ACCREDITATION CANADA

Driving Quality Health Services

Accreditation Report

Campbellford Memorial Hospital

Campbellford, ON

On-site survey dates: September 9, 2013 - September 12, 2013

Report issued: October 30, 2013

ACCREDITATION CANADA
AGRÉMENT CANADA

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

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About the Accreditation Report

Campbellford Memorial Hospital (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. As part of this ongoing process of quality improvement, an on-site survey was conducted in September 2013. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

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

Confidentiality

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

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

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

A Message from Accreditation Canada's President and CEO

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

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

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

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

We look forward to our continued partnership.

Sincerely,

Wendy Nicklin
President and Chief Executive Officer

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Section 1 Executive Summary

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

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

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

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

1.1 Accreditation Decision

Campbellford Memorial Hospital's accreditation decision is:

Accredited with Exemplary Standing

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

1.2 About the On-site Survey

- **On-site survey dates: September 9, 2013 to September 12, 2013**

- **Location**

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

  1 Campbellford Memorial Hospital

- **Standards**

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

  System-Wide Standards

  1 Leadership
  2 Governance

  Service Excellence Standards

  3 Managing Medications
  4 Operating Rooms
  5 Reprocessing and Sterilization of Reusable Medical Devices
  6 Surgical Care Services
  7 Emergency Department
  8 Infection Prevention and Control
  9 Biomedical Laboratory Services
  10 Diagnostic Imaging Services
  11 Laboratory and Blood Services
  12 Medicine Services

- **Instruments**

  The organization administer:

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

1.3 Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
 Population Focus (Working with communities to anticipate and meet needs)	38	0	0	38
 Accessibility (Providing timely and equitable services)	60	0	1	61
 Safety (Keeping people safe)	385	1	15	401
 Worklife (Supporting wellness in the work environment)	98	1	0	99
 Client-centred Services (Putting clients and families first)	61	0	5	66
 Continuity of Services (Experiencing coordinated and seamless services)	23	0	0	23
 Effectiveness (Doing the right thing to achieve the best possible results)	592	9	9	610
 Efficiency (Making the best use of resources)	56	0	1	57
Total	**1313**	**11**	**31**	**1355**

1.4 Overview by Standards

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

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

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

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

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	43 (97.7%)	1 (2.3%)	0	34 (100.0%)	0 (0.0%)	0	77 (98.7%)	1 (1.3%)	0
Leadership	45 (97.8%)	1 (2.2%)	0	85 (100.0%)	0 (0.0%)	0	130 (99.2%)	1 (0.8%)	0
Diagnostic Imaging Services	65 (100.0%)	0 (0.0%)	2	61 (100.0%)	0 (0.0%)	0	126 (100.0%)	0 (0.0%)	2
Infection Prevention and Control	53 (100.0%)	0 (0.0%)	0	44 (100.0%)	0 (0.0%)	0	97 (100.0%)	0 (0.0%)	0
Biomedical Laboratory Services **	16 (100.0%)	0 (0.0%)	0	36 (100.0%)	0 (0.0%)	0	52 (100.0%)	0 (0.0%)	0
Emergency Department	31 (100.0%)	0 (0.0%)	0	82 (98.8%)	1 (1.2%)	12	113 (99.1%)	1 (0.9%)	12
Laboratory and Blood Services **	81 (100.0%)	0 (0.0%)	0	95 (100.0%)	0 (0.0%)	0	176 (100.0%)	0 (0.0%)	0
Managing Medications	66 (100.0%)	0 (0.0%)	10	49 (100.0%)	0 (0.0%)	3	115 (100.0%)	0 (0.0%)	13
Medicine Services	27 (100.0%)	0 (0.0%)	0	68 (98.6%)	1 (1.4%)	0	95 (99.0%)	1 (1.0%)	0
Operating Rooms	67 (98.5%)	1 (1.5%)	1	28 (93.3%)	2 (6.7%)	0	95 (96.9%)	3 (3.1%)	1

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Reprocessing and Sterilization of Reusable Medical Devices	39 (100.0%)	0 (0.0%)	1	58 (100.0%)	0 (0.0%)	1	97 (100.0%)	0 (0.0%)	2
Surgical Care Services	27 (93.1%)	2 (6.9%)	1	63 (96.9%)	2 (3.1%)	0	90 (95.7%)	4 (4.3%)	1
Total	**560 (99.1%)**	5 (0.9%)	15	703 (99.2%)	6 (0.8%)	16	1263 (99.1%)	11 (0.9%)	31

