physician was in the huddle and voiced his gratitude to the student for catching the dose error.

There are awards for long-service staff.

While working in the community, staff have access to the safety protocol to ensure their safety. This includes topics such as safety preparation, initial meetings with patients in the community, and managing potentially violent or harassing behaviours. The protocol also includes a simple safety assessment tool for staff.

Priority Process: Episode of Care

The admissions process is multidisciplinary (involving nurses, psychiatrists, and others), with a recovery objective and discharge planning in mind. IDEAL (Include the patient and family, Discuss with the patient and family five key areas to prevent problems at home, Educate the patient, Assess how well practitioners communicate with the patient and family, Listen to the patient's needs and goals) discharge planning is used to ensure staff follow a consistent approach.

Medication reconciliation and suicide prevention is in place. Both are facilitated by the electronic medical record and multidisciplinary involvement.

Staff are constantly learning from their patients about how care affects the patient. For example, they use patient stories followed by staff reflections, the PEP, and regular team meetings. Patient physical activity and wellbeing are considered and various services (e.g., nicotine replacement.) are offered.

The team is commended for its close collaboration with the emergency department, security staff, and external partners such as the police.

The closed loop medication initiative ensures patients are matched with their medication. A scan of the patient's bracelet provides live information about the patient's medication dosage and list. Patient identification is completed.

A staff debriefing tool is used for seclusion and/or restraint events. The number of seclusions and/or restraints is monitored and each of the events is analyzed as to what happened, what contributed to the event, and what was learned.

There is a culture of openness and transparency with regard to incident reporting and staff feel comfortable discussing patient issues together.

The team is encouraged to improve the physical environment of the adult inpatient unit to ensure the walls are painted to address peeling paint and graffiti, there are no components that could be used as sharps, and a thorough environmental risk assessment is done and issues arising addressed.

Priority Process: Decision Support

An electronic medical record (which is hospital wide) is used in the mental health department. When patients are transferred across departments and/or units, staff have access to patient information in the medical record to treat the patient. Hard copies of some documents still exist, such as Schedule 1, which upon discharge are scanned into the permanent record.

A privacy officer is available when staff need support with what to include in the patient record, access, and destroying medical record information.

The team is commended for its use of telemedicine and Vocera.

Priority Process: Impact on Outcomes

The team is commended for its approach to and management of an infection outbreak since the last on-site survey. The team is encouraged to continue its surveillance of hand hygiene and share the outcomes to encourage support of best practices.

The department is a Schedule 1 facility for children and as such partners closely with The Hospital for Sick Children.

The team is congratulated for spearheading of the closed loop medication project which is now being implemented across the organization. Programs such as the rapid access program, Kids in Transition, and Building Bridges are truly innovative. The mobile crisis intervention team, which is a police and mental health co-response, has resulted not only in improved clinical outcomes, but has influenced the culture of care in the Toronto community. This innovation is receiving international attention.

The team is encouraged to use indicators on a continuous basis to inform improvement activities (e.g., incidence of code white).

The patient interviewed expressed that the staff do their best and that she has seen an improvement in her mental health status since she was admitted. One area she would like to improve is to talk to a health care practitioner in private.

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	
11.9 Established policies on handling, storing, labelling, and disposing of medications and breast milk safely and securely are followed.	!
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 team is a cohesive, interprofessional group that displays respect for the role and contribution of each member, along with a shared resolve for quality patient care and services. The number of obstetricians and midwives is almost equal, and the organization and the Medical Advisory Committee are commended for their support with creating a department of midwifery with a voting position on the Medical Advisory Committee. This has drawn recognition and award for MGH. The team also places value on partnering with both regional peer and tertiary care hospitals, as well as with primary care providers and community-based partners.

The support given to patient- and family-centred care is described well by the team and is affirmed in discussion with patients and families. There is evidence of the partnership between care providers and patients/families in planning and delivering care at the prenatal, intrapartum, postpartum, and post-discharge points along the continuum. As well, although the team is still in the early stages of including and embedding the patient voice directly at meetings such as the unit-based council, it is committed to engaging patients in co-designing improvements.

