ACCREDITATION CANADA

Driving Quality Health Services

Accreditation Report

Kingston General Hospital

Kingston, ON

On-site survey dates: September 9, 2012 - September 13, 2012

Report issued: September 28, 2012

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

Kingston General Hospital (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. As part of this ongoing process of quality improvement, an on-site survey was conducted in September 2012. 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.

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

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.

Accreditation Canada is a not-for-profit, independent organization that provides health services organizations with a rigorous and comprehensive accreditation process. We foster ongoing quality improvement based on evidence-based standards and external peer review. Accredited by the International Society for Quality in Health Care, Accreditation Canada has helped organizations strive for excellence for more than 50 years.

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 Kingston General Hospital on your participation in the Qmentum accreditation program. Qmentum is designed to integrate with your quality improvement program. By using it 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 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

Table of Contents

Section 1 Executive Summary

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. Organizations that are accredited by Accreditation Canada undergo a rigorous evaluation process. Following a comprehensive self-assessment, trained surveyors from accredited health organizations conduct an on-site survey to evaluate the organization's performance against Accreditation Canada's standards of excellence.

Kingston General Hospital (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. This Accreditation 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.

Kingston General Hospital 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

Kingston General Hospital has earned the following accreditation decision.

Accredited with Exemplary Standing

1.2 About the On-site Survey

- **On-site survey dates: September 9, 2012 to September 13, 2012**

- **Location**

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

  1 Kingston General Hospital

- **Standards**

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

  System-Wide Standards

  1 Governance
  2 Leadership

  Service Excellence Standards

  3 Managing Medications
  4 Cancer Care and Oncology Services
  5 Operating Rooms
  6 Reprocessing and Sterilization of Reusable Medical Devices
  7 Organ and Tissue Donation Standards for Deceased Donors
  8 Organ and Tissue Transplant Standards
  9 Surgical Care Services
  10 Critical Care
  11 Emergency Department
  12 Point-of-Care Testing
  13 Infection Prevention and Control
  14 Ambulatory Care Services
  15 Biomedical Laboratory Services
  16 Laboratory and Blood Services
  17 Medicine Services
  18 Mental Health Services
  19 Blood Bank and Transfusion Services
  20 Obstetrics Services
  21 Diagnostic Imaging Services

- **Instruments**

  The organization administer:

  1 Governance Functioning Tool
  2 Patient Safety Culture Tool
  3 Worklife Pulse 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 lists the quality dimensions and shows how many of the criteria related to each dimension were rated as met, unmet, or not applicable during the on-site survey.

Quality Dimension	Met	Unmet	N/A	Total
 Population Focus (Working with communities to anticipate and meet needs)	63	0	0	63
 Accessibility (Providing timely and equitable services)	105	0	0	105
 Safety (Keeping people safe)	626	15	26	667
 Worklife (Supporting wellness in the work environment)	159	3	0	162
 Client-centred Services (Putting clients and families first)	229	1	0	230
 Continuity of Services (Experiencing coordinated and seamless services)	62	0	0	62
 Effectiveness (Doing the right thing to achieve the best possible results)	980	13	7	1000
 Efficiency (Making the best use of resources)	88	2	2	92
Total	**2312**	**34**	**35**	**2381**

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 contribute to achieving the standard as a whole.

System-wide standards address quality and safety at the organizational level in areas such as governance and leadership, while population-specific and service excellence standards address specific populations, sectors, and services. The sets of 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	41 (95.3%)	2 (4.7%)	0	35 (100.0%)	0 (0.0%)	0	76 (97.4%)	2 (2.6%)	0
Leadership	42 (100.0%)	0 (0.0%)	0	87 (100.0%)	0 (0.0%)	0	129 (100.0%)	0 (0.0%)	0
Diagnostic Imaging Services	65 (98.5%)	1 (1.5%)	0	60 (100.0%)	0 (0.0%)	1	125 (99.2%)	1 (0.8%)	1
Obstetrics Services	55 (100.0%)	0 (0.0%)	7	71 (95.9%)	3 (4.1%)	2	126 (97.7%)	3 (2.3%)	9
Infection Prevention and Control	51 (100.0%)	0 (0.0%)	0	44 (100.0%)	0 (0.0%)	2	95 (100.0%)	0 (0.0%)	2
Ambulatory Care Services	34 (100.0%)	0 (0.0%)	3	72 (97.3%)	2 (2.7%)	2	106 (98.1%)	2 (1.9%)	5
Biomedical Laboratory Services **	16 (100.0%)	0 (0.0%)	0	36 (100.0%)	0 (0.0%)	0	52 (100.0%)	0 (0.0%)	0
Blood Bank and Transfusion Services **	42 (100.0%)	0 (0.0%)	0	17 (100.0%)	0 (0.0%)	0	59 (100.0%)	0 (0.0%)	0
Cancer Care and Oncology Services	28 (100.0%)	0 (0.0%)	0	73 (98.6%)	1 (1.4%)	1	101 (99.0%)	1 (1.0%)	1
Critical Care	28 (96.6%)	1 (3.4%)	0	87 (97.8%)	2 (2.2%)	5	115 (97.5%)	3 (2.5%)	5

Standards Set	High Priority Criteria			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Emergency Department	31 (100.0%)	0 (0.0%)	0	95 (100.0%)	0 (0.0%)	1	126 (100.0%)	0 (0.0%)	1
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	70 (93.3%)	5 (6.7%)	1	49 (94.2%)	3 (5.8%)	0	119 (93.7%)	8 (6.3%)	1
Medicine Services	25 (96.2%)	1 (3.8%)	0	67 (97.1%)	2 (2.9%)	1	92 (96.8%)	3 (3.2%)	1
Mental Health Services	30 (100.0%)	0 (0.0%)	0	69 (97.2%)	2 (2.8%)	1	99 (98.0%)	2 (2.0%)	1
Operating Rooms	69 (100.0%)	0 (0.0%)	0	30 (100.0%)	0 (0.0%)	0	99 (100.0%)	0 (0.0%)	0
Organ and Tissue Donation Standards for Deceased Donors	34 (100.0%)	0 (0.0%)	1	79 (100.0%)	0 (0.0%)	1	113 (100.0%)	0 (0.0%)	2
Organ and Tissue Transplant Standards	59 (100.0%)	0 (0.0%)	0	80 (100.0%)	0 (0.0%)	0	139 (100.0%)	0 (0.0%)	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	39 (100.0%)	0 (0.0%)	1	57 (100.0%)	0 (0.0%)	2	96 (100.0%)	0 (0.0%)	3
Surgical Care Services	29 (100.0%)	0 (0.0%)	0	65 (100.0%)	0 (0.0%)	1	94 (100.0%)	0 (0.0%)	1
Total	**907 (98.9%)**	10 (1.1%)	13	1316 (98.9%)	15 (1.1%)	20	2223 (98.9%)	25 (1.1%)	33

** 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

In Qmentum, a Required Organizational Practice (ROP) is defined as 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 how the applicable ROPs were rated during the on-site survey.

Required Organizational Practice	Overall rating	Test of 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 As A Strategic Priority (Leadership)	Met	1 of 1	1 of 1
Client Safety Quarterly Reports (Leadership)	Met	1 of 1	2 of 2
Client Safety Related Prospective Analysis (Leadership)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Communication			
Client And Family Role In Safety (Ambulatory Care Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Cancer Care and Oncology Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Critical Care)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Diagnostic Imaging Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Medicine Services)	Met	2 of 2	0 of 0

Required Organizational Practice	Overall rating	Test of Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client And Family Role In Safety (Mental Health Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Obstetrics Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Surgical Care Services)	Met	2 of 2	0 of 0
Dangerous Abbreviations (Managing Medications)	Met	4 of 4	3 of 3
Information Transfer (Ambulatory Care Services)	Met	2 of 2	0 of 0
Information Transfer (Cancer Care and Oncology Services)	Met	2 of 2	0 of 0
Information Transfer (Critical Care)	Met	2 of 2	0 of 0
Information Transfer (Emergency Department)	Met	2 of 2	0 of 0
Information Transfer (Medicine Services)	Met	2 of 2	0 of 0
Information Transfer (Mental Health Services)	Met	2 of 2	0 of 0
Information Transfer (Obstetrics Services)	Met	2 of 2	0 of 0
Information Transfer (Surgical Care Services)	Met	2 of 2	0 of 0
Medication Reconciliation As An Organizational Priority (Leadership)	Met	12 of 12	0 of 0
Medication Reconciliation At Admission (Ambulatory Care Services)	Met	5 of 5	2 of 2

Required Organizational Practice	Overall rating	Test of Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication Reconciliation At Admission (Cancer Care and Oncology Services)	Unmet	0 of 4	0 of 1
Medication Reconciliation At Admission (Critical Care)	Met	4 of 4	1 of 1
Medication Reconciliation At Admission (Emergency Department)	Unmet	0 of 4	0 of 1
Medication Reconciliation At Admission (Medicine Services)	Met	4 of 4	1 of 1
Medication Reconciliation At Admission (Mental Health Services)	Unmet	0 of 4	0 of 1
Medication Reconciliation At Admission (Obstetrics Services)	Unmet	0 of 4	0 of 1
Medication Reconciliation at Transfer or Discharge (Ambulatory Care Services)	Met	4 of 4	1 of 1
Medication Reconciliation at Transfer or Discharge (Cancer Care and Oncology Services)	Unmet	0 of 4	0 of 1
Medication Reconciliation at Transfer or Discharge (Critical Care)	Met	4 of 4	1 of 1
Medication Reconciliation at Transfer or Discharge (Emergency Department)	Unmet	0 of 4	0 of 1
Medication Reconciliation at Transfer or Discharge (Medicine Services)	Met	4 of 4	1 of 1
Medication Reconciliation at Transfer or Discharge (Mental Health Services)	Unmet	0 of 4	0 of 1

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

Required Organizational Practice	Overall rating	Test of 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 (Point-of-Care Testing)	Met	1 of 1	0 of 0
Two Client Identifiers (Surgical Care Services)	Met	1 of 1	0 of 0
Verification Processes For High-Risk Activities (Ambulatory Care Services)	Met	2 of 2	1 of 1
Verification Processes For High-Risk Activities (Cancer Care and Oncology Services)	Met	2 of 2	1 of 1
Verification Processes For High-Risk Activities (Critical Care)	Met	2 of 2	1 of 1
Verification Processes For High-Risk Activities (Diagnostic Imaging Services)	Met	2 of 2	1 of 1
Verification Processes For High-Risk Activities (Medicine Services)	Met	2 of 2	1 of 1
Verification Processes For High-Risk Activities (Mental Health Services)	Met	2 of 2	1 of 1
Verification Processes For High-Risk Activities (Obstetrics Services)	Met	2 of 2	1 of 1
Verification Processes For High-Risk Activities (Surgical Care Services)	Met	2 of 2	1 of 1

Required Organizational Practice	Overall rating	Test of Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Concentrated Electrolytes (Managing Medications)	Met	1 of 1	0 of 0
Heparin Safety (Managing Medications)	Met	4 of 4	0 of 0
Infusion Pumps Training (Ambulatory Care Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Cancer Care and Oncology Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Critical Care)	Met	1 of 1	0 of 0
Infusion Pumps Training (Emergency Department)	Met	1 of 1	0 of 0
Infusion Pumps Training (Managing Medications)	Met	1 of 1	0 of 0
Infusion Pumps Training (Medicine Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Obstetrics Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Operating Rooms)	Met	1 of 1	0 of 0
Infusion Pumps Training (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	0 of 0	2 of 2

Required Organizational Practice	Overall rating	Test of 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
Client Safety: Roles And Responsibilities (Leadership)	Met	1 of 1	2 of 2
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 Control Guidelines (Infection Prevention and Control)	Met	1 of 1	0 of 0
Infection Rates (Infection Prevention and Control)	Met	1 of 1	3 of 3
Influenza Vaccine (Infection Prevention and Control)	Met	3 of 3	0 of 0
Sterilization Processes (Infection Prevention and Control)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Falls Prevention			
Falls Prevention Strategy (Ambulatory Care Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Cancer Care and Oncology Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Diagnostic Imaging Services)	Met	3 of 3	2 of 2

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

1.6 Summary of Surveyor Team Observations

During the on-site survey, the surveyor team made the following observations about the organization's overall strengths, opportunities for improvement, and challenges.