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

1.5 Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Safety Culture			
Adverse Events Disclosure (Leadership)	Met	3 of 3	0 of 0
Adverse Events Reporting (Leadership)	Met	1 of 1	1 of 1
Client Safety Quarterly Reports (Leadership)	Met	1 of 1	2 of 2
Client Safety Related Prospective Analysis (Leadership)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Communication			
Client And Family Role In Safety (Diagnostic Imaging Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Medicine Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Surgical Care Services)	Met	2 of 2	0 of 0
Dangerous Abbreviations (Managing Medications)	Met	4 of 4	3 of 3
Information Transfer (Emergency Department)	Met	2 of 2	0 of 0
Information Transfer (Medicine Services)	Met	2 of 2	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information Transfer (Surgical Care Services)	Met	2 of 2	0 of 0
Medication Reconciliation As An Organizational Priority (Leadership)	Met	4 of 4	0 of 0
Medication Reconciliation At Admission (Emergency Department)	Met	4 of 4	1 of 1
Medication Reconciliation At Admission (Medicine Services)	Met	4 of 4	1 of 1
Medication Reconciliation At Admission (Surgical Care Services)	Met	4 of 4	1 of 1
Medication Reconciliation at Transfer or Discharge (Emergency Department)	Met	4 of 4	1 of 1
Medication Reconciliation at Transfer or Discharge (Medicine Services)	Met	4 of 4	1 of 1
Medication Reconciliation at Transfer or Discharge (Surgical Care Services)	Met	4 of 4	1 of 1
Surgical Checklist (Operating Rooms)	Met	3 of 3	2 of 2
Two Client Identifiers (Diagnostic Imaging Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Emergency Department)	Met	1 of 1	0 of 0
Two Client Identifiers (Managing Medications)	Met	1 of 1	0 of 0
Two Client Identifiers (Medicine Services)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Two Client Identifiers (Operating Rooms)	Met	1 of 1	0 of 0
Two Client Identifiers (Surgical Care Services)	Met	1 of 1	0 of 0
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Managing Medications)	Met	4 of 4	1 of 1
Concentrated Electrolytes (Managing Medications)	Met	1 of 1	0 of 0
Heparin Safety (Managing Medications)	Met	4 of 4	0 of 0
Infusion Pumps Training (Emergency Department)	Met	1 of 1	0 of 0
Infusion Pumps Training (Managing Medications)	Met	1 of 1	0 of 0
Infusion Pumps Training (Medicine Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Operating Rooms)	Met	1 of 1	0 of 0
Infusion Pumps Training (Surgical Care Services)	Met	1 of 1	0 of 0
Medication Concentrations (Managing Medications)	Met	1 of 1	0 of 0
Narcotics Safety (Managing Medications)	Met	3 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Client Safety Plan (Leadership)	Met	2 of 2	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Worklife/Workforce			
Client Safety: Education And Training (Leadership)	Met	1 of 1	0 of 0
Preventive Maintenance Program (Leadership)	Met	3 of 3	1 of 1
Workplace Violence Prevention (Leadership)	Met	5 of 5	3 of 3
Patient Safety Goal Area: Infection Control			
Hand Hygiene Audit (Infection Prevention and Control)	Met	1 of 1	2 of 2
Hand Hygiene Education And Training (Infection Prevention and Control)	Met	2 of 2	0 of 0
Infection Rates (Infection Prevention and Control)	Met	1 of 1	3 of 3
Sterilization Processes (Infection Prevention and Control)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Falls Prevention			
Falls Prevention Strategy (Diagnostic Imaging Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Medicine Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Surgical Care Services)	Met	3 of 3	2 of 2
Patient Safety Goal Area: Risk Assessment			
Pressure Ulcer Prevention (Medicine Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Surgical Care Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (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			
Venous Thromboembolism Prophylaxis (Surgical Care Services)	Met	3 of 3	2 of 2

1.6 Summary of Surveyor Team Observations

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

The organization, Campbellford Memorial Hospital (CMH) is commended on preparing for and participating in the Qmentum survey program. This is a 34-bed health care facility that serves approximately 30,000 residents. Of the thirty-four beds, twenty-nine beds are acute care and five beds are alternate level of care. There are issues with the high number of bed days for alternate level of care (ALC) patients and in an attempt to reduce this, the organization is introducing various initiatives. One initiative is increasing the discharge planners scheduled time from one day per week to three days per week.

The organization is part of the Campbellford Memorial Hospital Campus which includes the Campbellford Memorial Health Centre, Campbellford Memorial Lodge, Campbellford Memorial Community Wellness Centre and Campbellford Memorial Hospital Foundation. The CMH serves a large catchment area with approximately 80 percent of the patients coming from within a 40 mile radius of Campbellford. The top five case mix groups are congestive heart failure, chronic obstructive pulmonary disease, palliative, rehabilitation and pneumonia. It is estimated that 90 percent of the admissions occur via the emergency (ER) department. One of CMH's recent achievements is the implementation of a video link between the Kingston Trauma Unit and the ER department. This initiative supports the immediate assessment and needs of the patients. The emergency department is well supported by diagnostics and laboratory services.

There are approximately 3,700 out-patient clinic visits per year. These clinics are provided by host consultants and include internal medicine, cardiology, rheumatology, urology, general surgery, otolaryngology, gynaecology, nephrology, arthritis and cardiovascular-cardiology. The emergency (ER) department has approximately 21,000 visits per year. In February 2013 a nurse practitioner was introduced in the department to address ER wait times. The CMH has recently increased the number of endoscopy volumes completed in the surgical program. Two procedure days are offered to physicians from other communities, namely, Peterborough and Belleville.

The CMH is currently operating with a balanced budget. The organization has considered different options to help maintaining a balanced budget. An example of an innovative idea was to approach the CMH Foundation to secure funding assistance to support staff education, recruitment, and retention strategies. There is strong community support from the Foundation. A digital mammography machine, new endoscope washer and an anesthetic machine are part of a million dollar campaign. The Foundation and its successful fundraising events are held in high regard by the Campbellford Hospital Memorial Campus.

Volunteers are much appreciated by staff members at CMH. Their roles include being greeters at the main doors, helping with way finding, assisting patients with registration at the kiosk and manning the gift shop. Many of the volunteers have lived and worked in the community for most of their lives. They see volunteering as a way to give back to the community.

The organization is facing some staffing challenges. The number of nurses able to retire in the next two to five years is a concern for the organization. An internal scan reveals that one hundred percent of the registered practical nurses (RPNs) and eighty nine percent of the registered nurses (RNs) working in the ER department are able to retire within the next five-year period. The CMH takes advantage of several ministry initiatives such as the Late Nurse Career and New Graduate incentives. The organization encourages succession planning from inside the organization and supports ongoing learning opportunities. There are several managers in the organization that can also retire in the near future. There is some succession planning being completed for the management team. Physician recruitment is ongoing for CMH. Currently, there is an identified need for an otolaryngology (ENT) specialist and locum physicians in the community.

Recently, 30 staff members completed a National Research Council (NRC) Picker employee survey. The NRC Picker tool is used to collect patient satisfaction data. The responses show that more than 90 percent of those surveyed would recommend CMH to someone who needed access to health care. As well, those surveyed rated CMH at 90.2 percent as a good place to work. In 2012, CMH received (for the second time) the Quality Healthcare Workplace Gold Award which recognizes excellence for quality healthcare workplaces.

The organization has a formal communication plan. Internally, CMH publishes a weekly newsletter entitled: The Monday Report. This newsletter provides updates on current events, changes in the organization, and with patient care processes. The local media attends board meetings and publishes supportive articles in the local newspapers. The organization has a questions and answers (Q&A) column that was created by CMH and it is printed weekly in local newspapers. The purpose of this Q&A column is to inform community members about the service provided. For example, the column has provided information on how to access the congestive heart failure and chronic obstructive pulmonary disease clinics.