The team has a good understanding of the patient population needs and of performance measures. Data sources include the provincial perinatal data base BORN, the Canadian Institute for Health Information

(CIHI), and internal metrics. Using this data and analysis, the team has aligned its program priorities and activities to support the corporate strategy. As an example, with the corporate goal of addressing the C-section rate, the team has focused on tactics that support increased vaginal birth after C-section (VBAC), increased supportive care in labour, and consideration of how to address induction rates. These have resulted in designing and evaluating, each with patient input and engagement, education materials and classes related to VBAC.

Structures support the team's focus on quality and safety. Huddles enable communication between the executive leaders, program leaders, and staff. Quality/huddle boards display select pieces of information, and additional information is shared verbally during the huddles and at meetings. The team has been very ambitious with the number of change initiatives and explained that some initiatives, which show as red, have actually been put on pause due to lack of capacity to support change. The team is encouraged to support the need to reprioritize and, if necessary and with a transparent rationale, postpone or abandon lower priority initiatives.

Priority Process: Competency

The team describes good support for orientation and ongoing education with both professional and leadership development. The value placed on interprofessional communication, collaboration, and teamwork is evidenced by the continued investment and support of the MORE-OB program, with its standardized shared education with simulated exercises. The Learning Management System for the most part is used to provide, capture, and monitor the status of mandatory education. Education that is specific or customized to the program is catalogued and overseen by leaders in the program. Members of the team describe support for leadership development, and describe this as both incentive and reward for becoming engaged with corporate and program improvement initiatives.

The orientation programs are customized to each specific area of service (labour and delivery, special care nursery [SCN]), and staff describe there being time and support to ensure competency (e.g., scrubbing in, ventilator/continuous positive airway pressure). There is also access to resources to support professional practice, such as the Registered Nurses' Association of Ontario Best Practice Guidelines. Leaders and staff describe a variety of ongoing educational methodologies and opportunities including conferences, workshops, mock codes, and in-house certifications (e.g., paediatric advanced life support, neonatal resuscitation program).

The nursing staffing complement consists of registered nurses and registered practical nurses with ward aide support. The relative roles and responsibilities of team members and the criteria for assignment are clear. Changes with the staffing model have been supported by realigning functions, such as hearing screening, to public health.

The team has instituted a program-specific award honouring a former nursing colleague who died a few years ago. This award, which has criteria and ultimately is decided by the staff, is regarded as a particular privilege.

Priority Process: Episode of Care

Perinatal patients have access to obstetricians, midwives, and family physicians as primary support, and the care team is augmented by nursing, dietitians, social workers, pharmacists, and others as needed to ensure comprehensive support.

The interprofessional team takes justifiable pride in the care and services it provides. The organization is an exemplar with the Baby Friendly Initiative, having been awarded the designation from the World Health Organization and UNICEF in 2009 and 2012, to be reassessed in 2017. Based upon its success, the organization was selected to be the lead, with targeted ministry funding, for advancing the initiative with other hospitals at the provincial level. This commitment has also resulted in post-discharge support for mothers at the breastfeeding clinic for families.

The team embraces opportunities to improve practices. While being long-time supporters of skin-to-skin care in the postpartum setting, since February 2016 there has also been support for the options of skin-to-skin care in the operating room with parents having a planned C-section delivery. This process was witnessed during the on-site survey and the parents expressed satisfaction before and following the delivery.

The team described its commitment to partner with patients and families, and the partnership in direct care is evident along the continuum of care from prenatal planning to soliciting feedback with post-discharge follow-up calls. There is obvious support for family presence around the clock as wished, and support for families in the SCN with the presence of and access to the care by parent unit. There appears to be sensitivity to the diversity of the patient population (cultural, socioeconomic, LGBT, etc.) and the team describes taking a flexible approach and working to understand and support each patient's needs. There is access to printed materials in different languages and interpretation services as needed. As well, strategically placed posters help reinforce the rights, expectations, and requests of patients and families.

There is a medication reconciliation process that is supported primarily by capturing medication history on presentation to the program, documentation of medication orders and administration during the episodes of care, and final reconciliation at the point of discharge by the obstetricians who are educated in how to conduct medication reconciliation with their patients. There would be value in ensuring all members of the interprofessional team understand the process to ensure they are able to support the team and the patient as needed with medication safety.