The organization, Kingston General Hospital (KGH) is commended on preparing for and participating in the Qmentum survey process.

There has been a significant renewal at the leadership level of KGH during the past three years. Board renewal has also occurred with a new board chair being welcomed this year. The board and leadership teams at KGH are dynamic groups of passionate professionals that are committed to providing outstanding care, always. The chief executive officer (CEO) is highly visible both at KGH and at the local and provincial, national and international levels. There are opportunities for staff to participate in leadership and quality education programs. The leadership team is guiding KGH's organizational transformational journey and is implementing innovative strategies to integrate quality, safety and patient-centred care for all aspects of the patient experience. Creativity, innovation and sharing of knowledge are some of the fundamental activities that drive the leaders' actions on a daily basis and this is supported by a can-do attitude. Leaders interact with frontline teams regularly and staff members appreciate the access they have to the leaders in the organization. The leaders at KGH are encouraged to continue to develop opportunities to engage with one another, staff and physicians.

There is a very positive community partner satisfaction associated with KGH. Attendance at the partnership meeting included Southeast Local Health Integrated Network (SELHIN) partners namely hospital CEOs and other representatives and community agencies such as Community Care Access Centre (CCAC) and Frontenac Community Mental Health Services. When KGH commenced its strategic planning process, there was an impressive opportunity for stakeholders and the community to participate and provide meaningful and honest information. A tremendous improvement in organizational transparency and openness has occurred over the last several years. The partners believe that KGH provides exceptionally high-quality complex acute care services. Overall, there is a general theme of collaboration, networking and inclusiveness on the part of KGH where the partners look to the hospital as being a leader since they are the largest provider of health care services in the region. Staff members report they are proud to say they work at KGH when they are out in the community. There are both formal and informal linkages and communication venues. The CEO provides partner hospitals with activity summaries on a regular basis to enhance communication and sharing of information. Networking and collaboration is strong at the clinical program and team levels. Partners encourage the organization to continue to participate in joint LHIN endeavours being mindful that all partners have an equal voice in decision-making.

An extensive network of programs and services are available to staff members and physicians to ensure there is a sustainable healthy work environment. The development and sustainability of a healthy workplace is a priority of the organization. A staff satisfaction survey (Worklife Pulse Survey) was conducted recently and teams are working on developing and implementing strategies to address the noted priority issues. Staff members reported that they love their jobs and are proud to work at KGH. When staff are asked if they can feel a shift in the culture at KGH during the past three years they are quick to respond in a positive manner. Attention is consistently focused on retention and recruitment efforts, the latter being especially important because many positions are difficult to recruit given the specialized nature of the organization's services and programs. There is an array of educational opportunities provided at the organization and some bursary funding is available for courses. On-boarding processes and resources for new staff and physicians are well-developed. The organization is affiliated with Queen's University and strong relationships exist particularly with physician recruitment processes and cross-appointments. Research is a priority at KGH and the organization is dedicated to increasing this funding to fulfil its mandate. In KGH's highly unionized environment, union leaders and other

organization is monitoring and evaluating span of control issues in concert with staffing stress and fatigue levels. A new model of care has been implemented in the last several years in concert with a commitment to ensure staff members are functioning at the full scope of practice where appropriate. Physician engagement is impressive and recently, a new vice president (VP), medical affairs role was created.

This transformational organization is much-admired for the collaborations, networks and partnerships it has developed to achieve its mandate of outstanding care, always. There is an expectation that a culture of patient and family centred care, inter-professional collaborative practice and quality is embedded into every aspect of patient care delivery. Patients are the primary driver and focus of every interdisciplinary team. Inter-professional collaboration enables supportive and effective teamwork based on respect and trust.

The organization is considered to be a leader in the SELHIN as it delivers high-quality complex acute care services. Teams work with partners to identify the most appropriate services and programs that should be delivered at KGH. In order to provide effective and efficient services within the healthcare system in the SELHIN, selective ambulatory care services are in the process of being transferred to Hotel Dieu and inpatient mental health beds were recently transferred to KGH. Documentation is completed in both paper and electronic formats and the organization is encouraged to move towards adoption of a total e-health record. An extensive redevelopment project was recently completed and the organization is supported in its advocacy for additional redevelopment projects to address safety and infection control concerns and best practices in the aging and inefficient old physical plant.

Insofar as client satisfaction, patients and families report an extremely high level of satisfaction with KGH. Staff and physicians are considered to be kind, caring and compassionate, treating patients and families with dignity and respect. There has been a palpable improvement in the manner in which patients are cared for by patient care teams. The transformation journey in which KGH is engaged focuses on ensuring patients are the driving force behind care decisions. The introduction of patient experience advisors is a leading edge project and one that is gaining attention externally. One patient stated that she would not consider going to any other healthcare facility to receive the type of care she requires. Client satisfaction surveys are conducted regularly and results are exceptionally high regarding overall satisfaction with their care and willingness to recommend the organization to others. Results of these satisfaction surveys are reviewed at the board and executive levels right down to the bedside care teams.

Section 2 Detailed Required Organizational Practices Results

This section gives more information about unmet ROPs. It shows the patient safety goal area into which the ROP falls, the requirements of the ROP, and the set of standards where it can be found.

The patient safety goal areas are safety culture, communication, medication use, worklife/workforce, infection control, and risk assessment.

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Communication	
Medication Reconciliation At Admission The team reconciles medications for clients with a decision to admit, with the involvement of the client, family or caregiver.	· Obstetrics Services 9.5 · Cancer Care and Oncology Services 7.5 · Mental Health Services 7.6 · Emergency Department 8.3
Medication Reconciliation at Transfer or Discharge The team reconciles the client's medications with the involvement of the client, family or caregiver at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).	· Obstetrics Services 12.3 · Cancer Care and Oncology Services 11.3 · Mental Health Services 11.3 · Surgical Care Services 11.4 · Emergency Department 11.5

Section 3 Detailed On-site Survey Results

This section shows detailed on-site results. When reviewing these results, it is important to review the service excellence and the system-wide results together, as they are complementary.

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

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

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

See Appendix B for a list of priority processes.

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

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

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

3.1 Priority Process Results for System-wide Standards

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

Some priority processes in this section also apply to the service excellence standards. Where there are unmet criteria that also relate to services, those results should be shared with the relevant team.

3.1.1 Priority Process: Planning and Service Design

Developing and implementing the infrastructure, programs and service to meet the needs of the community and populations served.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

In June 2010, KGH launched its strategic plan entitled: "KGH 2015: Strategy for achieving Outstanding Care, Always." An extensive planning process that involved the participation and engagement of over 2000 staff, physicians, volunteers and community/stakeholders was instrumental in informing this strategic plan. The board of directors and executive team members are commended for the strategic process that was developed in order to create a meaningful and living strategic guide that has painted a vivid picture of the future they aim to create and where the patient and family is central to everything that is done at KGH. The plan is based on the intensive consultative process in which they engaged. The voice of all of KGH stakeholders is integrated into the four strategic directions. Five principles were developed namely; respect, engagement, accountability, transparency and value for money. Enablers have been identified that must be in place in order to support the achievement of the organization's four strategic directions. The aim of the organization, which is: "Outstanding Care, Always" is the central theme that integrates all activities, processes, strategies and decisions in the organization.

The organization is commended for some unique engagement strategies that were implemented throughout this consultative strategic planning process. A speed-dating session was conducted with the leadership team that involved twenty minute rapid-cycle discussions to develop and articulate the tactics that would be identified and implemented to make this new strategic plan come to fruition. This resulted in enhanced engagement by the team members. Enhanced understanding and comprehension of intra-program dependencies were highlighted and a capacity matrix was developed to understand and highlight expectations.

Once the tactics were identified, milestones and accountabilities were developed and indicators and metrics were subsequently identified to ensure that effective monitoring and reporting with clear accountabilities could occur. Performance management tools enable regular monthly and quarterly reviews to occur at all pertinent committees and meeting from the level of board engagement down to frontline staff meetings. Performance reports are now submitted to various committees with analysis of data in a user-friendly format, with each of the indicators clearly tied to the various milestones that have been developed. Interpretation of data enables understanding of the status of the organization relative to identified targets. Activities across the organization are very well-coordinated and focused on the strategic plan to ensure alignment and a consistent focus on what has been identified as essential for the achievement of the organization's vision (aim) and the four strategic priorities.

The organization is committed to confirming the role it has within the LHIN, as KGH is considered to be and is looked at by others as a leader. As a tertiary care academic health centre, the organization continues to review its mandate to ensure KGH is providing the most appropriate care given the resources and role. Complex acute care is the main focus and as such, the organization has revisited the clinical services provided with other key stakeholders. This has included the LHIN and Hotel Dieu and as such, KGH is in the process of transferring many outpatient clinics to Hotel Dieu and has transferred mental health inpatient services to KGH. During the community and partnership meeting, participants acknowledged that this most recent KGH strategic planning process was transparent and highly inclusive and one that provided many opportunities for dialogue and debates. There is a clear understanding with stakeholders both internally and externally regarding the direction of this organization for the next many years.

The Minister of Health has been a strong supporter of this organization and has commended KGH for the turnaround that has been the result of a relentless focus on quality, meaningful and strategic planning and consistent attention to the needs of the patient.
The organization is encouraged to maintain momentum with the strategic plan and continue to share the results of the performance reports with frontline staff in a meaningful way for all staff, physicians and volunteers.

3.1.2 Priority Process: Governance

Unmet Criteria		High Priority Criteria
Standards Set: Governance		
13.6	The governing body regularly evaluates the performance of the board chair based on established criteria.	!
13.7	The governing body regularly reviews the contribution of individual members and provides feedback to them.	!

Surveyor comments on the priority process(es)

The board of directors is a highly engaged, committed and passionate group of individuals whose mission is to ensure that Kingston General Hospital (KGH) provides compassionate care, always and this is the aim or vision of the organization. This driving force was evident throughout the on-site survey. There is a clear focus on quality and safety and continuous improvement and an expectation that patients and families are at the centre of all organizational activities, strategies and directions.

The energy in an organization is influenced significantly by a strong leadership team and the board's relentless attention to advancing the organization's new strategic plan demonstrates this commitment. The board acknowledges the outstanding work of the CEO and executive team and is appreciative of the honesty and trust that exists between the board and the executives. There has been a significant improvement in the type and detail of information that is received by board members which enables them to be effective and informed members of the governance team. The board recognizes the impressive amount of change that has taken place in the organization during the past three years and is cognizant of the potential stress and change-fatigue that might be felt by the dedicated staff, physicians and volunteers. The board is extremely proud of the outstanding accomplishments that have been realized at KGH. The board members have a clear concept of their continued journey to ensure that their community continues to receive exemplary care, that research continues to advance and improve patient outcomes and to be the best employer for staff.