Campbellford Memorial Hospital works closely with internal and external parties. The Community Care Access Centre, Emergency Medical Services, Community Care, Ontario Shores Mental Health, Community Care, Hospice Centre, Peterborough Hospital, and retirement centres feel the organization is excellent at communicating and including them in change. Several members of the community were included in the development of the strategic plan. Patient information flows from the CMH to other centres and is inclusive of all necessary information. The family health teams feel supported by the organization's board, administrative staff, and the Foundation. Staff members and physicians note that the accessibility and support of the chief executive officer and senior management are organizational strengths. Staff members feel their input is valued and heard. There is an identified gap in transportation for the community and for those people that must come to the hospital after 2000 hours. Taxi services close at that hour and there is no other means of transportation support.

The CMH has introduced some new programs this past year. These include palliative care, restorative care, a new integrated chronic disease management program offered in partnership with the Trent Hills family health team, and a nephrology clinic. The organization recently hired a full-time physiotherapist, a recreational therapist and two part-time physiotherapy assistants to support the restorative care program and to support patients' return to home with added functional capacity. Nephrologists from Peterborough assess those patients diagnosed with renal disease to stabilize the illness and delay renal disease progression. The integrated chronic disease team of nurses, pharmacists, physiotherapists, and recreational therapists work with patients diagnosed with chronic diseases such as chronic obstructive pulmonary disease or congestive heart failure.

Campbellford Memorial Hospital recently celebrated its sixtieth anniversary. The organization is commended for the excellent services it provides to the community. There is a great deal of pride in the community for providing health care closer to home and sustaining services currently provided by the hospital. The CMH board members are working closely with the LHIN and participating in integrations discussions. Although there is a fair amount of anxiety around change and what the future holds, the board is seeing this in a positive light and as an opportunity.

Section 2 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

2.1 Priority Process Results for System-wide Standards

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

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

2.1.1 Priority Process: Planning and Service Design

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The strategic plan developed for the period 2010-2013 has recently been reviewed and updated. At this reveiw, the mission, vision, and values of Campbellford Memorial Hospital (CMH) were re-evaluated and maintained. Internal and external partners were included and invited to provide input to the strategic plan. The key strategic goals are to: Ensure CMH is sustainable as a hospital; Ensure safe quality care and service excellence; Recruit and retain the best people; Share the CMH story; Enhance the physical plant, clinical equipment, and technological infrastructure.

The Local Health Integrated Network (LHIN) in this region is currently discussing the integration of services across the region. It is difficult for CMH to move forward with its strategic plan when there is uncertainly about the future of service delivery decisions by the LHIN as well as the changes that will be placed on CMH. The board and staff are remaining positive about the possible upcoming changes and are preparing themselves and staff for future change.

Campbellford Memorial Hospital (CMH) uses the environmental scans completed by the Local Health Integration Network (LHIN) and the Ontario Hospital Association (OHA). The scan results are used to support current services and the future needs of the community. The number of seniors in the community is projected to grow immensely by the year 2036, and includes the Peterborough, Northumberland and Hastings counties. There is an estimated increase of anywhere from 112.4 percent to 135 percent expected in the senior citizen population growth.

The organization is commended for introducing the restorative program. The Campbellford Memorial Lodge is next door to the hospital facility and is supported by several of the CMH's services, such as housekeeping and facility management. T

The organization is attempting to introduce sustainable programs that meet community needs.

2.1.2 Priority Process: Governance

Meeting the demands for excellence in governance practice.

Unmet Criteria		High Priority Criteria
Standards Set: Governance		
13.4	The governing body follows a process to regularly evaluate its performance and effectiveness.	!

Surveyor comments on the priority process(es)

Campbellford Memorial Hospital (CMH) has a board of directors' policy manual. The majority of these policies were revised in 2012. There are established policies that support board member orientation, accountability, education, self-reflection, and guidelines for in-camera sessions of the board. There are roles and responsibilities polices specific for the board chair and board members. Other policies include confidentiality, conflict of interest, meeting without management, as well as policies and performance templates for the chief executive officer (CEO), chief of staff, and the board chair.

The board meets approximately nine times per year and every board member is expected to attend at least six of these meetings. The board receives quality and safety audit reports for staff and patients for falls and medication errors. At the end of board meetings, the members of the board meet without the presence of management.

The CMH has an ethics policy and framework. The board has received education on the framework and members feel that they are able to apply it in practice.

The Governance Functioning Tool was completed by the board. The governance committee has reviewed and analyzed the results. Recommendations for change based on the findings of the Governance Functioning Tool were provided to the board. The board uses the Ontario Hospital Association (OHA) resource entitled: "Guide to Good Governance."

The majority of board members complete three, three-years terms for a total of nine years on the board. As much as possible, a skills matrix is used when recruiting new members to the board. Local newspapers and word of mouth are used as a means of advertising to recruit new board members. An interview process is used to screen and choose the best candidates for board vacancies. The CMH provides new board members with an education package and information sessions. As well, a mentor from the board membership is assigned to inform, educate, and support every new board member. At the end of a one-year term, constructive feedback is provided to the new board member. The board is encouraged to provide annual or bi-annual performance reviews to its members to ensure members are familiar with and are performing their roles. The board is encouraged to take this opportunity to hear and receive feedback from board members.

Peer feedback and physicians' performance appraisals are currently not done at CMH. The organization is encouraged to perform 360s with physicians, especially as there are numerous locums working in the organization. The board is also encouraged to consider performance reviews as part of the credentialing process. The board sets and reviews the CEO's performance objectives on a regular basis and adheres to the compensation policy.

Board membership is represented on various committees in the organization. There is representation on the quality, governance and financial/auditing committees, on ad hoc committees, and on the medical and nursing advisory committees. The board feels that it receives essential information to make informed decisions and that its members understand their roles. The organization is encouraged to consider consolidating the medical and nursing advisory committees.