A comprehensive electronic record called power chart maternity supports a standardized approach to documentation and sharing of information. It is generally embraced as an efficient tool that captures detail and time lines, and reduces duplication of documentation.

Staff described the resources available in the event that they encounter difficulties, including line manager(s), nurse educator, and professional and interprofessional colleagues.

In general there is sensitivity to risk and security. While medications (of note, formula is treated as a medication) in the obstetric area were secured in locked rooms, the medication cart in the SCN had unlocked drawers (not containing narcotics) and there was no process for a count to support early detection of loss or theft. Although there is controlled access to the SCN, once in the unit, the location of this cart in a corridor with the general public introduces an avoidable risk that must be addressed.

Priority Process: Decision Support

The team described a recent organizational change affecting a decision support position which resulted in a temporary interruption to mining data and generating reports for planning and decision making; however, they also described that the subsequent design of decision support in the program is now very effectively meeting their needs. The value of the decision support team to the program is evident.

Decision making is supported through access to and analysis of BORN, CIHI, and internal metrics. The team works with local, regional, and provincial partners to understand options for change. Evidence-based practices are reviewed, adopted, or customized as appropriate, and monitored on an ongoing basis. An example is the C-section indicator.

Documentation is well supported by the electronic medical record. Paper documentation received on point of admission to the hospital (i.e., antenatal record) is ultimately scanned and becomes part of the electronic record. The team describes excellent support from patient records with generating timely discharge summaries and communication to continuing care providers.

Corporate policies and processes are in place to support access to information and handle issues pertaining to confidentiality and privacy of information. Collaboration among representatives of the program, the executive, and the privacy officer are well described and documented.

Priority Process: Impact on Outcomes

Clinical debriefs and critical incident reviews occur, and typically involve affected patients and families.

The huddle boards display select indicators and items for communication, and are a central point for regular dialogue and updates on performance measures or current issues. It was unclear if there are specific criteria for what is to be included on a huddle board, and the team is encouraged to consider a range of metrics including satisfaction and patient quality and safety (e.g., incidents, surgical safety checklist audits), budget status/variance, and health human resource measures. Consideration also could be given to the format of the content on the boards to ensure it can be easily read and that it informs and engages the team with continuous improvement.

Team members described the opportunity to be involved with academic and research initiatives, typically in partnership with the tertiary centres. There is a known process to ensure ethics review and organizational support for such ventures.

Staff were observed to be very professional, enthusiastic, and genuinely happy in the work setting. Their encounters with patients, their partners, and the infants were observed to be very respectful and caring, with a goal of sharing knowledge and working together. Patients spoke highly of their care teams. They described feeling that they were part of their care planning, and that they had the right and necessary information for the situation, pre C-section and pre discharge.

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

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
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

Organ and tissue donation is well managed by the hospital, with the assistance of the Trillium Gift of Life Network (TGLN). There are standard operating practices to determine the processes to be undertaken in the retrieval of organs or tissue and delivery to the recipient.

There is an increased awareness regarding the organ donor program by staff, patients, and families due to excellent publicity campaigns.

Priority Process: Competency

Initial and ongoing education is provided to all staff and physicians providing organ and tissue donation services.

A qualified donation coordinator from the TGLN is available 24/7 to assist the hospital when a potential donor is identified.

Priority Process: Episode of Care

Priority Process: Decision Support

Donor information is carefully managed to maintain privacy and confidentiality. Communication is provided only to those who require it to carry out the appropriate services.

Priority Process: Impact on Outcomes

Quality improvement initiatives are used to determine improvements to the process for organ and tissue donation. Families and staff are involved in looking at the process and strategies are implemented to advance the process as new learnings occur. In addition, missed opportunities are reviewed.

There are monthly and quarterly committee meetings addressing organ and tissue donation issues. These committees include members from TGLN, along with hospital employees.

Priority Process: Organ and Tissue Donation

TGLN works closely with the hospital. It assists with all aspects of the organ and tissue donation from the time of consent to retrieval.

Thank you letters with information about the donation are sent to the family and staff, and finally to the celebration of life.