The board and CEO and executive team underwent an impressive and inclusive strategic planning process in 2010, with more than 2000 participants including community members and all other pertinent external stakeholders. The process resulted in the creation of a five-year plan entitled: "KGH 2015: Strategy for achieving Outstanding Care, Always." Four strategic directions were identified, five principles were agreed upon and enablers that would be required to support the strategic directions and principles were clearly defined and included in the model. All organizational activities are aligned to the model and strategy and this is considered to be the 'KGH Way". Milestones and indicators have been developed.

The board chair and CEO ensure that the board members receive their monthly meeting packages one week in advance of the meeting to allow adequate time for member preparation. The package includes the agenda, briefing notes to facilitate board member understanding and comprehension of the materials that will be discussed, and minutes of the previous meeting. Members reported that they were well-informed and that this process was consistently implemented. Performance reports with indicators and milestone updates are provided to the board quarterly. The reporting strategy was recently refreshed to ensure the board was receiving the right information at the right level so that members could effectively perform their

responsibilities. Therefore, various reports were streamlined for fiscal 2012-2013. Twenty-five strategic milestones based on the strategic priorities and 47 unique indicators are now provided in the strategic performance report. More than 100 indicators are reviewed by the leadership team and portfolio membership. The alignment of reporting indicators that reflect the strategic plan are impressive, resulting in reduced duplication yet thorough communication and analysis.

Bylaws and policies are reviewed annually or as required should situations arise that require more frequent revisions. The bylaws are complete, thorough and well-written. Policies are current and appropriate.

The board works with the organization's ethical framework as appropriate and education regarding the framework occurs during board member orientation. New board members feel well-prepared, supported and the mentoring process is impressive. There is an excellent board recruitment process and board sub-committee membership allows for non-board member participation. This provides an excellent opportunity for succession planning of new potential board membership. The board conducts an annual review of their effectiveness and functioning as a team and makes improvements as a result of this assessment. The new board chair met with all board members over the summer to discuss a variety of issues, one of which included how to evaluate individual board member functioning and effectiveness. Ongoing discussions will occur and plans will be put in place to ensure that every member receives a performance assessment, which likely will be a type of 360 degree evaluation. The board composition is based on skill and competency set criteria. Board members could clearly articulate that they are aware of their governance responsibilities and check in with the executive team periodically to ensure that the management and governance lines of accountabilities are not crossed. There are many board sub-committees that have terms of references and work plans in place. These sub-committees receive performance indicator reports that are tailored to their focus and work plans, where more in depth analysis, review and discussions occur. Then this information is reported up the board of the whole. There is a significant amount of work accomplished by these sub-committees and the membership is commended for their dedication and commitment.

There is much evidence that demonstrates the board's support of the organization's aim (vision) and strategic plan and directions. The board is visible across the organization and members attend award ceremonies, fundraising initiatives and other hospital and community events. The board is commended for the creation of the KGH board award in 2011 that recognizes outstanding individual or team contributions towards the achievement of the organization's new strategy and aim of outstanding care, always.

3.1.3 Priority Process: Resource Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization has a comprehensive and integrated operating and capital budgeting process. Leaders report that significant improvements have occurred during the past three years both in the planning process and information that end-users receive to make effective and appropriate resource allocation decisions. Variance reports are user-friendly, complete and thorough with online tools available to afford leaders capability to drill down and mine for appropriate information to inform their financial analyses.

Long-term planning now exists in the organization and new strategies and the focus on reinvesting dollars into capital needs have resulted in significant improvements. The organization has delivered a balanced budget for the first time in many years. The entire organization is applauded for its outstanding and dedicated work to identify strategies to eliminate waste, and to reduce the large deficit, which is resulting in ability to reinvest funds into much needed capital equipment. Previously, staff members and teams would request capital equipment and expect that nothing would be forthcoming due to a lack of funds. This culture is now changing and reflects the significant turnaround that has occurred in the organization for the last three years. Staff are beginning to trust processes and strategies and with an emphasis on transparency, staff members understand the rationale behind funding allocations with capital equipment.

Patient and staff safety are at the centre of resource allocation decisions. Patient experience advisors are a special group of volunteers that represent the voice of the patient and are valuable assets, which are included in consultations about priorities.

3.1.4 Priority Process: Human Capital

Developing the human resource capacity to deliver safe and high quality services to clients.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Kingston General Hospital (KGH) has a staff complement of more than 3800, 900 volunteers and more than 500 credentialed professionals. Ninety-three percent of the staff are unionized and there are five unions in the organization. During the past several years, the team has experienced an evolution of its service delivery model for the organization. The role of human resource (HR) advisor was created to provide improved services to staff members and leaders. The team is passionate and committed to making improvements to the worklife at KGH. There is a palpable focus on continuous quality improvements in the services provided and in the processes and programs that the team delivers.

There is a strong working relationship between management and the union leaders, which includes proactive regular monthly meetings that ensure enhanced communication and inclusion.

The creation and sustainability of a healthy workplace is a key priority for the organization. There is a code of behaviour called: "Be Real" and an excellent program on preventing workplace violence is in place. Posters are visible in hospital elevators to ensure that not only staff, physicians and volunteers know about the program, but also patients and their families. The organization's guiding principles (values) are aligned with the workplace code of behaviour. In the fall of 2012, a KGH commitment pledge will be rolled out to KGH staff to reinforce and enhance accountabilities for appropriate behaviours. There is a workplace violence prevention committee in place and pertinent polices and procedures have been reviewed and revised as a result of the 2010 Occupational Health and Safety Act. The behavioural crisis alert program identifies patients at risk for violence and they are identified with a purple dot. Safe plans are developed when staff identify that they are experiencing an unsafe situation.

Kingston and the Islands has been designated under the French Language Services Act and therefore, an active French language committee has been formed to address French language issues.

Various indirect indicators of stress and fatigue are regularly evaluated by the team and strategies are implemented when trends and patterns are recognized. A survey was distributed to staff members off work and on sick leave to assess for ways to improve processes for a return to work. If a staff member is on sick leave for greater than four days, the team assesses the situation to determine if stress was a factor in the absence. Significant attention and priority have been placed on creating a healthy workplace. Many improvements have been implemented such as the arrival of Tim Horton's on site, having hot food in vending machines available at all times (24/7), discounts at fitness clubs, on-site weight watchers, day care, dry cleaning services, hair salon, dentist and banking services. There is a team spirit group whose mandate is to enhance staff satisfaction with the provision of fun and engaging activities such as delivering Halloween candy, decorating for special holidays and events, supporting the through-your-eyes program of shadowing staff members in other departments and offering activities on evenings for shift workers. As part of the organization's focus on quality of worklife, the team has worked with the city of Kingston to address bus routes to make transportation to KGH simpler and safer.

Greater than 80 percent of position profiles at KGH have been completed in the last year to include the staff commitment and responsibilities for code of conduct and appropriate behaviour and their role in safety and quality.

All senior leaders and directors have experienced a 360 degree performance evaluation using the Ontario Hospital Association (OHA) framework. Personal development and goal-setting tools were recently introduced. The principles that form part of the organization's strategic plan are the driver for assessing individual performance. Leaders and physicians are being held accountable for outcomes. Senior leadership compensation is directly linked to achievement of outcomes as per the quality improvement plan. The team has plans in place to roll out a more comprehensive and useful performance management tool to make the evaluation process more streamlined and useful. The team reports that 40 percent of staff have had performance appraisals and this was validated during the survey. The organization is strongly encouraged to ensure that all staff receive a performance evaluation so that appropriate goals and objectives can be developed to ensure staff may continue to be engaged and grow personally and professionally. Department heads are expected to conduct annual meetings with physicians and reports are submitted annually. A more formal process is encouraged to ensure that the performance assessment becomes part of the credentialing process. Department head compensation is linked to the achievement of outcomes.

The KGH is acknowledged for its participation in the December 2011 work-well audit, achieving an impressive score of 93 percent compliance. There are many corporate occupational heath and safety activities evident in the organization. Performance indicators are posted and safety bulletins are distributed regularly. Musculoskeletal Injury prevention is a large focus for KGH. The program includes safe patient handling coaches and safety champions. There is an active joint occupational health and safety committee (JOHSC) that conducts safety walk-abouts according to a schedule.

As part of the organization's focus on creating a healthy workplace, emphasis has been placed on ensuring that staff members take their vacations.

Patient experience advisors participate in new hire interviews. This is a leading practice and the organization is commended for this innovative and impressive strategy. Education support is available to staff in the form of bursaries. The organization is encouraged to continue its support of and focus on critical care staffing.

3.1.5 Priority Process: Integrated Quality Management

Continuous, proactive and systematic process to understand, manage and communicate quality from a system-wide perspective to achieve goals and objectives.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization is commended for the excellent work accomplished since its previous accreditation survey regarding the development of an integrated risk management program. This new framework was modelled after the International Standard (ISO) strategy. Summary reports are provided to the board indicating the status of activities in the organization. Evaluation of the framework has occurred resulting in two major changes to the program. Quality, safety and risk programs were realigned to report to one senior team member and the role of director of quality, safety and risk, which is currently vacant. Also, a fourth domain was added to the risk management model.

The KGH has identified staff safety and healthy environments as an enabler in the strategic plan. Milestones and indicators have been developed to track progress towards specific outcomes. The organization's first strategic priority has been identified as transforming the patient experience by way of a relentless focus on quality, safety and service. As this is a key corporate priority, all subsequent program and unit operating plans including tactics and milestones will ensure that quality is woven into all activities, processes and indicator monitoring.

There has been education offered to leaders and staff on LEAN methodologies and the organization is encouraged to continue to focus on enhancing quality tools and process education to ensure that a quality and improvement culture becomes embedded across the organization.

The board of directors has designed a reward to recognize staff members that are involved in projects that help the organization realize its aim. Further details in this regard can be found in the governance section of this document.

Staff report incidents and near misses using an online reporting system that is called 'Safe'. Reports are generated and results of various indicators are tracked and posted on safety boards on all units. Disclosure policies are well-written and are extremely comprehensive.

A comprehensive and effective performance reporting system has been developed in an integrated manner, based on the new strategic plan. The board receives regular useful and detailed reports that include interpretations and analysis for easy comprehension and understanding at all levels of the organization. The recent review of the indicators that are reported to the board resulted in revisions to ensure that appropriate information is presented. There is strong evidence that suggests this organization is committed to quality improvement, with the patient experience being central to everything that is done. The corporate strategic plan includes quality and safety as priorities for the organization, and the strategy and supporting tools integrate what would be considered a traditional safety plan and quality plan into one comprehensive living and working document. Priority indicators and goals have been identified in that document however, a quality improvement plan includes more components such as strategies and tools for quality improvement work including education.

The organization is encouraged to submit its Strategy and KGH-Way document to be considered for a leading practice as it is an innovative and effective methodology to embed quality and safety into everyday activities.