2.1.3 Priority Process: Resource Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The capital list is created annually and the items on the list are prioritized. The operational and capital budgets are approved by the board. There is no contingency budget set aside at this time. If a piece of equipment is an urgent purchase, then changes are made to the priority of the purchases on the capital list. The CMH's financial reports are included in the annual general meeting.

Every program department has their own departmental budget envelope. Budget reports are available online and accessible to the management team. The financial situation of the organization is reviewed at the senior team meeting every week. Variances are reviewed and discussed at regular intervals. When necessary, finances may be transferred from one cost centre to assist another cost centre.

The requests for proposals (RFP) criteria are met according to legislation. The organization is in the process of purchasing a digital mammography machine and the RFP has been submitted.

2.1.4 Priority Process: Human Capital

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
10.10	The organization's leaders implement policies and procedures to monitor staff performance that align with the organization's mission, vision, and values.	!

Surveyor comments on the priority process(es)

The National Research Council (NRC) Picker tool was used by Campellford Memorial Hospital (CMH) instead of the Worklife Pulse Tool. The organization has reviewed the NRC Picker results and distributed them to the management team. The management team has analyzed the data and identified areas for improvement. It is noted that one of the indicators, "staff actively doing things to improve patient safety" had increased form 73 percent on the last survey to 87 percent on this survey. The organization is commended for the improvements of this important indicator.

The organization is in need of developing a standardized process for completing staff performance appraisals. A policy does exist and it states that every employee should have a performance appraisal every two years; however, there is no evidence of this in practice. Accountability for the completion of performance appraisals begins with the top level of management and that level sets the stage for middle management. Clear practice expectations with time lines must be set for management to ensure that performance appraisals are completed in the required time frame. Exit interview results at CMH highlight that staff would like performance feedback. The research shows that when staff members feel valued, job satisfaction increases and patient care improves with regular performance feedback. This may be a staff retention strategy for the organization.

The personnel files reviewed included signed confidentiality forms, police checks, and health histories, including immunizations. It was noted however, that at times, new staff members commence work in the organization without all of the necessary human resources (HR) paper work completed. It is highly recommended that CMH does not provide a start work date of employment for new employees until all of the necessary paper work is complete and submitted to the HR department. This will reduce the stress placed on the HR department. In addition, this will ensure a safer work environment for patients, staff members, and the new employee, as well as reduce the legal risks to the organization.

The organization does not have an occupational health nurse. An external contractor is used for staff members with modified injuries and the plan of returning to work.

The organization provides tool kits to every manager. This tool kit contains recognition letters, notes, stickers and other things. Management is encouraged to use this resource to recognize staff members and to demonstrate appreciation for a job well done.

Leadership courses are provided by the organization for management and front-line staff. A recent course included topics such as stress management, decision-making and problem solving, time management, customer service, and communication for success.

The organization is dealing with sick time management and is working toward a maximum of a six-day target per year for sick time. Six wellness workshops will be provided to staff members on topics such as boosting your positive outlook, getting restful sleep, and dealing with difficult personalities.

There is an identified generation gap at CMH between recently graduated new employees and staff that have been working in healthcare for many years. To assist with bridging the gap, CMH is organizing a workshop on generation diversity. The organization has a cultural committee in place.

A gymnasium has been created for the staff to use. It includes stationary bicycles and tread mills, weight lifts, and other equipment. The gymnasium is much appreciated and well used by staff members.

Code white training is done in the organization. One person has been trained on code white protocol and is responsible for training others. The organization uses the de-escalation technique.

Staff members have available to them some learning and education modules that are online and others that are hard copy modules. It is recommended that the organization tracks staff who have completed education sessions. This is important if completion of a course or education module is mandatory, such as workplace hazardous management information system (WHMIS) and code white training. This tracking list needs to be located in one place for easy reference, for example, with information pertaining to the Ministry of Labour visits. Timelines for the training and completion of mandatory courses and requirements should be established and adherence to them monitored. Managers need to be held accountable for the timely completion of mandatory learning modules and practices.

2.1.5 Priority Process: Integrated Quality Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The senior management staff members audit and compile occurrence events related to patient and staff safety. The results from the audit are presented to the board on a quarterly basis. The organization is trending occurrences annually. Occurrence reports are addressed and posted in the patient care units for staff members to review and discuss.

The organization recognizes staff members who incorporate patient safety or recognize patient safety issues in the workplace. The recognition is in the form of Patient Safety Advocate, which is featured in an article and the advocate's picture is placed on a television screen in the front lobby. There is a sense of strong commitment to patient safety expressed from the board level and down to the front-line staff. The organization is commended for its ongoing commitment to providing safe care.

Medication reconciliation is completed for all patients admitted via the emergency (ER) department. These medications are again reconciled upon the patient's transfer to another hospital or discharge home. The organization uses a single unit dispensing machine. If the dispensing machine is overridden for any reason, a double signature by two staff members is required. Overriding the medication dispensing unit usually occurs for new admissions and after pharmacy staff have left for the day. Pharmacy reviews all medication orders.

The results of the Patient Safety Culture Tool were reviewed and analyzed by senior management. The management is attempting to better understand the red flags and the departments and staff perceptions associated with the red flag indicators. The organization feels that it has a non-punitive environment and makes every attempt to learn from every occurrence.

The organization has completed several prospective analyses this past year, along with associated improvements. Examples are, the move of the pharmacy department, and the initiation of a sleep apnea clinic.

Some of the doors to the patient units are locked or have a key pad access. There is an exit directly to the outside at the end of the unit and it is not locked. A locking device should be considered. Bed monitors and door alarms are used for patients prone to wandering.

There is a security guard in the building from 2200 to 0600 hours daily. This measure was put in place approximately three years ago for staff safety. Staff members commented that they do feel safe and more secure on the night shift with the security guard in place. The security guard is trained to use Pinel restraints.

The organization has a disclosure policy. The disclosure policy has supported staff members in steps and processes to follow when disclosure was necessary with patients and family members.

Patient experience and satisfaction data are reported and collected using the National Research Council (NRC) Picker tool.