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	
23.2 The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
23.3 There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
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

This is an outstanding team with strong medical and nursing leadership. The team is multidisciplinary and has strong engagement from all staff.

The team holds regular huddles and monitors quality indicators on a daily, weekly, monthly, quarterly, and annual basis as appropriate to the indicator. The on-time start for OR is widely visible.

Standardized treatment approaches have been established. The introduction of standardized OR trays will decrease variation in practice, improve patient outcomes, and reduce waste.

There has been a 90 percent reduction in flash sterilization in the past seven years, with flash sterilization now only used in well-defined and emergency situations. The team is applauded for this change.

The surgical safety checklist is well established and audits show extremely high levels of compliance.

The inclusion of surgeons in the management of the financial side of the OR is recognized. Transparency of this magnitude will pay huge dividends in terms of engagement and generation of further ideas.

Priority Process: Competency

All staff are fully trained in their respective fields.

Collaboration between staff members is at a high level.

Priority Process: Episode of Care

Patients expressed strong satisfaction with the care received.

Morbidity and mortality rounds are held regularly. To strengthen rounding, consider Including non-medical staff and nurses refering patients for discussion at M&M rounds.

Priority Process: Decision Support

The patient records reviewed were of ahigh standard of completion with all necessary information readily available.

Priority Process: Impact on Outcomes

Outcomes are regularly reviewed.

The team is encouraged to include a patient or patient representative when considering changes or reviewing treatment approaches to surgical procedures.

The organization is encouraged to have physicians sign team agreements on all units and departments where they provide care.

Priority Process: Medication Management

With the support and engagement of the pharmacy team, medication management in the OR and the surgical inpatient unit complied with all standards.

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

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

The organization has met all criteria for this priority process.

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

In 2016, the laboratory participated in the Ontario Laboratory Accreditation program conducted by the IQMH.

All point-of-care testing is appropriately completed by the intended staff on the units. The laboratory ensures that education and maintenance of certification for those providing this type of service is complete.

Equipment for point-of-care testing is kept in good working order.

Standards Set: Substance Abuse and Problem Gambling - 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	

Withdrawal Management Services (WMS) operates as a satellite site of the MGH. It consists of observation beds, residential beds (male only), a day program (male and female), a satellite that supports the Aboriginal day program, and partnerships with numerous community partners (academic hospitals, police, telemedicine, etc.).

The service is described as non-medical insofar as there is not a consistent presence of a physician or regulated care providers. There is a medical director and an advance practice nurse supports this service as well as comparable programs in a limited number of GTA hospitals. The WMS team works in close partnership with the four other WMS services in Toronto in designing and/or sharing practices, documentation tools (transfer summaries), comparative data, and metrics. This exemplifies the importance and value of nurturing and sustaining effective partnerships in the community to create confidence and trust in the nature of care and the calibre of service. The team has fostered effective relationships with those who rely on them to accept clients from EDs, referrals, or by way of police intervention, and similarly with those who support discharge with healthy, successful integration to the community, such as primary care providers, housing groups, and CAS. Problem gambling is not a focus of the service.

The WMS team is a relatively small yet highly collaborative group of individuals who are invested in providing welcoming and non-judgemental support for their clients. They have adopted a recovery and trauma-informed approach to care and services, addressing current withdrawal needs as well as the underlying or root issues that result in trauma-informed self-medication. They continue to use metrics of both success and service gaps to build a case for additional resources to meet the evolving needs of the program. The team articulates a vision of someday having crisis intervention, residential support, day programming, and community-based service supported in one location by an integrated team.

Priority Process: Competency

As a team of primarily unregulated health providers, time and resources have been invested to help staff acquire information and skills to support them in providing care in the crisis intervention, residential, and day program settings. The MSW staff work closely with colleagues in the MGH mental health program to share knowledge and education programs that ensure staff professional development and safe care and services. As MGH staff they are expected to complete all mandatory education; updates on MGH policies and processes; and relevant education such as crisis intervention, de-escalation of violent behaviours, CPR, and first aid.