3.1.6 Priority Process: Principle-based Care and Decision Making

Identifying and decision making regarding ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

This innovative organization is carving out a novel and meaningful approach to managing decisions and issues for both clinical and operational issues. Typically referred to as ethics in most traditional healthcare organizations, KGH has made a deliberate decision to develop a strategy that is used to guide decisions and activities related to patient care that otherwise is addressed by several layers of various plans and frameworks. This simplistic yet meaningful approach ensures that the organization's principles and priorities guide all decisions. Therefore, one will not find a framework at KGH that is entitled: "Ethical Framework." Rather, one will be encouraged to review the document: KGH Way--The Strategy, which was developed in June 2010 and drives the patient-centred care approach that is central to all that staff do in concert with the inter-professional collaborative practice model. Staff members are not expected to specifically articulate the words 'ethics and ethical framework' but rather identify resources and team members to whom they would consult to discuss patient issues. The organization's principles (values) are closely linked to a commonly used framework known as accountability for reasonableness (A4R). The organization is commended for this unique and leading edge approach to principle-based care and decision-making.

During one tracer meeting, staff members were able to articulate that the principles of the accountability for reasonableness model were used for decision-making situations such as the allocation of resources, drug shortage situation and the Chalk River Isotope shortage. There is a staff ethicist available for consultations however, this person is currently on a leave and the position is vacant. it is noted that staff are very patient and family centred and use the Inter-professional collaborative practice model to ensure that decisions made involve the patient and family. It is evident that the teams advocate for their patients. A patient experience advisor participated in this priority process discussion and reinforced that KGH makes patient-centric decisions.

Research at KGH is vetted by the Queen's University research ethics board (REB). Several years ago, a fully electronic submission process was implemented. This has reduced delays in research approvals by the various stakeholders at KGH and it also allows for an ongoing review of the status of studies.

3.1.7 Priority Process: Communication

Communication among various layers 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 communication tracer was well-organized and well-attended, with a high level of collaboration and support noted between the communications program and the leaders and specialists in the organization. Demonstrated evidence is seen to enhance communication across the organization.

A high level of engagement and collaboration has been noted between communications and the leaders. Leaders feel supported in their communication needs.

Changes to staff identification (ID) badges to have them double-sided and with larger print size of first name is much appreciated by the patients.

Tremendous amount of efforts have been put forth to ensure a proactive approach with communication as opposed to reactive.

Way finding across the organization is challenging for staff and patients.

3.1.8 Priority Process: Physical Environment

Providing appropriate and safe structures and facilities to successfully carry out the mission, vision, and goals.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The KGH has some excellent facilities' initiatives upcoming, particularly the redevelopment of the emergency department (ED) and operating suite (OR). The organization has just designed and implemented a new catheterization laboratory. There is keen awareness and understanding around regulations and laws as KGH works closely with the ministry (MOHLTC) to ensure compliance with facility templates and approvals.

Strong maintenance programs exist and are well-supported with resources. The buildings are older, and some are historic, and they appear as well-maintained, spotlessly clean and uncluttered.

Security services are visible and appropriately involved in much of the organization's activities. Areas with restricted access are well marked and security services do a good job of limiting access to areas by assigning limitations on ID cards. Further, there seems to be enough surveillance tools in place to monitor the facilities. Maintenance activities are very sensitive to patient care, and collaborate regularly with infection control staff to limit patient and staff exposure to dust, fumes or other contaminants.

Disposal of waste seems satisfactory and KGH has a strong relationship with a contractor that provides incineration services. The physical plant is supported well by a published preventive maintenance (PM) program, supported by technological program. The physical plant includes sufficient redundancies/back-up systems to support electrical, water, and heat failures. The PM activities extend to hospital beds, technical/plant equipment and general facility upkeep and repair. Housekeeping staff seem well-informed on workplace hazardous management information system (WHMIS), infection prevention and control (IPAC) activities and adverse event reporting.

The neonatal intensive care (NICU) environment requires attention. The environment is not ideal for the vulnerable population serviced, as it does not meet the recommended standards for NICU space allocations, has infection control concerns and is not conducive to safe care. There is only one isolation space, which does not afford opportunity for separate ventilation. The unit is limited in its ability to provide oxygen outlets and suction at every bedside. The old bassinettes in use could be replaced by more ergonomically friendly and safer standards for bedding needs for infants. In the NICUs there are two sinks that are actively leaking, paint is chipping off the walls, tape is used to hold the drywall in place, there is a hopper in open space which is used for waste and to obtain hot water to heat expressed breast milk. There is no medication room. In the obstetrical area duct tape is being used to hold the linoleum down on the floor in an attempt to mitigate trip hazards.

3.1.9 Priority Process: Emergency Preparedness

Dealing with emergencies and other aspects of public safety.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The KGH's emergency preparedness plans are up to date and extremely well-developed. The organization updates plans as a point of good practice and as well, plans are updated as a result of the outcome from hazard analysis and actual incidents. Education around preparedness is delivered via e-learning using the LMS system, inservice sessions are held and both of which are mandatory for all staff and are supported by a performance review if not satisfactory.

The KGH collaborates with a broad population of stakeholders when planning and exercising the plans. Code red and green are tested frequently. Exercises around code brown, orange, yellow and black have been completed.

Recognition is given to the implementation of the 'call-em-all system (VOIP) call-back system, the vendor credentialing system, and the organization's aggressive approach to the municipality to ensure that health care is at the table for all municipal planning.

Encouragement is given to undertake a regular recertification process for all Executives to complete emergency operations centre (EOC) training to ensure that they understand their role and the role of the EOC during an incident.

Since there was no evidence of any tool/device that would facilitate moving a non-ambulatory patient down a staircase, it is suggested this be addressed to the organization's satisfaction.

3.1.10 Priority Process: Patient Flow

Smooth and timely movement of clients and their families through appropriate service and care settings.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The program demographics are that of an aging population. The Kingston area is a popular location to retire to and this places pressures on the need for alternative level of care (ALC) facilities. A recent closure of a 78-bed ALC facility is associated with a decrease in bed availability at KGH. This summer there was an increase in trauma patients. The result has been increased stress for admissions to KGH. Communication among the various managers has been excellent in addressing this issue.

Inpatient beds are allocated on the severity of illness and an escalating logarithm to guide the processes is developed. Communities' resources are notified and interim decanting of patents to Home Care is in concert with the goal to ALC in the future. Bed allocation from the ED is done by the ED bed allocation team. The bed allocation team works well and is inclusive.

Safety issues are addressed when overflow patients are decanted to the Outpatient Procedure Unit (OPPU) overnight and area C in the ED. Admission of trauma, cardiac and neuro surgical patients are not decanted elsewhere as KGH is the designated area for these services.

There exists an opportunity to explore and share experiences of patient flow in other LHINs.

3.1.11 Priority Process: Medical Devices and Equipment

Machinery and technologies designed to aid in the diagnosis and treatment of healthcare problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The team members have demonstrated interesting innovations as a result of their introduction to LEAN methodology. The Central Processing Services (CPS) area assigns work tags to staff members when they arrive on site, and these tags identify the area and tasks they have been assigned that day.

There are a number of different work assignments/tags and staff rotate in each on a rolling week to week, month to month basis. This ensures skill retention and competency in a number of areas and as well, it has considerably improved morale. There is a desire for more information technology (IT) specialized software from the staff of CPS as well as from biomedical engineering, and both require a more efficient way to track equipment for recall and PM purposes.

Local work space is extremely clean and personal protective equipment (PPE) is employed consistently by all staff and visitors. The work flow and physical set up of this department is excellent. Incoming contaminated equipment is sequestered from clean areas. The events and tasks associated with cleaning and sterilization are set up in the physical space in a sensible chronological design.

3.2 Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Point-of-care Testing Services

- Provision of testing outside the laboratory, near where care is delivered to the client, in order to provide practitioners with information about the presence of health problems, and the procedures and processes used by these services.

Organ Transplant

- Organ transplant services provided from initial assessment of potential transplant candidates through the provision of follow up recipient care.

Clinical Leadership

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

Competency

- Developing a highly competent interdisciplinary team with the knowledge, skills and abilities to develop, manage, and deliver effective and efficient programs, services, and care.

Episode of Care

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

Decision Support

- Information, research and evidence, data, and technologies that support and facilitate management and clinical decision-making.

Impact on Outcomes

- The identification and monitoring of process and outcome measures to evaluate and improve the quality of services to clients and the impact on client outcomes.

Medication Management

- Interdisciplinary provision of medication to clients.

Organ Donation

- Donation services provided from identification of a potential donor to donor management and organ recovery.

Infection Prevention and Control

- Measures practiced by healthcare personnel in healthcare facilities to decrease transmission and acquisition of infectious agents.

Surgical Procedures

- Delivery of safe surgical care to clients, from preparation and the actual procedure in the operating room, to the post-recovery area and discharge.

Diagnostic Services: Imaging

- Availability of diagnostic imaging to provide health care practitioners with information about the presence, severity, and causes of health problems, and the procedures and processes used by these services.

Diagnostic Services: Laboratory

- Availability of laboratory services to provide health care practitioners with information about the presence, severity, and causes of health problems, and the procedures and processes used by these services.

Blood Services

- Safe processes to handle blood and blood components, from donor selection and blood collection through to providing transfusions.

3.2.1 Standards Set: Ambulatory Care Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
3.5	The organization provides sufficient workspace to support interdisciplinary team functioning and interaction.	
4.2	The team orients new team members about their roles and responsibilities, the team goals and objectives, and the organization as a whole.	
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		
Although the renal dialysis unit is new and superbly designed, the renal clinic is much too small to facilitate the number of patients being seen in this area. Further, the plan to move the clinic to Hotel Dieu have staff feeling that this move may result in significant transition issues for patients moving through renal services.		

The organization would benefit the care of its patients by factoring in the ease in which its patients move along the system, eliminating the duplication of services and sequestering services within one area of disease when planning and designing care space, or making decisions around care space.

Priority Process: Competency

The team would benefit from adding to their training curriculum for new staff, a formal review of the psychosocial dimensions that are unique to treating patients with chronic renal disease.

Priority Process: Episode of Care

The ambulatory care renal group has demonstrated a strong commitment to the care of patients suffering from chronic kidney disease. The department appears to have good resources from a human capital and specialist perspective. Access to care is free of barriers and there is considerable effort spent at making the transition between services as smooth as possible. Having said that, the senior staff in renal feel that separating the renal clinic from the renal dialysis unit by moving to another building, might negatively impact efforts for a smooth transition between services.

Given the risks and complexities inherent with patients suffering from chronic kidney disease, the department ensures a strong clinical leadership and quality in practice. The team members support their efforts by utilizing research and developing and collaborating on best practices and education. The KGH leads the province in vascular access for dialysis patients. The clinic and the renal dialysis unit which is new, provide a strong infrastructure for the care of these patients.

The strong collaboration with the Ontario Renal Network has recognized KGH as a leading provincial contributor to the development of best practices. It has been noted for sharing its successes in the management of chronic renal disease with other centres in the province. Patients receive clear and comprehensive information regarding the plans for their care and are happy and satisfied with the care they receive.

Priority Process: Decision Support

Although formal tracking programs do not exist, the clinic is fortunate enough to have a talented IT resource capable of generating helpful reports with the tools at hand.

The link to Queen's University is well-utilized and there are a couple of very ambitious research studies. The clinic collaborates on a regular basis with the Ontario Renal Network on best practice sharing, and overcoming common barriers and improving the patient experience within the LHIN.

Priority Process: Impact on Outcomes

The team measures a variety of mandatory and self-imposed program/outcome measures. Vascular access is one measure for which the KGH is leading the province with regard to percentage of successful completion. The partnership and strong link to the Ontario Renal Network will serve to facilitate capture and analysis and identification of influential indicators.