2.1.6 Priority Process: Principle-based Care and Decision Making

Identifying and decision making regarding ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The ethical framework is robust and has been in effect for several years. The staff members are aware of this framework and have no difficulty in recognizing potential ethics issues and bringing it to the attention of the committee chair. Ethics issues are addressed by the committee on a case-by-case basis. Where required, a consultation may be obtained from an independent ethicist who is a member of the ethics committee but not an employee. Responses and recommendations are communicated to the appropriate staff members. Statistics and trends regarding ethical matters are recorded and used to implement possible change and quality improvement. The major role of the ethics committee would appear to be education and heightening awareness of ethical issues.

Although there is not a great deal of research conducted at Campbellford Memorial Hospital there is a policy for reviewing and monitoring of any research that does take place.

2.1.7 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 organization has developed and is currently utilizing several internal and external communication strategies and means effectively. The Monday Report, monthly staff forums, and strategic planning meetings with every department are all exemplary internal practices.

Recognition is given to the weekly question and answer (Q&A) section in the Community Press and the collaborative media coverage by way of media attendance at all board meetings. These are exceptional communication practices with external stakeholders and the local media. The well-established and functional relationship with the local media is serving to keep the community and stakeholders well-informed and aware of service delivery trends and issues. This means of communication will continue to prove helpful as the organization participates in the integration process.

2.1.8 Priority Process: Physical Environment

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

This organization is a facility that is small in size which was designed and constructed to provide a greater scope of service than what it is currently providing. Three different constructions have taken place. The original construction took place in 1953, a major renovation and upgrade took place in the 1970s, and a major addition took place in 1985. The utilities have been re-wired to service the additions. Overall, the Campbellford Memorial Hospital facility is bright and easily accessible, except for the front entrance which presents a challenge to individuals with mobility difficulties. Safety issues are addressed for staff, patients, and families.

Back-up systems are in place and there is close communication, continuity, and sharing with community agencies. The organization has done everything possible to be part of the "green revolution" and works closely with its surrounding community to minimize operational environmental impacts.

2.1.9 Priority Process: Emergency Preparedness

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Emergency preparedness plans are well-established and up to date. During the on-site survey, good collaboration within the organization and with key community partners was observed.

2.1.10 Priority Process: Patient Flow

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

This organization is acutely aware of flow, the value of statistical information, and alignment of services with other partners. The discharge planning team works closely with other organizations and agencies to facilitate transfers, relocations, and placements. Significant improvements were made around the decrease in alternate level of care (ALC) patient days. Despite this, however, there has been a recent gradual increase. This is due to increasing occupancy of available long-term care beds. The daily bullet rounds allow for a full scale multidisciplinary discussion about all inpatients and facilitate actions and directions to be taken.

The emergency (ER) department has the ability to request extra staffing when demands increase. Wait times are acceptable and are monitored closely. This information is shared and benchmarked so that changes that are suggested can be supported. The addition of a nurse practitioner (NP) is an example of one such supported change. Patients that are admitted occasionally have a prolonged ER wait time but internal communication processes minimize theses occurrences.

The Emergency Medical Services (EMS) off-load times are acceptable and there is good communication between providers in the transfer process. The ER has good access to discharge planning, Community Care Access Centre (CCAC) personnel, and crisis intervention workers.

There exists a challenge in the community such that there is no local public transport after 2000 hours. This means that coming to and more importantly, going from the ER after hours may be compromised.

Although the operating room has improved its utilization and flow, there is still room for improvement. Specifically, improvement is needed in the post procedure follow-up policy, both in regard to compliance with and revision of the policy. The current one-to-four day period is too long.

2.1.11 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)

Qualified staff members are engaged in this service. Reprocessing and sterilization areas include the central sterilization reprocessing (CSR) and the operating room. Consistent compliance with the standards by the staff in both areas was noted. A commitment to maintaining standards and pursuing excellence was noted in meeting with the staff.

2.2 Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Clinical Leadership

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

Competency

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

Episode of Care

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

Decision Support

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

Impact on Outcomes

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

Medication Management

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

Organ and Tissue Donation

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

Infection Prevention and Control

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

Surgical Procedures

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

Diagnostic Services: Imaging

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

Diagnostic Services: Laboratory

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

Blood Services

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

2.2.1 Standards Set: Biomedical Laboratory Services

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

Surveyor comments on the priority process(es)
Priority Process: Diagnostic Services: Laboratory
Biomedical laboratory services is a well-organized service. There is an excellent electronic document management program.

2.2.2 Standards Set: Blood Bank and Transfusion Services

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

Surveyor comments on the priority process(es)
Priority Process: Blood Services
There are no comments identified for blood bank and transfusion services.

2.2.3 Standards Set: Diagnostic Imaging Services

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

Surveyor comments on the priority process(es)
Priority Process: Diagnostic Services: Imaging
It is noted that good prioritization of the services delivered locally to meet the needs of the population has occurred during the past several years. Strong technical and medical leadership is evident. There is good use of the manager's time to enable the part-time management component of the position to work effectively. There is good collaboration with the other diagnostic imaging (DI) managers in the Local Health Integrated Network (LHIN). Good 24/7 staffing coverage with a minimum number of positions is also noted.

2.2.4 Standards Set: Emergency Department

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
4.13 Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	
Priority Process: Organ and Tissue Donation	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The emergency (ER) department is a 24/7 ER service. The medical human resources are four full-time ER physicians and a pool of locums. Noted is the addition of a nurse practitioner (NP) in early 2013. Compensation for the physician group is on an hourly per shift basis. The department processes approximately 20,000 visits per year. It utilizes the accepted Canadian Triage Acuity Scale (CTAS) classifications for both adult and pediatric visits.

The ER provides a level of service that is compatible with that of the whole organization and fits the strategic and operational plans. The ER team meets regularly, and in collaboration with senior leaders, develops aims and objectives for service delivery and improvement. The initiation of two isolation rooms with alternate air flow arose from such discussions.

Some family practice residents undertake ER work with their preceptors and there is some licensed practical nursing presence on an ad hoc basis.