Staff describe feeling very supported with ongoing professional development through workshops and conferences, and also with developmental opportunities such as secondments to other work settings that complement the services provided at the centre. There is an expectation that staff will rotate through the different areas of the centre, appreciating that this supports personal development and also builds the organization's capacity to respond if client activity necessitates a change in staffing needs.

The advance practice nurse, in addition to her role with direct care of patients in the many WMS in Toronto, facilitates education sessions. Recent sessions focused on high-risk alcohol and opiate withdrawal, and preventing death from withdrawal or loss of opiate tolerance.

Staff recognize the importance of self-care in this setting and describe a strong network of support among the immediate team, and awareness of the corporate resources for staff wellbeing. They share in the celebration of team members and spoke with great pride of a colleague who was recognized by Brock University for leadership within the Aboriginal community in relation to the MSW's work.

Priority Process: Episode of Care

The team is very proactive in ensuring access to services and the safety of all clients. Criteria are in place for admission to the services, and on admission behaviour expectations and the parameters for remaining in the program (i.e., abstinence on the residential unit) are shared and discussed. In addition to the range of services geared to clients with addiction issues, there is also a family support group which deals with the impact of someone else's addition on family members.

Standardized tools facilitate assessment of risks, and processes are in place to guide transfer from the satellite location to the ED as needed.

Given that the majority of the team are unregulated care providers, particular attention has been paid to medication safety. There is a process of reconciling client medication with the dispensing pharmacy, following which the staff then safeguard the medication and oversee clients as they self-administer the medication.

The team participates on a local Quality and Practice Committee, made up of representatives from partner hospitals and WMSs. In collaboration with University Hospital Network, St. Michael's Hospital, and St. Joseph's Health Centre, there have been improved practices and processes related to medication reconciliation, staff education, and transfer of information at transition points and shift handover. The team is encouraged to continue to learn from and share with other provincial and national organizations that support mental health, ED, and WMS.

Client feedback is solicited by way of surveys and is welcomed directly, and has been used to inform improvements.

Priority Process: Decision Support

Documentation at the WMS is primarily paper based. There are standardized tools to support initial assessments to each of the areas of service (i.e., residential, day program), and patients are engaged in goal setting and care planning.

The team worked very proactively to address a risk/quality of care concern related to transfer of information. Patients who were being received by WMS from the ED were being regarded as discharges from ED instead of transfers to WMS. As such, there was an absence of timely exchange of key information, particularly in relation to medication administration. This issue was being experienced by other WMSs and therefore all collaborated with GTA hospitals to create a standardized document that would accompany these patients. It provides the patient's current status at the time of discharge from any ED and transition to an WMS.

As part of the intake process, patients are invited to disclose issues they might have with the legal system, and the team is transparent in describing the parameters they honour with regard to protecting privacy and confidentiality. There appears to be a very respectful relationship with the police.

Priority Process: Impact on Outcomes

The team described the reality of patients who return repeatedly to crisis and residential components of the system, and also proudly described the value of the WMS in terms of improved patient access and flow from ED and improved access with a centralized intake process. They also talked about the number of patients who transition to trauma-informed therapy programs and after care programs and those who continue with those programs.

As well, although relatively small in number, they described the powerful impact of the Aboriginal community reunification ceremonies of patients with their families and/or children who may have been taken into care. The value of the work of this team is affirmed by the fact that Women's Correctional Services are exploring programming similar to that provided by the Aboriginal day program.

A client in the residential program spoke of staff taking the time to listen, always welcoming him, making him do his work, and making him feel safe. His respect for the team was obvious.

Standards Set: Transfusion Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Transfusion Services	

The organization has met all criteria for this priority process.

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

In 2016, the laboratory participated in the Ontario Laboratory Accreditation program conducted by the Institute for Quality Management in Healthcare.

Transfusion services are well managed within laboratory services.

Home transfusion services are not provided.