3.2.2 Standards Set: Biomedical Laboratory Services

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

Surveyor comments on the priority process(es)
Priority Process: Diagnostic Services: Laboratory
Please refer to accompanying priority processes related to Laboratory Services for comments.

3.2.3 Standards Set: Blood Bank and Transfusion Services

Unmet Criteria	High Priority Criteria
Priority Process: Blood Services	

The organization has met all criteria for this priority process.

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

Transfusion and blood management services are well done at KGH. All specimen receiving processes, as well as the receipt of blood from the Canadian Blood Services are received under a critical eye in terms of identification and confirmation. The laboratory is clean and organized and has good resources in terms of staffing and equipment. Staff members on the nursing units are knowledgeable about the process required for ordering and administering blood products.

3.2.4 Standards Set: Cancer Care and Oncology Services

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
The organization has met all criteria for this priority process.			
Priority Process: Competency			
The organization has met all criteria for this priority process.			
Priority Process: Episode of Care			
7.5	The team reconciles the client's medications upon admission to the organization, with the involvement of the client, family or caregiver.		ROP
	7.5.1	There is a demonstrated, formal process to reconcile client medications upon admission.	**MAJOR**
	7.5.2	The team generates a Best Possible Medication History (BPMH) for the client upon admission.	**MAJOR**
	7.5.3	Depending on the model, the prescriber uses the BPMH to create admission medication orders (proactive), OR, the team makes a timely comparison of the BPMH against the admission medication orders (retroactive).	**MAJOR**
	7.5.4	The team documents that the BPMH and admission medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.	**MAJOR**
	7.5.5	The process is a shared responsibility involving the client and one or more health care practitioner(s), such as nursing staff, medical staff, pharmacists, and pharmacy technicians, as appropriate.	**MINOR**
11.3	The team reconciles the client's medications with the involvement of the client, family or caregiver at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).		ROP
	11.3.1	There is a demonstrated, formal process to reconcile client medications at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).	**MAJOR**
	11.3.2	Depending on the model, the prescriber uses the Best Possible Medication History (BPMH) and the active medication orders to generate transfer or discharge medication orders (proactive), OR, the team makes a timely comparison of the BPMH, the active medication orders, and the transfer or discharge medication orders (retroactive).	**MAJOR**

11.3.3	The team documents that the BPMH, the active medication orders, and the transfer or discharge medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.	**MAJOR**
11.3.4	Depending on the transition point, an up-to-date medication list is retained in the client record (internal transfer), OR, the team generates a Best Possible Medication Discharge Plan (BPMDP) that is communicated to the client, community-based physician or service provider, and community pharmacy, as appropriate (discharge).	**MAJOR**
11.3.5	The process is a shared responsibility involving the client or family, and one or more health care practitioner(s), such as nursing staff, medical staff, and pharmacy staff, as appropriate.	**MINOR**
11.5	Following transition or end of service, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning.	

Priority Process: Decision Support

The organization has met all criteria for this priority process.

Priority Process: Impact on Outcomes

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The oncology program demonstrates strong and engaged leadership. Some parts of the program are managed by Cancer Care Ontario and KGH, with strong collaboration and the patient is put at the centre of all programming and planning.

Priority Process: Competency

There are no unmet criteria for the competency priority processes in cancer care and oncology services.

Priority Process: Episode of Care

The nursing team and administrative leaders are highly engaged and make great effort to meet all of the needs of the patients. The patients feel they are heard by the staff and feel the effort made to ensure their care and comfort is exemplary.

Priority Process: Decision Support

There are no unmet criteria pertaining to decision support.

Priority Process: Impact on Outcomes

There were mixed responses to safety briefings/walkarounds taking place. It is clear these occur however, the communication of the events and follow-up may be communicated more broadly.

3.2.5 Standards Set: Critical Care

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
1.5 The team regularly reviews its services and makes changes as needed.	
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	
14.1 The team identifies its needs for new technology and information systems.	
15.1 The organization has a process to select evidence-based guidelines for critical care services.	!
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	
Priority Process: Organ Donation	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The service is well organized and well run.The multidisciplinary team leads to very good communication with all adult care services represented. There are 47 ICU bed spaces located on two floors. Twenty-one are level two beds and run as an open unit. A rapid assessment (RACE) team was introduced three years ago and has resulted in a reduction in the number of code blues and readmissions to critical care.

Nurse educators are available and in the past year, have taken more than 40 nurses through the critical care training. There is concern about the level of workplace stress, as there is a high turnover in critical nursing and labour standards dictate that only a two-week notification is required.

A safety and quality culture is evident. Completion of a project that reduced the incidence of ventilated associated pneumonia (VAP) resulted in the hire of a full-time critical care quality coordinator. Quality risk assessments are evident in a number of areas including fall preventions and deep vein thrombosis.

There is a well-organized volunteer service for the ICU in place, supported by the community.

The program reports quality issues using the critical care scorecard.

A plan is in place to recruit two additional intensivists and at that time, the open care delivery service is to switch to a closed unit. An impact analysis has been done. The results of a high performing ICU checklist were provided. Areas of improvement include the need for a palliative care plan for quality of life during the dying process.

The transfer of long-term ventilated patients to a home or community facility is limited to three beds in a community facility which are fully occupied. This emphasizes the need for additional resources in this area if long-term ventilated patients are not to linger in the ICU.

Priority Process: Competency

Critical care is well-organized, with a well-structured multidisciplinary team.

Priority Process: Episode of Care

Critical care has a well-organized, well-structured multidisciplinary team. There are well-funded in research protocols, strong quality improvement initiatives and multiple safety outcomes.

Priority Process: Decision Support

The quality and safety issues in critical care are well-developed and the intensive care (ICU) high performance checklist provides evidence of this. The ICU at KGH is one of eleven certified Canadian training programs. At this time there are five critical care residents that support the educational and clinical goals of the programs. The ICU program and its personnel are commended for their procurement of significant t research funds.

Risk assessment is being embedded into the critical care residency program.

The NICU program needs to have its physical environment updated to reduce infection risk.

Priority Process: Impact on Outcomes

The ICU is well-embedded in risk reduction by way of several avenues including the Ontario High Performing ICU network.
The NICU is a member of the Canadian Neonatal Network and has contributed to quality outcome research as a result of this association.

Priority Process: Organ Donation

The organ donation program is well-standardized under the Ontario Trillium Gift of Life foundation.

3.2.6 Standards Set: Diagnostic Imaging Services

Unmet Criteria	High Priority Criteria
Priority Process: Diagnostic Services: Imaging	
4.3 For nuclear medicine, the team designates separate waiting areas to segregate clients who have been injected with radioactive substances from other clients.	!
Surveyor comments on the priority process(es)	
Priority Process: Diagnostic Services: Imaging	

The diagnostic imaging (DI) program is seen to have strong administrative and medical leadership that works collaboratively to ensure the program meets the needs of the patients requiring their services. The increasing need for services has been met despite the need for capital and facility enhancements and in the absence of increased funding.

The wait times for computerized tomography (CT) and magnetic resonance (MR) exceed standards and the timing for suspected stroke patients is managed well. The staff are highly dedicated, work collaboratively and demonstrate strong teamwork. A lengthy delay in facility changes may hinder the ability for the program to continue to function at the level it currently does.

All pediatric patients are supported by anesthesia where required and the attention required to this vulnerable population is commendable.

The policy and procedure documentation for diagnostic imaging is currently under development to ensure accuracy and to be reflective of new equipment where it exists.

3.2.7 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			
The organization has met all criteria for this priority process.			
Priority Process: Episode of Care			
8.3	The team reconciles medications for clients with a decision to admit, with the involvement of the client, family or caregiver.		ROP
	8.3.1	There is a demonstrated, formal process to reconcile client medications for clients with a decision to admit.	**MAJOR**
	8.3.2	The team generates a Best Possible Medication History (BPMH) for clients with a decision to admit.	**MAJOR**
	8.3.3	Depending on the model, the prescriber uses the BPMH to create admission medication orders (proactive), OR, the team makes a timely comparison of the BPMH against the admission medication orders (retroactive).	**MAJOR**
	8.3.4	The team documents that the BPMH and admission medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.	**MAJOR**
	8.3.5	The process is a shared responsibility involving the client and one or more health care practitioner(s), such as nursing staff, medical staff, pharmacists, and pharmacy technicians, as appropriate.	**MINOR**
11.5	The team reconciles the client's medications with the involvement of the client, family or caregiver at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).		ROP
	11.5.1	There is a demonstrated, formal process to reconcile client medications at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).	**MAJOR**
	11.5.2	Depending on the model, the prescriber uses the Best Possible Medication History (BPMH) and the active medication orders to generate transfer or discharge medication orders (proactive), OR, the team makes a timely comparison of the BPMH, the active medication orders, and the transfer or discharge medication orders (retroactive).	**MAJOR**

11.5.3	The team documents that the BPMH, the active medication orders, and the transfer or discharge medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.	**MAJOR**
11.5.4	Depending on the transition point, an up-to-date medication list is retained in the client record (internal transfer), OR, the team generates a Best Possible Medication Discharge Plan (BPMDP) that is communicated to the client, community-based physician or service provider, and community pharmacy, as appropriate (discharge).	**MAJOR**
11.5.5	The process is a shared responsibility involving the client or family, and one or more health care practitioner(s), such as nursing staff, medical staff, and pharmacy staff, as appropriate.	**MINOR**

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 Donation

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The emergency department (ED) has made great effort and has solicited significant co-operation in reducing the length of stay (LOS) and moving patients out of the ED and into the units. Although the ED still experiences episodes of gridlock, it has been aggressive in managing the problem. The presence of full-time internal medicine consultants has helped this process significantly. The inclusion of a patient experience advisor for ED planning and development activities was a brilliant move. This individual is a valuable link to the patient/community. The input of the advisor has been invaluable to date, particularly in facilitating the redesign of the patient experience in triage.

The ED appears to have sufficient resources in terms of staffing and equipment. Space and layout however, would benefit from a redesign and this is addressed in recent redevelopment proposals which are at the approval level at MOHLTC.

Priority Process: Competency

The process for improvement seems to rely directly on the annual strategic planning process. There exists both opportunity and benefit to the ED to begin this process independently prior to formal organizational strategic planning processes. The ED leadership should arrive at organizational strategic planning sessions proactively, with well-developed priorities for action.

There is a variety of very strong research studies occurring, especially decision supporting/guideline studies, which all strongly link to valid issues in emergency medicine.

Fewer than 15 percent of ED staff members have received any form of performance appraisal.

Priority Process: Episode of Care

Ambulance off-load performance falls within the standards for emergency departments. The ED has implemented an off-load nurse position to facilitate timely off-load from emergency medical services (EMS).

The LOS in the ED indicators are measured and are in compliance. Admitted patients awaiting a bed on the unit are placed in Area C. On certain days, this area is overwhelmed and patients spill over into other areas. There is good communication and co-operation across the hospital to move these patients out of the ED and onto the units.

There are dedicated internal medicine specialists in the ED available for timely assessment, treatment and decision-making for this ever growing population of patients. The new emergency information system (EDIS) has become an invaluable tool for viewing and managing the status and timelines in real time of all patients in the ED. A working group inclusive of a patient experience advisor representative has been tasked with streamlining the triage process in terms of educating the clients and expediting the process from a client satisfaction perspective.

In speaking with different frontline staff members, none of them was able to articulate an understanding of medication reconciliation or seemed to appreciate its role in patient safety as well as being a required practice.