Priority Process: Competency

The ER staff members have been in place for some time. Succession planning with an aging staff complement will be an ongoing problem particularly with the nation-wide demands for recruitment.

There are well-defined roles and responsibilities for all staff at this organization. The physician complement has access to consultant referrals in all areas and many of these are pre-established and denote partnership type relationships.

The staff members have the appropriate credentials and qualifications to work in this area. This includes advanced cardiac life support (ACLS), advanced trauma life support (ATLS) and pediatric advanced life support (PALS). Staff members are encouraged to partake of local and distance learning and upgrading. Orientation is provided for new staff members and the competency for independent involvement is determined by both management and the individual.

It is noted that regular, consistent performance evaluations are not being completed. This may interfere with assignments, reappointments, and potential promotion.

Priority Process: Episode of Care

Access to the emergency (ER) department is 24/7. Pre-established partnerships are also available when requested. Calls to the ER are fielded by the unit clerk and information is received and appropriately directed. Patients arriving at the ER are processed using established protocols. Triage occurs upon registration and the guidelines for re-evaluation and re-assessment are followed. Consents are obtained and ER information is given to the patient and family at this stage.

There is evidence of good information transfer both with Emergency Medical Services (EMS) off-loading and ER admission to the inpatient unit. There are good liaisons with referral hospitals, so that patients requiring further investigation and management are moved efficiently. Note is made of the recent excellent audit of patients requiring cardiac care being sent to Peterborough in a timely manner. The addition of a camera in the trauma area to provide real-time consultation with the Kingston Trauma centre has provided a greater level of comfort for the ER physicians and has expedited transfer after stabilization.

Patient information is collected and recorded along with investigative results and plans for therapy, and is made available to other providers. A best possible medication history (BPMH) is obtained at triage and it forms the basis for medication reconciliation upon discharge or transfer.

Priority Process: Decision Support

The emergency (ER) department utilizes evidence-based guidelines and pathways to help provide appropriate care. The guidelines are updated and adjusted with input from the ER team. Electronic technology is available for picture archiving computerized system (PACS) and Medi-tech and order entry systems. Training and mentoring is available and given to all necessary staff by the appropriate individuals.

Priority Process: Impact on Outcomes

The emergency (ER) department staff members provide care in a safe and practical manner that protects both themselves and the patients. Training is provided to facilitate this care and to mitigate potential difficulties that may arise. Safety briefings are held in conjunction with report processes and issues are discussed and possible solutions suggested.

Benchmarking of data is done and comparisons are made with like-size organizations. It is noted that currently, the wait times are slightly greater than the provincial average. The addition of the nurse practitioner (NP) role may help reduce this; however, it has yet to be audited.

All staff members are attuned to adverse event reporting and may be involved in these investigative processes.

Priority Process: Organ and Tissue Donation

Organ and tissue donation does not occur in this unit therefore, most of the related standards are non-applicable. Cornea donation did occur in the past and harvesting was done locally; however, this has not occurred for a long time. There is recognition of potential registered donors and appropriate notifications take place but all procedural activity occurs at another referral centre.

It is acknowledged that the organization is considering developing new policies regarding organ and tissue donation albeit, this is at an early stage.

2.2.5 Standards Set: Infection Prevention and Control

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
A well-run infection prevention and control (IPAC) service has been established. The service delivery meets the related standards and it operates on a collaborative basis both internally and with the organizations community partners. The staff members across the organization are involved with IPAC and take pride in their work. Several staff champions have been trained and are supported by the IPAC coordinator.

2.2.6 Standards Set: Laboratory and Blood Services

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

Surveyor comments on the priority process(es)
Priority Process: Diagnostic Services: Laboratory
The laboratory is well organized, equipped and configured. Appropriate collaborative relationships exist with private providers, public health, and other laboratories in the Local Health Integrated Network. Experienced technical leadership is noted, and it will serve the organization well in the integration process. An excellent electronic document management system has been developed by the laboratory manager and it is effectively utilized by the laboratory staff.

2.2.7 Standards Set: Managing Medications

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

There is a well-established pharmacy and therapeutics committee that is multidisciplinary and meets regularly. Formulary additions and deletions are discussed and approved by this committee. Staff members are fully aware of the hospital formulary and have access to drug and pharmaceutical information at all times. A pharmacist contact is available 24/7, usually via the available pharmacy technician. There is excellent communication with community pharmacists and regular interactions occur either face to face or via facsimile information requests.

The anti-microbial stewardship program has been in place for several years and is yielding increasing compliance. Regular audits show that the algorithm is being followed and this information is communicated to staff.

Pharmacy orders are sent via facsimile to the pharmacy, having been written by the ordering physician. The pharmacy technician enters that order into medi-tech system which has a number of internal mechanisms that help prevent medication errors. The medications are then entered into a medication administrator record (MAR) and dispensed via a Pyxis machine on the unit. The machines are regularly monitored by pharmacy. All medications are in a unit dose package, many of which are re-created in the hospital pharmacy so that date and lot numbers are available. Access to these machines is by authorization only and is regularly monitored.

The pharmacy has a major role in medication education on new drugs, potential interactions, high-risk drugs and in medication error adverse event reporting and investigation.

Storage areas are bright and well lit. There is clear labeling and naming similarities on packaging are avoided. The pharmacy takes responsibility for regular inspections, audits and inventory control.

Medication dispensing on the units follows the policies and procedures of the organization. There is heightened awareness of medication dispensing by the staff because of the higher than normal complement of elderly and potentially mentally compromised patients.

Quality control mechanisms for monitoring and evaluation are in place.

2.2.8 Standards Set: Medicine Services

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
4.8 Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	
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 acute medical surgical unit has challenges with the number of alternate level of care (ALC) patients on the unit at any one time and their length of stay (LOS). The organization is aware of this and is working with community partners and other programs such as Home First.

The program has goals and objectives specific to the medical surgical unit. The organization is encouraged to ensure the goals and objectives have measurable outcomes.

On admission to the inpatient unit every patient undergoes assessment. The patient receives assessment with the Braden assessment tool, the Barthel tool for functional decline, a falls assessment, behavioural supports, and the delirium screening prevention and management protocol. These tools are repeated at designated intervals such as daily or weekly.

There are concerns with long wait times from the time of the emergency (ER) department decision to admit a patient to the time that the patient is admitted to the medical unit. It is recommended that the organization reviews the head to bed processes and the provincial average wait time of 60 minutes from the decision to admit to the time the patient is on the medical unit. The organization is urged to learn if 'batching' of admitted patients in the ER occurs. Encouragement is offered to look at the possibility of retaining one flex-bed on the medical unit for ER admissions.

The organization is encouraged to use the red, yellow and green dot methodology that is used across Ontario for discharge planning. Use of this practice will set the stage for discharge planning at the time of admission and keep the interdisciplinary team informed of and working toward the target discharge date.

Priority Process: Competency

There is a performance appraisal policy stating that a performance appraisal should be completed every two years. The organization is encouraged to complete this task and address performance with all staff members.

There is a mixture of registered nurses (RNs) and registered practical nurses (RPNs) working on the acute medical unit. The RPNs are hoping that they will soon receive the necessary education that will permit them to work toward their full scope of practice. In doing this, RPNs will experience increased job satisfaction and the retention of RPNs will increase.

The organization has had some challenges with the infusion pumps that they have been using. These pumps have been taken off of the unit and the organization is looking at purchasing a new model of infusion pumps.

Priority Process: Episode of Care

There are daily interdisciplinary bullet rounds on every patient. Discharge planning is part of the information exchange. There is evidence of a history and physical on every patient chart reviewed. It was reported that laboratory and diagnostic imaging were more efficient in completing the tests and returning the results to the unit in a timely way.

There are no major orthopedic cases performed at Campbellford Memorial Hospital. There is a deep vein thrombosis (DVT) protocol and order sets that support this required organization practice.

Three staff members in the department have acquired wound care training and are considered the experts for wound assessment, products, and treatment choices. These three personnel train and support other staff members in the area of wound care.

Priority Process: Decision Support

On admission to the medical surgical unit, several assessments are completed by the nursing staff. These assessments include a falls risk, Braden scale, confusion assessment method (CAM) and the Barthel tool. Some of these assessments are repeated daily, on admission and at discharge, or every seven days.

Priority Process: Impact on Outcomes

The organization has a disclosure policy. The policy has supported staff members with the necessary steps and processes to follow, on the occasions when disclosure with patients and family was necessary.

A falls prevention program has been developed and introduced by physiotherapy staff. A coloured leaf and a purple armband are used to identify the patients at risk of falling. Falls are reported to senior management and follow-up occurs with the patient and/or family.

Two patient identifiers are used prior to administering medications. Staff members are cautioned to ensure that bracelets have all of the necessary information prior to giving medication, as the typing on the bracelet washes off with regular exposure to water. The organization is encouraged to review the bracelet product or ensure that the bracelet is changed as necessary.

2.2.9 Priority Process: Surgical Procedures

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

Unmet Criteria		High Priority Criteria
Standards Set: Operating Rooms		
1.3	The team uses evidence-based client care maps or pathways to guide them through steps in the procedure, promote efficient care and achieve optimal client outcomes.	
2.8	The team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	
12.8	The team uses flash sterilization in the operating room only in an emergency, and never for complete sets or implantable devices.	!
Standards Set: Surgical Care Services		
7.1	The team uses a procedure-specific care map to guide the client through preparation for and recovery from the procedure.	
14.1	The organization has a process to select evidence-based guidelines for surgical care services.	!
14.2	The team reviews its guidelines to make sure they are up-to-date and reflect current research and best practice information.	!
14.3	The team's guideline review process includes seeking input from staff and service providers about the applicability of the guidelines and their ease of use.	

Surveyor comments on the priority process(es)

There has been a resurgence in operating room (OR) utilization since the organizations previous survey, with procedures and block time being made available to surgeons from other sites. The full-time surgeon on site is in retirement mode and when retired, the organization will have to decide upon the OR's future direction and corresponding recruitment.

The OR staff members act professionally but their exposure to surgical cases is limited by the cases that are presented. They are dedicated and adhere to policies and procedures both of the organization and of their professional body. Orientations are done and are aligned to the role the person is to fill.

The OR space has been adapted to concur with standards. Nevertheless, the age of the building and its design compromise ideal flow for both patients and equipment. Privacy is a challenge and is difficult to provide completely. There is some admixture of clean and dirty equipment.

All peri-operative procedures are done according to standards. The appropriate documentation, monitoring and transfer were observed to be complete.

Data are collected and shared with staff members and this includes data from other institutions that is used for benchmarking with similar organizations.

All surgical day care (SDU) patients, which is almost the exclusive surgical load, are evaluated in clinics and are seen in SDU on the date of the procedure. All the necessary paperwork accompanies them or has been previously sent via the booking office. The best possible medication history (BPMH) is checked here along with procedure and consent. History and physicals are not required other than for general anaesthesia. There is no pre-operative assessment clinic.

Upon return from the post-anesthetic care unit (PACU), the patient remains in the unit for a period of time and when the patient meets discharge criteria, the patient is sent home with the appropriate instructions. There is a policy for post-anesthetic patients to receive a telephone call at one to four days post procedure. The surveyor suggested that this time frame is too long. There is also evidence that compliance with this policy is lacking.

Section 3 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.

3.1 Governance Functioning Tool

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

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

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

- **Data collection period: October 4, 2012 to November 15, 2012**
- **Number of responses: 12**

Governance Functioning Tool Results

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1 We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations.	0	8	92	92
2 Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	0	0	100	95
3 We have sub-committees that have clearly-defined roles and responsibilities.	0	0	100	96
4 Our roles and responsibilities are clearly identified and distinguished from those delegated to the CEO and/or senior management. We do not become overly involved in management issues.	0	0	100	93
5 We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decision-making.	0	0	100	92

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
6 Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	93
7 Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	98
8 Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	0	0	100	95
9 Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	0	0	100	94
10 Our governance processes make sure that everyone participates in decision-making.	0	8	92	93
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	92
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	95
14 Our ongoing education and professional development is encouraged.	0	0	100	86
15 Working relationships among individual members and committees are positive.	0	0	100	96
16 We have a process to set bylaws and corporate policies.	0	0	100	95
17 Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	96
18 We formally evaluate our own performance on a regular basis.	0	17	83	76
19 We benchmark our performance against other similar organizations and/or national standards.	0	17	83	68
20 Contributions of individual members are reviewed regularly.	0	0	100	66

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
21 As a team, we regularly review how we function together and how our governance processes could be improved.	0	17	83	77
22 There is a process for improving individual effectiveness when nonperformance is an issue.	0	0	100	59
23 We regularly identify areas for improvement and engage in our own quality improvement activities.	0	8	92	82
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.	0	0	100	84
25 As individual members, we receive adequate feedback about our contribution to the governing body.	0	25	75	68
26 Our chair has clear roles and responsibilities and runs the governing body effectively.	0	0	100	94
27 We receive ongoing education on how to interpret information on quality and patient safety performance.	0	0	100	86
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	8	92	83
30 The performance measures we track as a governing body give us a good understanding of organizational performance.	0	8	92	91
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	83
33 Our renewal cycle is appropriately managed to ensure continuity on the governing body.	0	0	100	88

		% 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	8	92	93
35	Clear written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	92
36	We review our own structure, including size and sub-committee structure.	0	8	92	87
37	We have a process to elect or appoint our chair.	0	0	100	92

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

3.2 Patient Safety Culture Tool

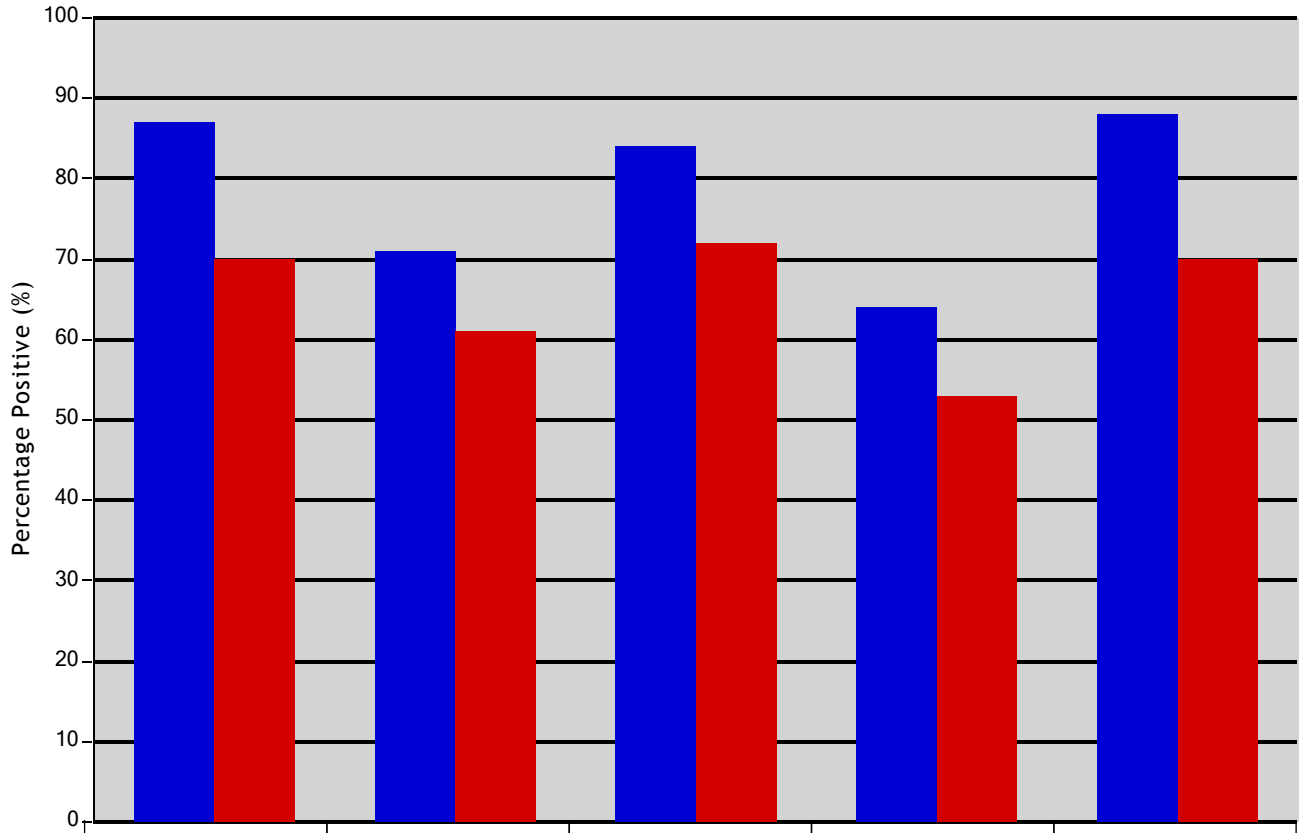
Organizational culture is widely recognized as a significant driver in changing behavior and expectations in order to increase safety within organizations. A key step in this process is the ability to measure the presence and degree of safety culture. This is why Accreditation Canada provides organizations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

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

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

- **Data collection period: September 21, 2012 to November 15, 2012**
- **Minimum responses rate (based on the number of eligible employees): 63**
- **Number of responses: 65**

Patient Safety Culture: Results by Patient Safety Culture Dimension



	Senior leadership support for safety (valuing safety)	Supervisory leadership support for safety	Patient safety learning culture	Communication barriers/talking about errors	Overall perception of patient safety
	87%	71%	84%	64%	88%
	70%	61%	72%	53%	70%

Legend

Campbellford Memorial Hospital

* Canadian Average

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

3.3 Worklife Pulse Tool

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

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

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

Client Experience Tool

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

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

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

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

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

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

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

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

Appendix A Qmentum

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

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

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

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

Action Planning

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

Evidence Review and Ongoing Improvement

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

Appendix B Priority Processes

Priority processes associated with system-wide standards

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

Priority processes associated with population-specific standards

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

Priority processes associated with service excellence standards

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

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