Instrument Results

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

Governance Functioning Tool (2011 - 2015)

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

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

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

- **Data collection period: August 13, 2015 to October 1, 2015**
- **Number of responses: 13**

Governance Functioning Tool Results

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1 We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations.	0	0	100	93
2 Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	0	0	100	96
3 We have sub-committees that have clearly-defined roles and responsibilities.	0	0	100	97
4 Our roles and responsibilities are clearly identified and distinguished from those delegated to the CEO and/or senior management. We do not become overly involved in management issues.	0	0	100	94

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
5 We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decisionmaking.	0	0	100	93
6 Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	15	85	95
7 Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	97
8 Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	0	0	100	97
9 Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	0	0	100	94
10 Our governance processes make sure that everyone participates in decision-making.	0	0	100	95
11 Individual members are actively involved in policy-making and strategic planning.	0	0	100	90
12 The composition of our governing body contributes to high governance and leadership performance.	0	0	100	93
13 Our governing body’s dynamics enable group dialogue and discussion. Individual members ask for and listen to one another’s ideas and input.	0	0	100	96
14 Our ongoing education and professional development is encouraged.	0	0	100	90
15 Working relationships among individual members and committees are positive.	0	8	92	97
16 We have a process to set bylaws and corporate policies.	0	0	100	96
17 Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	98
18 We formally evaluate our own performance on a regular basis.	0	0	100	83
19 We benchmark our performance against other similar organizations and/or national standards.	0	0	100	71

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
20 Contributions of individual members are reviewed regularly.	0	0	100	66
21 As a team, we regularly review how we function together and how our governance processes could be improved.	8	0	92	79
22 There is a process for improving individual effectiveness when non-performance is an issue.	8	8	85	62
23 We regularly identify areas for improvement and engage in our own quality improvement activities.	0	8	92	79
24 As a governing body, we annually release a formal statement of our achievements that is shared with the organization's staff as well as external partners and the community.	8	8	85	81
25 As individual members, we receive adequate feedback about our contribution to the governing body.	0	15	85	69
26 Our chair has clear roles and responsibilities and runs the governing body effectively.	0	0	100	96
27 We receive ongoing education on how to interpret information on quality and patient safety performance.	0	0	100	90
28 As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	96
29 As a governing body, we hear stories about clients that experienced harm during care.	0	0	100	88
30 The performance measures we track as a governing body give us a good understanding of organizational performance.	0	0	100	95
31 We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	0	0	100	91
32 We have explicit criteria to recruit and select new members.	0	0	100	87
33 Our renewal cycle is appropriately managed to ensure continuity on the governing body.	0	0	100	94

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
34 The composition of our governing body allows us to meet stakeholder and community needs.	0	0	100	93
35 Clear written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	95
36 We review our own structure, including size and subcommittee structure.	0	8	92	91
37 We have a process to elect or appoint our chair.	0	0	100	93