Access to diagnostic tests and quick turnaround of results/reports is apparent. This process has improved significantly over the past couple of years with the help of technology. The patients treated by the ED staff appear satisfied with their care regardless of long wait times for an inpatient bed, and this would confirm the attentiveness of staff and comments on the vigilance of staff in communicating with them.

Priority Process: Decision Support

The electronic ED chart provides patient and ED patient status and tracking information, as well as care notes and is an excellent tool for ED operations. Significant privacy protection features have been incorporated into this program. The physician group are scheduled to have their patient care charting move from paper based to the EDIS system soon. The EDIS system allows ED staff to evaluate the status of all patients in the department in real time and alerts the staff when patient wait times such as time to be seen by a physician approach maximum timeframes.

Pain scales and conscious sedation practices are in place in the ED as pain management strategies.

Priority Process: Impact on Outcomes

The ED currently meets many of the mandatory reporting benchmarks which may change once indicators change as a result of funding changes. The several research activities of the department are decision guidelines based and will influence outcomes for both the clinical and financial perspectives.

The sexual assault/domestic violence program is exemplary and has and will continue to improve outcomes and options of victims.
The inclusion of the patient experience advisors will continue to positively influence ED operations and decisions, and it already has with the streamlining of the triage process with a strong customer service slant.

Priority Process: Organ Donation

For live organ donor identification and recovery, the ED works closely with Trillium Gift of Life. There is a donor specialist from Trillium based at KGH to take care of most of this process.

3.2.8 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

The infection prevention and control (IPAC) service has good resources in terms of staffing/consultants. The organization is quite vigilant in carrying out its surveillance activities. Precise triggers exist to alert IPAC staff to the presence of infectious disease. Infection control consultants maintain a strong presence and appear to respond promptly to care units to address IPAC issues.

It is suggested that as a training opportunity, the organization will benefit substantially if it expedites the LMS learning system to build mandatory IPAC modules to be completed by all staff, including all senior management team members and leaders.

There appears to be a growing culture of appreciation and understanding around IPAC across the KGH.

3.2.9 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

All guidelines and standard operating procedures (SOPs) are developed from evidence-based practices issued to the laboratory from the Canadian Laboratory Standards Institute (CLSI). All policy/SOP manuals are extremely well-developed and the department demonstrates vigilance in ensuring that these are always current. All specimen processing procedures are thorough.

Staff education activities and documentation appear comprehensive and complete. The laboratory provides a forum for staff to put forth suggestions and ideas. It is called the: "should we address this board" and other staff suggestion forums are in use as well. The laboratory has also developed and issued a laboratory tests manual for medical staff to facilitate the process of ordering laboratory tests.

Overall, the laboratory seems to have sufficient resources and is well-equipped and tooled for its mission.

3.2.10 Standards Set: Managing Medications

Unmet Criteria		High Priority Criteria
Priority Process: Medication Management		
5.2	The organization positions intraveneous infusion containers so the manufacturer's label is clearly visible.	!
6.1	Medication storage areas are clean and orderly.	
6.2	Medication storage areas are equipped with sufficient lighting.	
6.3	Medications are stored in secure areas accessible only by authorized staff.	!
6.5	The organization separates or isolates look-alike, sound-alike medications; different concentrations of the same medication; high-risk/high-alert medications; and discontinued, expired, damaged, and contaminated medications pending removal.	!
6.6	Medication storage areas meet legislated requirements for controlled substances.	!
10.12	The organization provides quiet work areas where medication orders are written, transcribed, and entered into computer systems.	
13.3	The pharmacy dispenses medications in unit dose packaging.	!
Surveyor comments on the priority process(es)		
Priority Process: Medication Management		

The on-site tour of the pharmacy area revealed clutter and disarray that would not have been expected. There were garbage bins and paper bins that were seen to be overflowing. Empty, torn or tipped boxes were seen on many shelves in the warehouse area including the contents of the containers, which was often not orderly. Many of the labels are old and there are temporary labels/pieces of paper stuck on many boxes and shelves. In the main area, there were medications dropped and left on the floor.

There are two stations where pharmacy technicians carry out the task of stocking the patient bins for the medication carts. These are in the middle of a storage area and each station has a cart, with many old cardboard boxes being used as containers for medications. The medications found on this cart were not organized, as witnessed with multiple boxes with different concentrations, different medications and different types (injectables/ pills) all mixed together.

The door to the narcotic vault does not close automatically and staff manage this with a taped piece of paper on the door reminding them to close it. It is recommended the door be repaired to have automatic closing.

The amount of time the pharmacists spend on the units, which is 70 percent, is positive. There is a young team of staff that is eager to learn and will require adequate mentoring.

A medication room for the NICU is required to ensure safe storage and appropriate preparation space for staff.

Medication reconciliation needs attention, with emphasis given to the time that has lapsed since the previous survey and the fact there is only one program that can demonstrate the full spectrum of reconciliation. The awareness of medication reconciliation across the organization is highly variable.

There is one older hood for preparation in pharmacy which is only available for use on nights and weekends. Given the fact that there are three new ones perhaps the organization should consider taking it out of service as it does not have proper ventilation.

The counter space where medications are re-packaged is old and has missing parts exposing wood which poses an infection control concern. This same area is cluttered and is in close proximity to the staff lockers which are covered in taped up items.

Medication rooms across the organization are variable in both size and state of order. Many of the rooms are cluttered, have visible spatter on walls, and dirty pieces of paper on the walls that cannot be wiped. Refrigerators for medications are quite variable in terms of cleanliness and location. Many open and unlabelled vials were found across the organization in the refrigerators and these were primarily insulin.

3.2.11 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		
11.6	Following transition or end of service, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
15.3	Staff and service providers participate in regular safety briefings to share information about potential safety problems, reduce the risk of error, and improve the quality of service.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Strong and engaged leadership is noted in the medicine units, with particular note to the short stay unit. The work demonstrated here is exemplary and it is suggested the work already accomplished continue to be shared across the organization and submitted for presentation at conference events.

Priority Process: Competency

There are many staff members that have not received performance appraisals. It is understood there is a new template and process to be provided to leaders to assist in the provision of feedback to staff and to engage staff in peer-to-peer feedback.

Interdisciplinary collaborative practice is genuinely performed. Rounds include family members where possible. There is a visible presence of pharmacy and social work.

Priority Process: Episode of Care

The staff and leaders in medicine state that follow-up contact to patients and families post care is not an embedded practice.

Priority Process: Decision Support

Cardiology is a very active research arm of Queen's REB. Some current studies include antibiotic use in conjunction with internal cardiac defibrillation insertion. The KGH submitted more than 25 papers/research proposals this past year.

Priority Process: Impact on Outcomes

Safety reviews or walkabouts are not an embedded practice and there was inconsistency as to whether staff understood what they were, when they occurred or why they occurred.

3.2.12 Standards Set: Mental Health Services

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
The organization has met all criteria for this priority process.			
Priority Process: Competency			
The organization has met all criteria for this priority process.			
Priority Process: Episode of Care			
7.6	The team reconciles the client's medications upon admission to the organization, with the involvement of the client, family or caregiver.		ROP
	7.6.1	There is a demonstrated, formal process to reconcile client medications upon admission.	**MAJOR**
	7.6.2	The team generates a Best Possible Medication History (BPMH) for the client upon admission.	**MAJOR**
	7.6.3	Depending on the model, the prescriber uses the BPMH to create admission medication orders (proactive), OR, the team makes a timely comparison of the BPMH against the admission medication orders (retroactive).	**MAJOR**
	7.6.4	The team documents that the BPMH and admission medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.	**MAJOR**
	7.6.5	The process is a shared responsibility involving the client and one or more health care practitioner(s), such as nursing staff, medical staff, pharmacists, and pharmacy technicians, as appropriate.	**MINOR**
11.3	The team reconciles the client's medications with the involvement of the client, family or caregiver at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).		ROP
	11.3.1	There is a demonstrated, formal process to reconcile client medications at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).	**MAJOR**
	11.3.2	Depending on the model, the prescriber uses the Best Possible Medication History (BPMH) and the active medication orders to generate transfer or discharge medication orders (proactive), OR, the team makes a timely comparison of the BPMH, the active medication orders, and the transfer or discharge medication orders (retroactive).	**MAJOR**

11.3.3	The team documents that the BPMH, the active medication orders, and the transfer or discharge medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.	**MAJOR**
11.3.4	Depending on the transition point, an up-to-date medication list is retained in the client record (internal transfer), OR, the team generates a Best Possible Medication Discharge Plan (BPMDP) that is communicated to the client, community-based physician or service provider, and community pharmacy, as appropriate (discharge).	**MAJOR**
11.3.5	The process is a shared responsibility involving the client or family, and one or more health care practitioner(s), such as nursing staff, medical staff, and pharmacy staff, as appropriate.	**MINOR**
11.5	Following transition or end of service, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning, as appropriate.	

Priority Process: Decision Support

The organization has met all criteria for this priority process.

Priority Process: Impact on Outcomes

16.2	The team monitors clients' perspectives on the quality of its mental health services.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

A demonstrated high level of interdisciplinary collaboration including in planning is evident in this program. The mental health administrators, staff and physicians have strong collaborative relationship with the community partners. Engagement in service planning and patient services is evident.

Priority Process: Competency

Security service is highly supportive of the needs of the program and there is a high comfort level from nursing staff with the level of security provided.

Very engaged and experienced nursing staff are in place here. However, the team is currently without a clinical educator and this may pose challenges when on-boarding new staff.

The staffing for the child and youth unit would benefit from consideration given that there is an occupancy of 75 percent or greater and the ability to meet the needs of the children/youth would be a challenge with only one registered nurse (RN) and one child and youth worker.

There were inconsistent responses from staff regarding the opportunity for feedback both formal and non-formal from their leaders.

The team needs to continue advocating to meeting the needs of the units regarding the appropriate number of RNs and registered practical nurses (RPNs).

Priority Process: Episode of Care

The child and youth unit is not warm and welcoming and presents with an institutional feel however, there is wonderful window and light access. There is minimal use of colour or texture of any sort to create a more comforting atmosphere.

The medication room is cluttered with a medication refrigerator located in a side room, which also contains patient food supplies. The refrigerator is also in need of cleaning.

The location of the short-term beds is not ideal given the constant lighting and the location behind an access door.

The program has a high number of elderly patients that may be better served in a geriatric or palliative care setting. Advocacy for the geriatric population is highly encouraged as this creates a less than desirable experience for all patients and can create safety risks for patients.

Priority Process: Decision Support

There are no unmet criteria for decision support.

Priority Process: Impact on Outcomes

There is no mechanism to collect feedback from patients and their families on the services/care provided.

3.2.13 Standards Set: Obstetrics Services

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
2.8	The team has access to the supplies and equipment needed to deliver obstetrics services.		
Priority Process: Competency			
3.7	The organization provides sufficient workspace to support interdisciplinary team functioning and interaction.		
4.9	Team leaders evaluate and document each team member's performance in an objective, interactive, and positive way.		
Priority Process: Episode of Care			
9.5	The team reconciles the client's medications upon admission to the organization, with the involvement of the client, family or caregiver.		ROP
	9.5.1	There is a demonstrated formal process to reconcile client medications upon admission.	**MAJOR**
	9.5.2	The team generates a Best Possible Medication History (BPMH) for the client upon admission.	**MAJOR**
	9.5.3	Depending on the model, the prescriber uses the BPMH to create admission medication orders (proactive), OR, the team makes a timely comparison of the BPMH against the admission medication orders (retroactive).	**MAJOR**
	9.5.4	The team documents that the BPMH and admission medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.	**MAJOR**
	9.5.5	The process is a shared responsibility involving the client and one or more health care practitioner(s), such as nursing staff, medical staff, pharmacists, and pharmacy technicians, as appropriate.	**MINOR**
12.3	The team reconciles the client's medications with the involvement of the client, family or caregiver at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).		ROP
	12.3.1	There is a demonstrated, formal process to reconcile client medications at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).	**MAJOR**

12.3.2	Depending on the model, the prescriber uses the Best Possible Medication History (BPMH) and the active medication orders to generate transfer or discharge medication orders (proactive), OR, the team makes a timely comparison of the BPMH, the active medication orders, and the transfer or discharge medication orders (retroactive).	**MAJOR**
12.3.3	The team documents that the BPMH, the active medication orders, and the transfer or discharge medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.	**MAJOR**
12.3.4	Depending on the transition point, an up-to-date medication list is retained in the client record (internal transfer), OR, the team generates a Best Possible Medication Discharge Plan (BPMDP) that is communicated to the client, community-based physician or service provider, and community pharmacy, as appropriate (discharge).	**MAJOR**
12.3.5	The process is a shared responsibility involving the client or family, and one or more health care practitioner(s), such as nursing staff, medical staff, and pharmacy staff, as appropriate.	**MINOR**

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 team of professionals is dynamic and thoroughly engaged in providing the best possible care to women, infants and their families. Medical residents and midwives form part of this team and are embraced by staff and patients. The team has been involved with the managing obstetrical risk efficiently (MOREob) program for many years and is a leader in collaborative care, communication, identification of clinical risks and debriefings following either unexpected or uncomfortable outcomes.

The team has access to ethical supports however, many staff identified that they would consult with pastoral services and/or social work likely because currently, the ethicist is on a leave. There is a telephone number available for staff to contact an ethicist but many frontline staff may be unaware of this current situation.

The physical environment in which services are provided by this team are insufficient to adequately meet patient safety and infection control standards, particularly in the post partum unit. Lighting is inadequate particularly in the hallways and central nursing station. There is carpet throughout both units and it is acknowledged that there is a carpet removal plan in progress. The organization is encouraged to continue with this plan and to make this a priority for this team.

While the team has been successful at securing some new equipment, there still remains many extremely old and outdated pieces of equipment in the clinical areas for example, examination tables in the clinics and isolettes to name just two pieces. Support is given to continue to advocate for a redevelopment project that will include the labour and delivery and post partum units.

Priority Process: Competency

The clinical educator role provides a clinical orientation for new staff and provides updates and best practice evidence to staff. Many students from a variety of disciplines enjoy clinical placements on these units. Some staff members have been cross-trained to provide care in both labour and delivery and in post-partum.

The physical environment in which services are provided by this team are insufficient to adequately meet patient safety and infection control standards, particularly in the post-partum unit. Lighting is inadequate particularly in the hallways and central nursing station. There is carpet throughout both units and it is acknowledged that there is a carpet removal plan in progress. The organization is encouraged to continue with this plan and to make this a priority for this team.

While the team has been successful at securing some new equipment, there remains many extremely old and outdated pieces of equipment in the clinical areas for example, examination tables in the clinics and isolettes. The team is encouraged to continue to advocate for a redevelopment project that will include the labour and delivery and post-partum units. Further, the medication rooms are extremely small and cluttered and require attention to reduce risks associated with medication management.

Priority Process: Episode of Care

This interdisciplinary team is extremely engaged and proud of the services provided. Team members ensure that their focus is on the patient and family experience. This focus is embedded into all aspects of patient and family care processes. Staff report that there is respect and admiration for one another and that effective teamwork is their greatest strength.

Patient satisfaction is extremely high however patients and families are aware of the process in which to engage should they have any concerns. Patients receive education during their antenatal visits and many patient teaching guides are available for specific conditions and situations.

Documentation is manual and the partogram is comprehensive and thorough. Some documentation tools were recently revised to reflect the organization's emphasis on and transformation with the patient experience and the inter-collaborative practice model. The team would benefit from a thorough review of all documentation forms to ensure that duplication is reduced.

The staff members were able to identify who they would access for support and guidance should they experience a difficult situation or an ethical dilemma, although ethical support was not specifically discussed. The team would benefit from ethics education and opportunities to discuss potentially distressing situations.

The labour and delivery units and postpartum units are not locked or secured and there is minimal video surveillance. Given the nature of the patient population and the potential risks associated with infants, the team is encouraged to consider implementing a more robust security system to reduce the likelihood of infant abductions.

The bereavement room has been thoughtfully developed and demonstrates the team's focus on improving the patient experience.

Priority Process: Decision Support

The team is challenged with the ability to provide patients with confidential and private space given the current physical environment, particularly in the clinic areas.

The obstetrics team has successfully implemented an electronic fetal monitoring system.

Evidence-based practices are reviewed and implemented according to a clear process of development and approvals. The team uses a list-serve method to access best practices from partners in the region and beyond. The team is currently in the process of implementing breastfeeding improvements in collaboration with Public Health to ensure there is consistency in practice between the hospital and the community. Several new policies based on best practices are in the draft development stage and these include delayed cord clamping and magnesium sulphate for neuro protection.

Priority Process: Impact on Outcomes

Adverse and sentinel event reporting occurs and indicators and trends are reviewed by the manager, director and chief and shared with the team. Case reviews occur and recommendations resulting from analysis of the case findings are disclosed to the patient and/or family and a written record and outcome of the discussions are provided to members who attend the case review.

Goals and objectives have been developed for the team with clear alignment to the corporate plan, priorities and milestones. Indicators are tracked, reported and shared with staff on a regular basis with improvements made as a result of careful analysis.

3.2.14 Standards Set: Organ and Tissue Donation Standards for Deceased Donors

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 Donation	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)
Priority Process: Clinical Leadership
The standards are in line with those of the Organ Donation Network of Ontario.
Priority Process: Competency
Competency is evident in this area of service delivery.
Priority Process: Episode of Care
There are no unmet criteria pertaining to this episode of care.
Priority Process: Decision Support
There are no unmet criteria pertaining to decision support.

Priority Process: Impact on Outcomes

The team is an integral part of the Organ Donation Network of Ontario and as such works within these guidelines.

Priority Process: Organ Donation

These processes are addressed under the Ontario Trillium Gift of Life network.

3.2.15 Standards Set: Organ and Tissue Transplant Standards

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

Surveyor comments on the priority process(es)

Priority Process: Organ Transplant

The KGH is an active member of the Ontario Renal Network and currently, there are approximately 300 end-stage renal disease patients on renal dialysis.

Organ (kidney) procurement and renal transplant procedures are well-established for Ontario and in keeping with Ontario and Canadian standards.

An organ and transplant inter-professional group for kidney procurement and transplant is present at KGH. One year ago, the pre- and post-transplant multidisciplinary groups became one and this has lead to a very cohesive group of professionals. The group includes volunteer patient advocates.

First year and five year graft survival rates are very much in line with national and international standards

At this time, all kidneys are cadaver donations. The opportunity exists for live donations, and if done then this would impact on the number of yearly transplants as well as program requirements.

Priority Process: Clinical Leadership

The is a noted strength, with a well-developed program that is constantly being reviewed for best practice.

Priority Process: Competency

The organ and tissue transplant team follow the Canadian/Ontario processes for organ transplant.

Priority Process: Decision Support

Decision support is multidisciplinary for this service.

Priority Process: Impact on Outcomes

The standardization of processes and outcomes with other centres is to be supported and is great for quality assessment.

3.2.16 Standards Set: Point-of-Care Testing

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

Point-of-care testing is integrated well into the clinical operations at KGH. Training appears to be well-developed and supported by evaluation and mandatory participation and demonstration of competency.

3.2.17 Priority Process: Surgical Procedures

Delivery of safe surgical care to clients, from preparation and the actual procedure in the operating room, to the post-recovery area and discharge.

Unmet Criteria			High Priority Criteria
Standards Set: Surgical Care Services			
11.4	The team reconciles the client's medications with the involvement of the client, family or caregiver at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).		ROP
	11.4.1	There is a demonstrated, formal process to reconcile client medications at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).	**MAJOR**
	11.4.2	Depending on the model, the prescriber uses the Best Possible Medication History (BPMH) and the active medication orders to generate transfer or discharge medication orders (proactive), OR, the team makes a timely comparison of the BPMH, the active medication orders, and the transfer or discharge medication orders (retroactive).	**MAJOR**
	11.4.3	The team documents that the BPMH, the active medication orders, and the transfer or discharge medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.	**MAJOR**
	11.4.4	Depending on the transition point, an up-to-date medication list is retained in the client record (internal transfer), OR, the team generates a Best Possible Medication Discharge Plan (BPMDP) that is communicated to the client, community-based physician or service provider, and community pharmacy, as appropriate (discharge).	**MAJOR**
	11.4.5	The process is a shared responsibility involving the client or family, and one or more health care practitioner(s), such as nursing staff, medical staff, and pharmacy staff, as appropriate.	**MINOR**

Surveyor comments on the priority process(es)

The surgical services reflect the needs of the community, with 85 percent adult and 15 percent pediatric surgery. Adverse events are recorded and improvements made when warranted.

Education for the nursing staff is evident by a weekly journal club. Teaching to residents is ongoing.

The ORs are open for business on weekends to meet client needs. This is a noted strength as this service in now client orientated.

Section 4 Instrument Results

As part of Qmentum, client organizations administer instruments. Instruments (or tools) are surveys related to areas such as governance, patient safety culture, and quality of worklife. They are completed by a representative sample of clients, staff, senior leaders, board members, and other stakeholders.

4.1 Governance Functioning Tool

The Governance Functioning Tool enables members of the governing body to assess board structures and processes, provide their perceptions and opinions, and identify priorities for action. The four aspects of the governing body that it is designed to measure are:

- 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 Quality Performance Roadmap on the client organization portal. The organization then had the opportunity to address challenging areas.