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

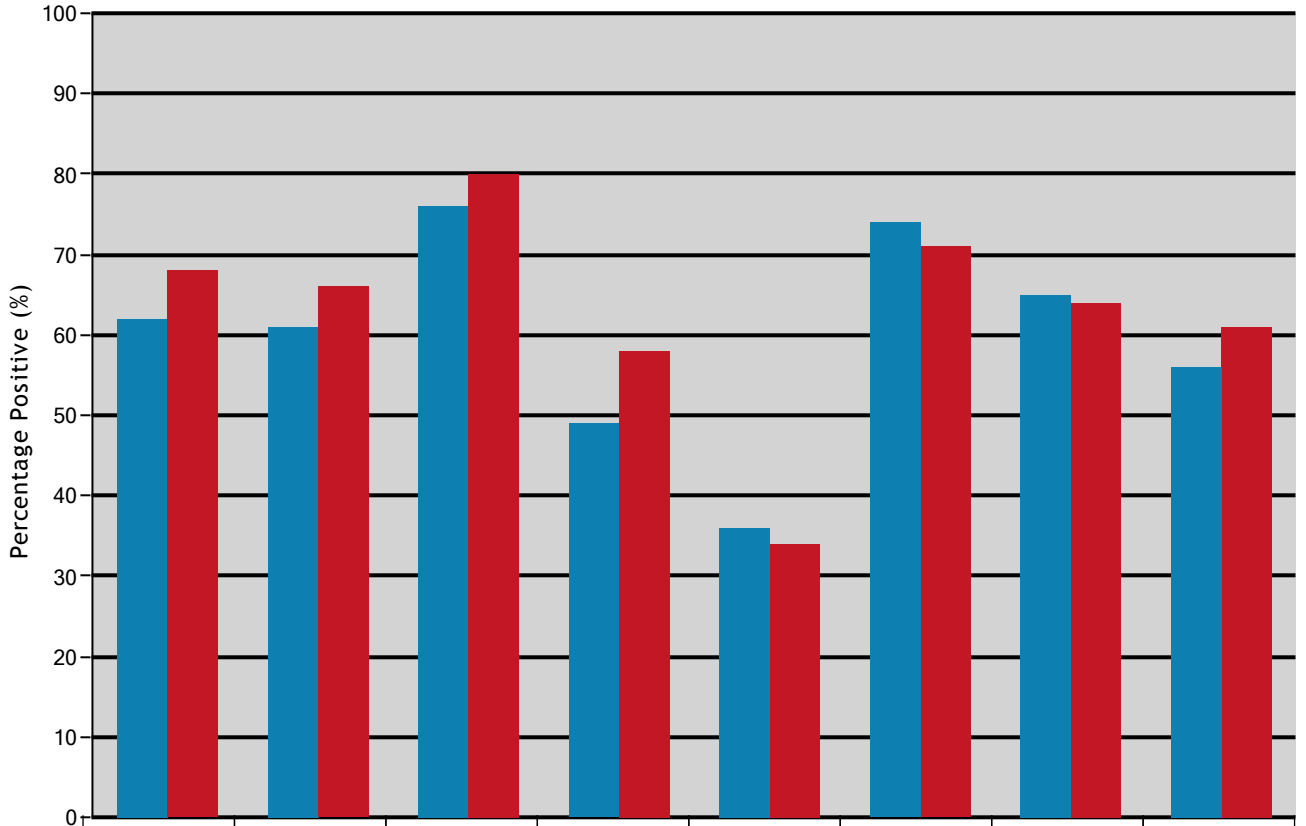
Canadian Patient Safety Culture Survey Tool

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

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

- **Data collection period: March 30, 2015 to May 9, 2015**
- **Minimum responses rate (based on the number of eligible employees): 266**
- **Number of responses: 281**

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



	Organizational (senior) leadership support for safety	Supervisory leadership for safety	Unit learning culture	Enabling Open Communication I: judgment-free environment	Enabling Open Communication II: job repercussions of error	Incident follow up	Stand-alone items	Overall Perceptions of Client Safety
	62%	61%	76%	49%	36%	74%	65%	56%
	68%	66%	80%	58%	34%	71%	64%	61%

Legend

Toronto East Health Network

* Canadian Average

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

Worklife Pulse

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

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

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

Client Experience Tool

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

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

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

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

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

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

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

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

Organization's Commentary

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

We would like to extend our heartfelt gratitude to our patients, families, staff, physicians and volunteers for the tremendous work they do to make the Toronto East Health Network a valued organization to work and receive care. For us, the Accreditation process is a direct reflection of the care that our communities put into the hospital: Patients and families improve the care we provide by giving us feedback through many avenues, our patient experience partners co-design services with us, and our staff, physicians and volunteers uphold the highest standards in safety, quality, and patient and family centred care.

This year is a pivotal year for us. We are in the process of redefining who we are to better reflect the work we do in the community. This includes changing our name to the Toronto East Health Network, undergoing a rigorous approach to strategic planning, and continuing to design our new building to better serve our communities.

We would like to thank our surveyors from Accreditation Canada for learning about our culture, reviewing how we serve our communities, and recognizing our staff, physicians and volunteers for the great work they do every day. They identified several best practices that they encouraged us to share with other organizations, including our patient video program, just culture, family presence policy and our workplace violence prevention program. They also encouraged us to expand how we engage patients and families even more, sustain the high performance we have achieved in quality and safety, and continue to involve the community in the design of our new building. We have already begun incorporating these recommendations across the organization and look forward to creating our future with our communities to provide the high standard of care that they deserve.

Appendix A - Qmentum

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

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

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

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

Action Planning

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

Evidence Review and Ongoing Improvement

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

Appendix B - Priority Processes

Priority processes associated with system-wide standards

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

Priority processes associated with population-specific standards

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

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

Priority processes associated with service excellence standards

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

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