- **Data collection period: April 11, 2012 to May 4, 2012**
- **Number of respondents: 12**

Governance Functioning Tool: Results by Aspect of Governing Body

		% 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	2
2	Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	0	0	100	2
3	We have sub-committees that have clearly-defined roles and responsibilities.	0	0	100	1
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	8	92	2
5	We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decision-making.	0	0	100	4

		% Disagree	% Neutral	% Agree	%Agree * Canadian Average
		Organization	Organization	Organization	
6	Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	17	83	2
7	Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	1
8	Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	0	0	100	1
9	Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	0	0	100	1
10	Our governance processes make sure that everyone participates in decision-making.	0	17	83	1
11	Individual members are actively involved in policy-making and strategic planning.	0	0	100	2
12	The composition of our governing body contributes to high governance and leadership performance.	0	8	92	2
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	1
14	Our ongoing education and professional development is encouraged.	0	8	92	2
15	Working relationships among individual members and committees are positive.	0	0	100	1
16	We have a process to set bylaws and corporate policies.	0	0	100	1
17	Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	1
18	We formally evaluate our own performance on a regular basis.	0	8	92	9
19	We benchmark our performance against other similar organizations and/or national standards.	0	0	100	10

		% Disagree	% Neutral	% Agree	%Agree * Canadian Average
		Organization	Organization	Organization	
20	Contributions of individual members are reviewed regularly.	8	25	67	15
21	As a team, we regularly review how we function together and how our governance processes could be improved.	0	17	83	7
22	There is a process for improving individual effectiveness when nonperformance is an issue.	8	25	67	14
23	We regularly identify areas for improvement and engage in our own quality improvement activities.	0	8	92	7
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	17	83	6
25	As individual members, we receive adequate feedback about our contribution to the governing body.	8	33	58	13
26	Our chair has clear roles and responsibilities and runs the governing body effectively.	0	8	92	1
27	We receive ongoing education on how to interpret information on quality and patient safety performance.	0	8	92	5
28	As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	2
29	As a governing body, we hear stories about clients that experienced harm during care.	8	0	92	9
30	The performance measures we track as a governing body give us a good understanding of organizational performance.	0	8	92	2
31	We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	0	0	100	2

		% Disagree	% Neutral	% Agree	%Agree * Canadian Average
		Organization	Organization	Organization	
32	We have explicit criteria to recruit and select new members.	0	8	92	5
33	Our renewal cycle is appropriately managed to ensure continuity on the governing body.	0	0	100	3
34	The composition of our governing body allows us to meet stakeholder and community needs.	0	0	100	1
35	Clear written policies define term lengths and limits for individual members, as well as compensation.	0	8	92	2
36	We review our own structure, including size and sub-committee structure.	0	0	100	3
37	We have a process to elect or appoint our chair.	0	0	100	3

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

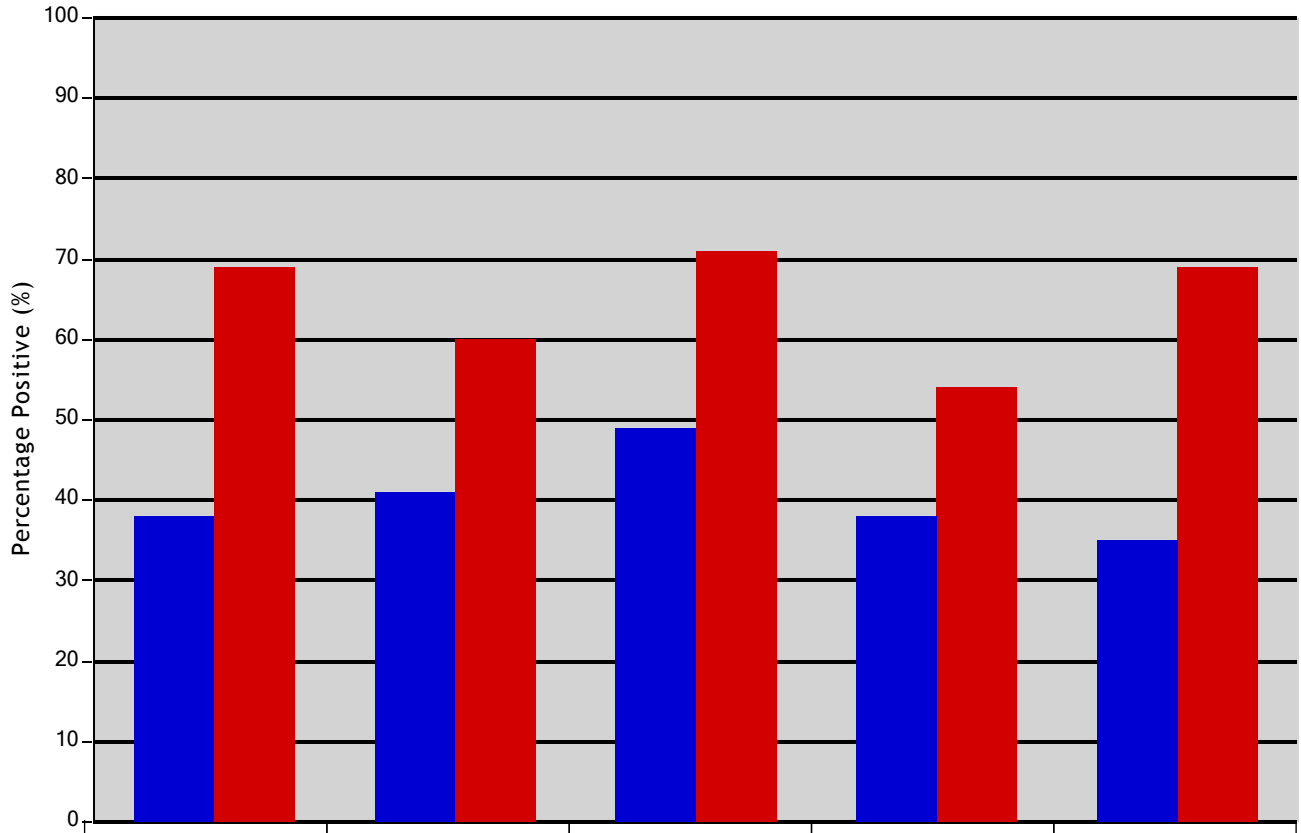
4.2 Patient Safety Culture Tool

The Patient Safety Culture Tool provides insight into staff perceptions of patient safety, allowing 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 Quality Performance Roadmap on 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 12, 2012 to April 17, 2012**
- **Minimum response rate (based on the number of employees): 342**
- **Number of respondents: 1201**

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
	38%	41%	49%	38%	35%
	69%	60%	71%	54%	69%

Legend

Kingston General Hospital

* Canadian Average

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

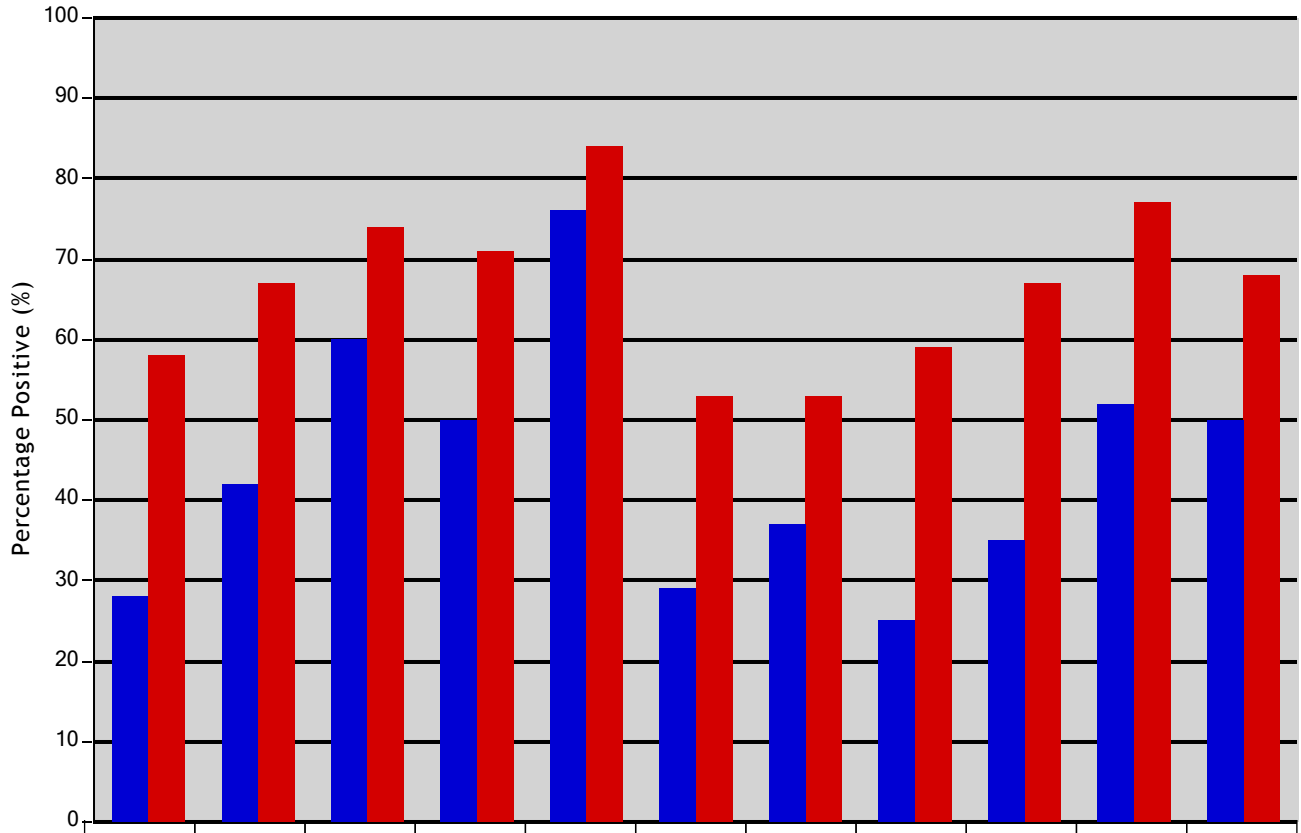
4.3 Worklife Pulse Tool

The Worklife Pulse Tool enables organizations to take the "pulse" of the quality of worklife by monitoring staff perceptions of various aspects of worklife, such as on-the-job communication, staff health and well-being, and job satisfaction. It collects information related to 11 aspects of the work environment that are known to contribute to individual quality of worklife and organizational performance.

Accreditation Canada provided the organization with detailed results from its Worklife Pulse Tool prior to the on-site survey, through the Quality Performance Roadmap on 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 12, 2012 to April 17, 2012**
- **Minimum response rate (based on the number of employees): 340**
- **Number of respondents: 1354**

Worklife Pulse Tool: Results of Work Environment



	Organizational communication	Work area communication	Supervision	Job control	Role clarity	Decision making involvement	Job demand	Trust	Learning environment	Safe environment	Worklife balance
	28%	42%	60%	50%	76%	29%	37%	25%	35%	52%	50%
	58%	67%	74%	71%	84%	53%	53%	59%	67%	77%	68%

Legend

Kingston General Hospital

* Canadian Average

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

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 three-year cycle, Accreditation Canada provides ongoing liaison and support to help the organization address issues, action plan, 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 conditions.

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
Human Capital	Developing the human resource capacity to deliver safe, high quality services
Integrated Quality Management	Using a proactive, systematic, and ongoing process to manage and integrate quality and achieve organizational goals and objectives
Medical Devices and Equipment	Obtaining and maintaining machinery and technologies used to diagnose and treat health problems
Patient Flow	Assessing the smooth and timely movement of clients and families through service settings
Physical Environment	Providing appropriate and safe structures and facilities to achieve the organization's mission, vision, and goals
Planning and Service Design	Developing and implementing infrastructure, programs, and services to meet the needs of the populations and communities served
Principle-based Care and Decision Making	Identifying and making decisions about ethical dilemmas and problems
Resource Management	Monitoring, administering, and integrating activities related to the allocation and use of resources

Priority processes associated with population-specific standards

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

Priority processes associated with service excellence standards

Priority Process	Description
Blood Services	Handling blood and blood components safely, including donor selection, blood collection, and transfusions
Clinical Leadership	Providing leadership and direction to teams providing services
Competency	Developing a skilled, knowledgeable, interdisciplinary team that can manage and deliver effective programs and services
Decision Support	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
Episode of Care - Primary Care	Providing primary care in the clinical setting, including making primary care services accessible, completing the encounter, and coordinating services
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 Donation	Providing organ donation services for deceased donors and their families, including identifying potential donors, approaching families, and recovering organs
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
Organ Transplant	Providing organ transplant services, from initial assessment of transplant candidates to providing follow-up care to recipients
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
Surgical Procedures	Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge