ACCREDITATION
AGRÉMENT
CANADA
Qmentum

Accreditation Report

Kingston Health Sciences Centre

Kingston, ON

On-site survey dates: April 24, 2022 - April 29, 2022

Report issued: May 20, 2022

About the Accreditation Report

Kingston Health Sciences Centre (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 April 2022. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

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

Confidentiality

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

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

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

A Message from Accreditation Canada

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

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

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

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

We look forward to our continued partnership.

Sincerely,

Leslee Thompson
Chief Executive Officer

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Executive Summary

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

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

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

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

Accreditation Decision

Kingston Health Sciences Centre's accreditation decision is:

Accredited with Exemplary Standing

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

About the On-site Survey

- **On-site survey dates: April 24, 2022 to April 29, 2022**

- **Locations**

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

  1. Hotel Dieu
  2. Kingston Health Sciences Centre

- **Standards**

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

  System-Wide Standards

  1. Governance
  2. Infection Prevention and Control Standards
  3. Leadership

  Service Excellence Standards

  4. Ambulatory Care Services - Service Excellence Standards
  5. Biomedical Laboratory Services - Service Excellence Standards
  6. Cancer Care - Service Excellence Standards
  7. Community-Based Mental Health Services and Supports - Service Excellence Standards
  8. Critical Care Services - Service Excellence Standards
  9. Diagnostic Imaging Services - Service Excellence Standards
  10. Emergency Department - Service Excellence Standards
  11. Inpatient Services - Service Excellence Standards
  12. Medication Management (For Surveys in 2021) - Service Excellence Standards
  13. Mental Health Services - Service Excellence Standards
  14. Obstetrics Services - Service Excellence Standards
  15. Organ and Tissue Donation Standards for Deceased Donors - Service Excellence Standards
  16. Organ and Tissue Transplant Standards - Service Excellence Standards
  17. Organ Donation Standards for Living Donors - Service Excellence Standards
  18. Perioperative Services and Invasive Procedures - Service Excellence Standards

19. Point-of-Care Testing - Service Excellence Standards
20. Reprocessing of Reusable Medical Devices - Service Excellence Standards
21. Transfusion Services - Service Excellence Standards

- **Instruments**

  The organization administered:

1. Canadian Patient Safety Culture Survey Tool
2. Governance Functioning Tool (2016)
3. Client Experience Tool

Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
Population Focus (Work with my community to anticipate and meet our needs)	66	0	0	66
Accessibility (Give me timely and equitable services)	115	1	1	117
Safety (Keep me safe)	838	3	10	851
Worklife (Take care of those who take care of me)	166	2	1	169
Client-centred Services (Partner with me and my family in our care)	557	6	1	564
Continuity (Coordinate my care across the continuum)	106	0	2	108
Appropriateness (Do the right thing to achieve the best results)	1287	7	5	1299
Efficiency (Make the best use of resources)	87	0	0	87
Total	3222	19	20	3261

Overview by Standards

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

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

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

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

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	50 (100.0%)	0 (0.0%)	0	36 (100.0%)	0 (0.0%)	0	86 (100.0%)	0 (0.0%)	0
Leadership	48 (96.0%)	2 (4.0%)	0	94 (97.9%)	2 (2.1%)	0	142 (97.3%)	4 (2.7%)	0
Infection Prevention and Control Standards	39 (97.5%)	1 (2.5%)	0	29 (100.0%)	0 (0.0%)	2	68 (98.6%)	1 (1.4%)	2
Medication Management (For Surveys in 2021)	98 (100.0%)	0 (0.0%)	2	49 (98.0%)	1 (2.0%)	0	147 (99.3%)	1 (0.7%)	2
Ambulatory Care Services	45 (100.0%)	0 (0.0%)	2	77 (98.7%)	1 (1.3%)	0	122 (99.2%)	1 (0.8%)	2
Biomedical Laboratory Services **	72 (100.0%)	0 (0.0%)	0	105 (100.0%)	0 (0.0%)	0	177 (100.0%)	0 (0.0%)	0
Cancer Care	101 (100.0%)	0 (0.0%)	0	128 (100.0%)	0 (0.0%)	0	229 (100.0%)	0 (0.0%)	0
Community-Based Mental Health Services and Supports	45 (100.0%)	0 (0.0%)	0	94 (100.0%)	0 (0.0%)	0	139 (100.0%)	0 (0.0%)	0

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Critical Care Services	60 (100.0%)	0 (0.0%)	0	102 (97.1%)	3 (2.9%)	0	162 (98.2%)	3 (1.8%)	0
Diagnostic Imaging Services	68 (100.0%)	0 (0.0%)	0	68 (98.6%)	1 (1.4%)	0	136 (99.3%)	1 (0.7%)	0
Emergency Department	72 (100.0%)	0 (0.0%)	0	105 (98.1%)	2 (1.9%)	0	177 (98.9%)	2 (1.1%)	0
Inpatient Services	60 (100.0%)	0 (0.0%)	0	82 (100.0%)	0 (0.0%)	3	142 (100.0%)	0 (0.0%)	3
Mental Health Services	50 (100.0%)	0 (0.0%)	0	91 (98.9%)	1 (1.1%)	0	141 (99.3%)	1 (0.7%)	0
Obstetrics Services	71 (100.0%)	0 (0.0%)	2	88 (100.0%)	0 (0.0%)	0	159 (100.0%)	0 (0.0%)	2
Organ and Tissue Donation Standards for Deceased Donors	54 (100.0%)	0 (0.0%)	0	94 (97.9%)	2 (2.1%)	0	148 (98.7%)	2 (1.3%)	0
Organ and Tissue Transplant Standards	87 (100.0%)	0 (0.0%)	0	117 (99.2%)	1 (0.8%)	0	204 (99.5%)	1 (0.5%)	0
Organ Donation Standards for Living Donors	66 (100.0%)	0 (0.0%)	0	116 (99.1%)	1 (0.9%)	0	182 (99.5%)	1 (0.5%)	0
Perioperative Services and Invasive Procedures	115 (100.0%)	0 (0.0%)	0	108 (99.1%)	1 (0.9%)	0	223 (99.6%)	1 (0.4%)	0
Point-of-Care Testing **	38 (100.0%)	0 (0.0%)	0	46 (100.0%)	0 (0.0%)	2	84 (100.0%)	0 (0.0%)	2
Reprocessing of Reusable Medical Devices	88 (100.0%)	0 (0.0%)	0	40 (100.0%)	0 (0.0%)	0	128 (100.0%)	0 (0.0%)	0
Transfusion Services **	71 (100.0%)	0 (0.0%)	5	68 (100.0%)	0 (0.0%)	1	139 (100.0%)	0 (0.0%)	6
Total	1398 (99.8%)	3 (0.2%)	11	1737 (99.1%)	16 (0.9%)	8	3135 (99.4%)	19 (0.6%)	19

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

Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client Identification (Emergency Department)	Met	1 of 1	0 of 0
Client Identification (Inpatient Services)	Met	1 of 1	0 of 0
Client Identification (Mental Health Services)	Met	1 of 1	0 of 0
Client Identification (Obstetrics Services)	Met	1 of 1	0 of 0
Client Identification (Organ and Tissue Transplant Standards)	Met	1 of 1	0 of 0
Client Identification (Organ Donation Standards for Living Donors)	Met	1 of 1	0 of 0
Client Identification (Perioperative Services and Invasive Procedures)	Met	1 of 1	0 of 0
Client Identification (Point-of-Care Testing)	Met	1 of 1	0 of 0
Client Identification (Transfusion Services)	Met	1 of 1	0 of 0
Information transfer at care transitions (Ambulatory Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Cancer Care)	Met	4 of 4	1 of 1
Information transfer at care transitions (Community-Based Mental Health Services and Supports)	Met	4 of 4	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information transfer at care transitions (Critical Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Emergency Department)	Met	4 of 4	1 of 1
Information transfer at care transitions (Inpatient Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Mental Health Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Obstetrics Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Organ and Tissue Transplant Standards)	Met	4 of 4	1 of 1
Information transfer at care transitions (Organ Donation Standards for Living Donors)	Met	4 of 4	1 of 1
Information transfer at care transitions (Perioperative Services and Invasive Procedures)	Met	4 of 4	1 of 1
Medication reconciliation as a strategic priority (Leadership)	Met	3 of 3	2 of 2
Medication reconciliation at care transitions (Ambulatory Care Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Cancer Care)	Met	9 of 9	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Community-Based Mental Health Services and Supports)	Met	3 of 3	1 of 1
Medication reconciliation at care transitions (Critical Care Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Emergency Department)	Met	1 of 1	0 of 0
Medication reconciliation at care transitions (Inpatient Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Mental Health Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures)	Met	4 of 4	0 of 0
Safe Surgery Checklist (Obstetrics Services)	Met	3 of 3	2 of 2
Safe Surgery Checklist (Organ and Tissue Transplant Standards)	Met	3 of 3	2 of 2
Safe Surgery Checklist (Organ Donation Standards for Living Donors)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Safe Surgery Checklist (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
The “Do Not Use” list of abbreviations (Medication Management (For Surveys in 2021))	Met	4 of 4	3 of 3
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management (For Surveys in 2021))	Met	4 of 4	1 of 1
Concentrated Electrolytes (Medication Management (For Surveys in 2021))	Met	3 of 3	0 of 0
Heparin Safety (Medication Management (For Surveys in 2021))	Met	4 of 4	0 of 0
High-Alert Medications (Medication Management (For Surveys in 2021))	Met	5 of 5	3 of 3
Infusion Pumps Training (Ambulatory Care Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Cancer Care)	Met	4 of 4	2 of 2
Infusion Pumps Training (Critical Care Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Emergency Department)	Met	4 of 4	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Infusion Pumps Training (Inpatient Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Obstetrics Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Organ and Tissue Transplant Standards)	Met	4 of 4	2 of 2
Infusion Pumps Training (Organ Donation Standards for Living Donors)	Met	4 of 4	2 of 2
Infusion Pumps Training (Perioperative Services and Invasive Procedures)	Met	4 of 4	2 of 2
Narcotics Safety (Medication Management (For Surveys in 2021))	Met	3 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Client Flow (Leadership)	Met	7 of 7	1 of 1
Patient safety plan (Leadership)	Met	2 of 2	2 of 2
Patient safety: education and training (Leadership)	Met	1 of 1	0 of 0
Preventive Maintenance Program (Leadership)	Met	3 of 3	1 of 1
Workplace Violence Prevention (Leadership)	Met	5 of 5	3 of 3

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Compliance (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Hand-Hygiene Education and Training (Infection Prevention and Control Standards)	Met	1 of 1	0 of 0
Infection Rates (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Cancer Care)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Critical Care Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Inpatient Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Mental Health Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Obstetrics Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Organ and Tissue Transplant Standards)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Perioperative Services and Invasive Procedures)	Met	2 of 2	1 of 1
Pressure Ulcer Prevention (Cancer Care)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Pressure Ulcer Prevention (Critical Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Inpatient Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
Suicide Prevention (Community-Based Mental Health Services and Supports)	Met	5 of 5	0 of 0
Suicide Prevention (Emergency Department)	Met	5 of 5	0 of 0
Suicide Prevention (Mental Health Services)	Met	5 of 5	0 of 0
Venous Thromboembolism Prophylaxis (Cancer Care)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Critical Care Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Inpatient Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Organ and Tissue Transplant Standards)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Organ Donation Standards for Living Donors)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2

Summary of Surveyor Team Observations

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

Kingston Health Sciences Centre is southeastern Ontario's complex, acute and specialty care, research, and teaching hospital. Consisting of Hotel Dieu site and Kingston General site, as well as the Cancer Centre of Southeastern Ontario and a research institute, that care for more than 500,000 patients and their families from across our region.

As one of the region's largest employers, the organization is home to over 6,000 staff, more than 2,000 health-care learners and 1,000 volunteers who are committed to partnering with patients and families to ensure they continually provide high quality, compassionate care. Fully affiliated with Queen's University, the organization is ranked as one of Canada's top research hospitals.

As a teaching hospital, Kingston Health Sciences Centre attracts some of the nation's brightest learners to pursue their health care education, which helps to create the capacity to provide highly specialized services close to home. The organization trains thousands of students every year and is home to hundreds of researchers whose curiosity drives them to make ground-breaking advancements in health care. The KGH site serves as the regional referral centre for cardiac, stroke, renal, trauma, neurosurgery, pediatrics, neo-natal, high-risk obstetrics, acute inpatient mental health, and cancer care. The HDH site offers specialized outpatient programs such as pediatrics, medicine, ophthalmology, cardiology, urology, dermatology, gastroenterology, surgery, mental health, oncology, and urgent care.

In April of 2017, Hotel Dieu Hospital (HDH) and Kingston General Hospital (KGH) joined together to create the Kingston Health Sciences Centre (KHSC). As a single organization, KHSC offers a continuum of complex, acute and specialty care, research, and teaching in both inpatient and outpatient settings for patients and families from across southeastern Ontario. As a new academic health sciences centre that builds on the proud traditions of Hotel Dieu Hospital and Kingston General Hospital, the planning process provided the exciting opportunity for KHSC to engage with the community to help to define purpose, shared values, and desired future state for KHSC.

Mission
We care for our patients, families and each other through everyday actions, significant moments, and exciting breakthroughs.

Vision
Partnering in care, discovery and learning to achieve better health for our communities while transforming our health care system.

Values
At the heart of our values is compassion. We care for some of the sickest and most vulnerable people in our

community. We treat each person with respect and dignity. We do this by caring for the whole person, when and where they need it most.
Partnership is at the core of how we work. We empower patients, families, and our teams to do great work together, and with our community. The pursuit of excellence drives everything we do. We will be good stewards of resources while continually enhancing the quality of care, research, and education we provide. Research and innovation reflect our courage to try new things, challenge what we know, create new knowledge, and transform health care.

The strategy development process included a detailed environmental scan, an analysis of population health demographics, a close look at the organization's current performance, and hundreds of conversations with stakeholders about the future of KHSC. The five-year strategy for "Transforming care, together" was shaped by more than two thousand people who work, learn, volunteer, receive care at and partner with KHSC. It positions the organization for a bold future where a steady focus on quality, innovation and partnership helps to transform the regional health care system. Strategic directions include:

- Ensure quality in every patient experience
- Nurture our passion for caring, leading and learning
- Improve the health of our communities through partnership and innovation
- Launch KHSC as a leading centre for research and education

The annual planning cycle begins in the fall of each year. The planning cycle provides an opportunity to 1) review progress on the strategic plan, 2) consider community needs, 3) review performance and patient survey results, 4) consider provincial priorities, and 5) engage team members and patients/caregivers. The annual corporate plan functions as the operating plan and is developed to support the achievement of the strategic plan, goals, and objectives, and to guide day-to-day operations. This planning identifies the resources, systems, and infrastructure needed to deliver services and achieve the strategic plan, goals, and objectives. Huddle (Quality/Performance) boards are prevalent throughout the organization and seem to be appropriately utilized.

A cohesive team is evident. Staff and physicians are actively engaged in providing care and in the success of the organization. Overall, the staff at the organization appear to be compassionate, professional, and committed to providing patient and family focused care. Staff across the organization are proud of their program/unit. Since early 2020, Kingston Health Sciences Centre has stepped up by serving as the anchor of the pandemic response in the region. They have demonstrated remarkable resilience and commitment under, oftentimes, punishing conditions. Working side-by-side with government and system partners, the hospital faced extraordinary pressure from COVID-19 to provide high quality people centred care to their own patients, while offering their support to long-term care homes, assessment centres and a successful vaccination effort, as well as conducting research to better understand the virus.

A Patient and Family Advisory Council is in place which provides formalized engagement with patients and families. Patient experience advisors are very engaged and integrated in operations and activities throughout the organization. Proactive involvement of patient experience advisors is evident in the design and evaluation of care delivery. Patients and their families report that they are very satisfied with the care they receive. Interviews with patients and/or family members across the services highlight the gratitude and

appreciation for the respect and compassion shown by all involved in service and care provision. Overall, patients and families report that: 1) they are engaged in their care, 2) care providers are authentic, 3) they feel safe and 4) staff are professional and provide excellent care. Interviews with patients expressed opportunities for improvement especially in areas of 1) explore strategies and technology that should be sustained post pandemic, 2) seamless integration of service delivery across the system, 3) mental health and addiction needs, and 4) supports for the aging population.

As a multi-site teaching and research hospital that provides complex, acute and specialty care, the organization offers the same highly specialized services that are normally offered in bigger cities such as Ottawa, Toronto, London, and Hamilton. The organization is one of Canada's Top 40 research hospitals and is fully affiliated with, and key partner of Queen's University. There is clear collaboration between Queen's University and KHSC. Discussions with community partners and agencies indicate a strong, collaborative, and respectful working relationship with all levels of the organization. The Hospital is viewed as "core to the community and a valued resource to the region" as well as the cornerstone for future sustainability. During the stakeholder meeting, participants highlighted that there are improved and solid foundational relationships in place to support enhanced collaboration in the future. In general, community partners are looking to be more involved with the hospital. The hospital is viewed as a solid, collaborative, and trusted partner. Community partners identified the following themes as shared initiatives that they would like to work with the hospital to improve care delivery in the community and across the region.

- Appreciate leadership team, their responsiveness and inclusion
- Desire to see partnerships and work that happened during COVID continue
- Engage partners earlier in processes
- Ongoing and enhanced integration/distribution of care delivery and information sharing

There is open and transparent communication, and this facilitates the care provided to the patients and their families. The leadership team has implemented various methods to facilitate the sharing of information with team members (including newsletters, e-mails, intranet, walkabouts). KHSC is implementing Lumeo (a large regional clinical transformation enabled by implementation of the Cerner HIS) with the other five independent South East hospitals: Brockville General Hospital (BHG), Lennox and Addington County General Hospital (LACGH), Perth and Smiths Falls District Hospital (PSFDH), Providence Care Centre (PCC), and Quinte Healthcare Corporation (QHC). This collective work will markedly improve the quality, safety, effectiveness, and efficiency of the care that the hospital provides for its patients for the next 30 years. It will transform both the patient's and practitioner's experience. Implementation is now in full swing. Over 500 clinical, administrative, and technical experts have been recruited from across the region to work alongside Cerner professionals to effect the change (~50% from KHSC). Feedback from system and process design workshops has been positive. Target go-live for KHSC is spring 2024. Continued adoption of the electronic medical record will improve care delivery and allow for efficiencies, more standardized care, and reduce the risks associated with the current hybrid chart. Continued transition from paper records/documents to electronic records should be pursued (for both clinical and administrative records) along with integration to other systems. Policies and procedures are in place. However, many policies and procedures are out of date and do not reflect current practice.

In 2018, KHSC developed a quality roadmap to support achievement of the strategic goal of "Quality in Every

Patient Experience" and create a robust culture and renewed focus on quality within a new integrated organization. Due to the available capacity at the time, the scope of the quality roadmap was foundational and modest, focusing on building blocks for quality improvement. The process for developing the roadmap engaged key organizational stakeholders including front-line staff, leaders, physicians, and patient experience advisors (PEAs). Between 2018 and early 2020, many activities were completed in support of the roadmap. Since early 2020, management of the COVID-19 pandemic has significantly impacted day to day operations at KHSC and altered the path of strategic initiatives. The organization has focused on ensuring continued access to safe care throughout the pandemic, and to ensuring a safe environment for patients, essential care partners, and staff. With the implementation of new services such as COVID assessment center, vaccination clinic, and IPAC hub and spoke model; shifting some outpatient care to a virtual platform; and creating a flexible incident command structure to enable ongoing response to changing conditions, there has been limited capacity for engagement in non-pandemic related QI projects or providing formal QI education. In 2021-22, quality priorities focused on ensuring that practices critical to quality and patient safety are well embedded and sustained in operations. This effort has been guided by Accreditation Canada's required organizational practices (ROPs) and compliance to ROPs became a goal on the organization's Integrated Annual Corporate Plan. An integrated risk management approach to mitigate and manage risk is in place. The risk management approach and contingency plans are not fully disseminated throughout the organization. Staff report that much of the risk mitigation activity has had to focus on the pandemic, HIS implementation, and the redevelopment project. Staff report that there has been some work with some of the HIROC risk assessments. However, planned work for many of the risk assessments has not moved forward at this time.

There are significant capital investments that have been completed, are planned and are underway. As with other healthcare facilities, it is evident that there is significant ongoing capital investment required to upgrade the buildings/facilities to ensure business continuity, and to meet evolving care delivery standards. Given the age and condition of the buildings, the need for infrastructure/redevelopment is more dire than most hospitals. Similarly, it is essential to continue planning for ongoing medical equipment investments. The organization will need to continue to consider the increasing standards associated with care delivery and service provision to mitigate risk and to ensure safe and quality care for patients and residents.

The organization has been active and successful in ongoing retention and recruitment of physicians and healthcare professionals including in some speciality areas. There is a developing approach to succession planning which facilitates promotion from within. Staff and physicians appear engaged, knowledgeable, and compassionate in the delivery of care and services. Formal change management processes/strategies are in place and well developed. Future challenges identified by the organization include ongoing health human resources, fiscal realities, aging infrastructure, and changing healthcare landscape.

The organization is well supported by a committed Board, engaged staff, patient experience advisors and compassionate medical staff. There is a strong leadership team. The staff communicate and model patient care values across the organization. There is a sense of team, community, and collaboration. Patients and their essential care partners feel well cared for by the staff and physicians and appreciate the compassion, empathy and care received.

Detailed On-site Survey Results

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

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

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

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

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

See Appendix B for a list of priority processes.

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

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

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

Priority Process Results for System-wide Standards

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

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

Priority Process: Governance

Meeting the demands for excellence in governance practice.

The organization has met all criteria for this priority process.
Surveyor comments on the priority process(es)

Kingston Health Sciences Centre is supported by a governing body that is dedicated and committed to the provision of care to the communities it serves. This accountability includes adopting and delivering on the organization's mission, vision, and values, as well as the development and fulfillment of its strategic plan. The Board is also responsible for making sure the organization meets the health care needs of its patients and families, effectively using the resources that are available to provide services to the community and the regional partners they serve. There is a strong corporate business model with well-developed collaborative partnerships. Services are readily accessible to those who need them in the context of the hospital's mission.

The governing body understands its roles and responsibilities, and those of senior management. New Board Members are oriented to their role as they join the organization. Formal mentorship is in place for new Board members to support sound onboarding of new members. Skills are considered when new Board members are sought. The members indicated that there are processes in place to evaluate the governance structure and function. A process is in place to monitor the performance of the Chief Executive Officer and the Chief of Staff. Formal performance reviews are completed as per organizational policies. The governing body's by-laws are reviewed periodically.

Staff and service providers are engaged and have the opportunity for input in the care planning. The organization is encouraging input from clients/families, other organizations, and the broader community in the delivery of services and in the operationalization of the strategic plan. Patient advisors are active on all Board Committees. Communication channels and linkages are built with the community, Foundation, volunteers, and other stakeholders.

Feedback from community partners consistently described the organization and governing body as collaborative, and as building positive relationships. The governing body demonstrates accountability for safety and quality of care and is committed to quality improvement. An integrated risk management approach to mitigate and manage risk is in place. The organization participates in the HIROC risk

assessment program. The governing body has approved the ethics framework and demonstrates an understanding of ethical decision making and has used the ethical framework in its deliberations.

The organization is proud of its patient focus and the governing body is supportive of and committed to meeting the needs of the patients and their families.

Priority Process: Planning and Service Design

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
4.12 Policies and procedures for all of the organization's primary functions, operations, and systems are documented, authorized, implemented, and up to date.	

Surveyor comments on the priority process(es)

Kingston Health Sciences Centre's leaders communicate and model the values of the organization. The strategic plan has been updated (Our Strategy for Transforming Care Together 2019-2024). Input from peers, stakeholders, staff, physicians, community, and patients was sought to inform decision making, and to chart the future direction of the organization. Annual planning cycle begins in the fall of each year. The planning cycle provides an opportunity to 1) review progress on the strategic plan, 2) consider community needs, 3) review performance and patient survey results, 4) consider provincial priorities, and 5) engage team members and patients/caregivers. An "annual corporate plan (operational plan)" is developed to support the achievement of the strategic plan which includes goals, and objectives, and helps guide day-to-day operations.

The Hospital plans for program and service development are well thought out, and the organization is involving appropriate parties to ensure they achieve their vision. Community input and needs are identified through a number of venues. The organization engages in formal evaluation of many of its programs and services. Communication between levels of the organization is open and transparent. There are opportunities and methods for staff, physicians, service providers and community to provide input into service planning. Strategies to engage hard to reach populations, such as (but not limited to), Indigenous members of the community, and patients with substance abuse are developed. The organization is actively involved and participates in ongoing community initiatives to support and promote health and prevent disease. The region has not been successful in securing more long-term care beds to support the aging population.

Leadership aligns their activities to the strategic priorities of the organization. Policies and procedures are in place. However, many policies have not been reviewed for several years. Staff advise that there is still work to do to integrate legacy organization policies. An inventory of policies has been completed, and work will proceed once pressures related to the pandemic subside. Leadership demonstrate accountability for safety and quality of care as well as a commitment to quality improvement.

Priority Process: Resource Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Systems for financial planning and controls are in place. The budgeting process is integrated into the planning process. The strategic plan guides the decision making around spending and resource allocation. There is appropriate oversight and planning in place to allow for both capital and operational budgets. Variance reporting is in place to review performance against the operating budget. A multiyear capital plan is maintained. The governing body provides appropriate oversight of resource management and ensures the viability of the organization.

The staff of the finance, procurement and other related departments are well qualified to manage the finances of this organization and are not only committed to financial sustainability for the organization but also to ensuring health services are available to meet the needs of the population served by this organization both today and into the future. These staff have implemented processes to ensure accountability for the resources they receive as well as compliance with applicable legislation. External audits are conducted, and appropriate financial controls appear to be in place including applicable segregation of duties.

The group uses utilization data to identify opportunities for improvement and to monitor performance. Relationships with departmental leaders are built. As such, a collaborative approach exists between Finance and Clinical and Support Services. The Fiscal Advisory Committee is utilized and makes recommendations to the Board with respect to the operation, use and staffing of the hospital.

Ongoing capital investment and infrastructure needs were highlighted as organizational and financial risks. In addition, the costs (and benefits) associated with advancing the adoption of the electronic health record are well understood by administration. With the pandemic coming to an end, ongoing funding and sustainability were raised as concerns.

Input is gathered from the staff members regarding purchases and when making resource allocation decisions. Staff advised that infection prevention & control and occupational health are routinely involved in making resource allocation decisions.

Priority Process: Human Capital

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization has staff who are knowledgeable, professional, and committed to providing patient centric services. They are enthusiastic towards the accreditation process and how the quality journey can help them ensure care is delivered within the context of their strategic goals.

A comprehensive Human Resources plan that identifies actions to support organizational priorities including ensuring supports for quality of work life, a safe work environment, and improvement activities has been developed. Similarly, a medical manpower plan is developed to provide insight and inform future planning. Human Resources has identified some specific goals with objectives, and these are monitored to track progress. The Human Resources team represents a broad range of services to support a healthy, competent work force. Many effective strategies have been employed to improve recruitment and retention. There are a considerable number of student and medical placements across the organization.

There is a focus and commitment to staff development in this organization. Training for staff is supported and core training needs are identified. Education and training opportunities are provided based on needs assessments. Many health promotion initiatives are available to staff. There is a workplace violence prevention program in place. There is an orientation and immunization program for staff and volunteers. With the pandemic, there has been no time to look at vaccination records for existing staff and this is a known gap.

The organization conducts staff and physician engagement/satisfaction surveys. Many staff report a positive work environment. There appears to be appropriate review of staffing and skill mix against acuity, workload, and job tasks. Sick time is reported to be high considering the pandemic. An attendance management program is in place. Fit testing is up to date. Flu vaccination rates are around fifty percent.

The organization has built a culture around service and meeting patient needs. Information is communicated and shared broadly with all levels of staff. The team is working to increase diversity, inclusion, and equity. The pandemic has challenged KHSC to review succession planning. There has been quite a turnover in management with many internal candidates moving up in the organization. The organization has had significant redeployment of staff through the pandemic. Redeployment was well understood by staff at the beginning of the pandemic. Goodwill has ended for changes on short notice. In speaking with staff, redeployment has become a staffing pattern and a “norm.” This is not well accepted and is causing significant concern for many. Human Resources is aware of this challenge and is investigating viable solutions. It will be important that shift reassignment be addressed quickly as this is causing anxiety amongst employees.

Recruitment and retention strategies are in place for staff and physicians. The Human Resources team has worked to develop positive working relationships. Performance (appraisals) is monitored across the organization with a standardized tool. Performance review completion rate is approximately 34%. Policy reviews are up to date. However, there are some policies that have not been reviewed for some time. The Human Resources team solicits input through various means including exit surveys, surveys, and face to face meetings.

The Human Resources team has advanced processes in place to support staff and to ensure organizational development. Staff files are maintained in a confidential manner and are accessible only to appropriate staff. There appear to be formalized processes in place to ensure that staff are appropriately licensed (and up to date) for the work they do in the organization. Credentialing processes are in place and completed in collaboration with Queens University. Human resources staff shared a desire to move to electronic records. Given the volume of work and the need to monitor human resources activities, the organization should consider software solutions for human resource and for document management.

Priority Process: Integrated Quality Management

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
12.4 The risk management approach and contingency plans are disseminated throughout the organization.	!

Surveyor comments on the priority process(es)

The staff are engaged in the Accreditation process and are focused around providing care to patients and their families. As one of the region's largest employers, KHSC is home to almost 6,000 staff, more than 2,000 health-care learners and 1,000 volunteers, who are committed to partnering with patients and families to ensure that they continually provide high quality, compassionate care.

The organization has developed a culture with a focus on teamwork and on the patient. The patient voice is truly reflected in the approach to care. The organization can track, monitor, and investigate rates and trends of sentinel events, near misses, and adverse events. A "just – no blame" culture appears to exist across the organization.

In 2018, KHSC developed a quality roadmap to support achievement of the strategic goal of "Quality in Every Patient Experience" and create a robust culture of quality within a new integrated organization. Between 2018 and early 2020, the following activities were completed in support of the roadmap:

- Education for leadership and Board members
- Broad stakeholder engagement in determining the quality improvement aims for the organization.
- Initiating an inter-professional quality and patient safety committee, which brings together physician quality leaders, hospital quality leaders, and a PEA to oversee the development of the KHSC's quality program, monitor performance, and as part of quality governance.
- Standardized reports showing prevalence of different types of Patient Safety Incidents and Patient Feedback reports were developed for Patient Care and Quality Committee of the Board, as well as for clinical programs (e.g., Emergency Department, Medicine, Oncology etc.).
- Annual Quality Improvement Plans were developed, and QI teams (inclusive of front-line staff, leaders, and PEAS) were educated in improvement methodology and introduced to standardized tools. Patient Safety Quality Specialists were assigned to support priority QI Projects
- The annual QIP priorities have been integrated into the Annual Corporate Plan (IACP)
- The Physician Quality Committee coordinated Workshops to highlight internal Quality Improvement work and provide education on QI related topics.
- Corporate Quality Improvement Projects as outlined on the QIP (including Reduction in prevalence of pressure injuries, Workplace Violence prevention, Reducing Time to inpatient Bed) have been developed and implemented.
- Programs have continued to work on QI projects within the program.

The quality improvement structure supports the organizational priorities and is linked to the strategic priorities of the organization. A formalized process for the governing body to receive regular, written reports from the Quality Team on the quality, risk and safety of services has been established. Huddle (Quality/Performance) boards are prevalent throughout the organization.

An integrated risk management approach to mitigate and manage risk is in place. The risk management approach and contingency plans are not fully disseminated throughout the organization. Staff report that much of the risk mitigation activity has had to focus on the pandemic, HIS implementation, and the redevelopment project. Staff report that there has been some work with some of the HIROC risk assessments. However, planned work for many of the risk assessments has not moved forward at this time.

A patient safety plan is newly developed. Processes are in place for patients and their families to provide feedback to the organization. There is a documented and coordinated process to disclose patient safety incidents to clients and families. A documented and coordinated medication reconciliation process is used to communicate complete and accurate information about medications across care transitions.

Staff and physicians are very committed to meeting the needs of patients. Patients feel the care they received is truly patient focused.

Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

An ethical framework is in place for use across the organization. KHSC uses the ASSIST ethical decision-making framework and an ethics worksheet tool. The organization does not have an Ethics Committee to oversee principle-based decision making for the organization. Oversight for Ethics lies with the ethicist. To help build capacity and to advance ethics and ethical decision making across the organization, an interdisciplinary group could be considered.

The ethicist is highly visible and engaged across the organization. In general, staff are aware of ethics and the supports that are available. An additional ethicist with knowledge and experience in the "Health Ethics Guide – Catholic Alliance of Canada" is on retainer to support the organization as the need arises.

Several examples were discussed when the ethical decision-making framework was utilized. Some examples included: parking, PPE allocation, vaccine allocations, operational decisions related to covid, and patient care delivery. A Visitor Exception committee was formed to review situations whereby visitors would be allowed during the pandemic. A Patient and Family Engagement representative was actively involved with this group (having responded to over 600 requests).

Information related to trends is gathered by the ethicist and reported to the organization. The ethicist provides support and education based on trends, issues, challenges, and situations. The organization does focus its efforts on promotion, communication and such things as benchmarking, research and evidence informed decision making to improve quality of services. Education sessions are designed based on types of ethical issues and challenges facing the organization. The organization supports and promotes research. Research projects are supported by the Queens University Research Ethics Board.

Given the considerable number of new staff that have been hired, it is recommended that the organization consider continuous education regarding ethics including how to identify, report and act on any questions or concerns.

The organization has Patient Rights and Responsibilities defined, well communicated to staff and patients, and widely posted across the facility. The group is extremely proud of the work they have completed related to principle-based decision making. Staff members report that users of this program have been thankful and appreciative of the support.

Priority Process: Communication

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

There is evidence of well developed multimodal and effective communication strategies at KHSC. The communication team demonstrates a high degree of expertise and a strong commitment to engaging stakeholders in developing communication strategies and in deploying innovative communication methods that are specifically targeted in consideration of the intended audience and their workflows.

For example, the comprehensive communication strategy for the organization's strategic plan has been complemented by a people managers' communication guide/toolkit in recognition of the importance in supporting effective communication between front-line managers and their teams to enhance relevance of the plan to a variety of roles and workplaces.

There is compelling evidence of patient advisor engagement in identifying communication needs and strategies. The patient advisory council seal is a visible demonstration of their contributions and of the importance KHSC places on patient and family partnership. Similarly, there are numerous examples of effective, collaborative communications with external stakeholders.

The organization has demonstrated agility in adapting to dynamic information needs related to evolving pandemic circumstances by using a wide variety of effective and inclusive communication strategies, paced according to the rate of critical information changes. Information technology has effectively managed the expanded need for hardware, software and learning to support virtual meetings, remote work and to support remote patient and family connection when presence has been restricted.

KHSC is far along in the planning process for a regional HIS. There is evidence of staff and patient advisor engagement in planning and much anticipation of benefits from an integrated electronic health record system.

There is evidence of mature and effective privacy and FOI processes, education, and continuous improvement. Changes are made from learnings arising from infrequent breaches. New risks associated with changes to pandemic workflows were anticipated and mitigated proactively.

Priority Process: Physical Environment

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
9.1 The physical space meets applicable laws, regulations, and codes.	!

Surveyor comments on the priority process(es)

The organization has a 10-year capital plan of which they are in their 4th year. The plan is reviewed annually with a strong focus on cost savings and energy efficiency. Since last accreditation there has been significant investment in replacing the air handlers (90% are new), chillers, hot water heaters, electrical panels which has resulted in annual savings upwards of one million dollars and saving 1,400 tonnes of carbon emissions across sites. The hospital receives provincial rebates for the efficiency of their heating system and continues to strive for a 2050 target of carbon neutral footprint. KHSC is committed to installing/retrofitting the hospital to meet legislative standards while maintaining the historical legacy of the buildings.

KHSC is partnered with Queens University on a CO-Gen facility for electricity and steam generation (40% owner). KHSC also has worked closely with Utilities Kingston to ensure there are redundant main power supplies to the hospitals to ensure stability to the electrical systems. Both partnerships have been key in addressing power outages that have been increasing over the past several years
There is a robust maintenance schedule of testing generators internally and with external vendors on a weekly, monthly, and annual basis. Generators fuelled by diesel allow for 72+ hours of energy in the event of catastrophic failure. Organizationally there are 'red outlets' that visually demonstrate a dedicated power source unaffected by power outage. The team also oversees the air handlers in an electronic environment where they can respond to issues quickly. The air handlers are easily identified in the computer program and monitored consistently.

KHSC has a pneumatic system for delivery of lab services (e.g., blood work) and other communications to specific areas in the hospital. The tubing system was maintained as an efficient way to reduce the number of footsteps people travel and increase the efficiency of transportation across the hospital. The system is monitored digitally, and the team can identify where 'jams' in the system might be to allow for investigation. There is standardized operating procedure (SOP) for clean up of biological mess that meets IPAC standards. The organization continues to replace the canisters to ensure minimal dysfunction or jamming. If a product is lost during transportation, the clinical side or origin site of the tube will complete an IRS using the SAFE system.

Another example of quality improvement/efficiency since last accreditation was the reduction of their inventory from $600,000 of product to 200,000 using the 'just in time' approach for procurement. The inventory is catalogued annually, and the reduction of products has allowed for standardization, reduction in the risks associated with multiple products and cost effectiveness.

Work orders are handled through the CMMS system with a hybrid approach to planned and 'ad hoc' maintenance. All information is placed in the portal for review and requests are typically completed within a day (except if a planned project or large repair).

Physical Area ~ Food Services ~ the area was clean, organized and structured to focus on patient safety in process. The team is cohesive and has redundancy to capture allergies and reduce the risk harm. The team was fully aware of the SAFE system and how to report an incident.

There is a strong presence of Patient Experience Advisors (PEAs) that are full partners in the designing of new space, feedback on space and provide input to several committees (e.g., AODA). PEAs are across the levels of the Board, including the Resource and Audit committee which sees all corporate level facility planning. The PEAs also function as ambassadors into the community to gather opinion on facility planning to ensure the perspectives and 'voices' are reflected. An example of feedback in 'real-time' was provided where the facilities team ensured a vulnerable parent in the community who could not find parking to bring their child to the ED or oncology was provided closer access. This was feedback provided through the AODA committee and acted upon.

Impact of COVID: The pandemic has impacted facilities management in both a positive and negative way. Within wave 1 with occupancy rates lower, this enabled much of the maintenance to be completed quickly without interruptions to clinical care of patient flow. To ensure redundancy in staffing and protecting health human resource (HHR) the portfolio implemented split shifts to stagger people to be responsive to the needs of the organization. Some of the challenges experienced have been the ability to access product from suppliers with COVID impact most logistics and purchasing entities. Shared was the fatigue of staff and how the organization is actively trying to address this issue.

Opportunities

1. Discussed was the lack of 'redundancy' of air handlers in the operating rooms and the need to address this soon.
2. External tenting ~ some mold was identified in the internal tent. Ensuring there is regular cleaning schedule.
3. The building is old and the air exchanges in some areas do not meet present day code. This will be an ongoing challenge for the organization.
4. As a historical site, the balance of preserving and modernizing may be a future challenge.
5. Ensuring 'restricted access' at HDH cafeterias is maintained given the proximity of outpatient MH services.

KHSC has much to celebrate. Staff shared many proud moments including the feeling of 'team' which was only heightened during COVID. People expressed feeling as a family and everyone supported one another. Within the food management area, proud moments shared was the ability of staff to adapt and thrive in transitioning from a paper environment to being able to navigate newer computer systems. Discussed was the feeling of being resilient in the face of change with technology.

Priority Process: Emergency Preparedness

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The emergency management (EM) team is highly skilled, collaborative, and pro-active in identifying, mitigating, and learning from emergencies. KHSC has several staff that have 200, 250, and 300 IMS level certification, and function to train not only the staff at KHSC, but they also provide training across the region. The executive team and EMS have healthcare specific training that has ensure preparedness for the challenges the organization faces. Executive at KHSC have been supportive of the emergency management plans and invested significantly to ensure preparedness. This has been well demonstrated in COVID responses, flood responses and the skill/knowledge of the team.

The team is part of a larger regional planning group with the province and municipality. The Director of Security sits on municipal EOC as well on the regional fire planning table.

There are business continuity plans that are reviewed annually, leveraging the HIRA model as well updated after-action reviews (AAR) when a code is implemented.

The team is responsive and consistently plans for all codes, ensuring a variety of engagement including tabletops, simulations, and mini-educational series.

There is clear evidence of a strong IMS structure with clear roles and responsibilities of leaders, cross-site collaborative approach, frequent tabletop exercises on codes (e.g., code purple, orange, green) and a standardized after-action review (AAR) process. The EM team consistently reviews all major events to prevent future ones and implement key changes to reduce future risk. Some notable examples include:

1. Code Silver ~ KHSC provides services to 9 correctional facilities in the region, with ~ 1% of all ED visits stemming from these facilities. A code silver occurred resulting in many recommendations in the AAR. KHSC developed more robust communication processes with Correction Services Canada (CSC), creating a pause during handover from correction officers to triage, creating protocols for 'urgent' care where prisoners are waiting with treatment rooms, versus 'non-urgent' where prisoners can wait in the police vehicle. The code resulted in many learnings and was used in the development process for the new ED. Other learnings included full scale 'code silver' exercises with participation from police and SWAT to train teams in real life events.

2. Code Flood ~ The KGH site is sensitive to flooding given the proximity to the water, and the building lower floors. In 2019 MDR was impacted where the area was completed flooded, surgery was postponed, and full business continuity was required to mitigate risk and reopen surgical flow at KGH. Within a noticeably brief period, with full partnership of IPAC, KGH was able to reopen services safely. However,

the most essential element was the AAR that identified several factors leading to change. Root cause identified the flood was caused by blockage in the pipes leading to cross organizational education to nursing, patients and families surrounding 'flushable items', a change in product selection and reusable product (e.g., cloth wipes), regular maintenance checks of pipes using scopes and signage across the organization. While the code was costly for KGH, the mitigation was highlighted by HIROC as a leading risk strategy and shared with HIROC subscribers pan-nationally.

During the survey, there was opportunity to experience a Code 'Brown' in real-time and observe the strength of the IMS structure, the EOC team and the preliminary recommendations for quality improvement in sharing information. The executive is present and active in the conversations and support the team by sponsoring the action items.

The EM team is well connected with the community, regional IMS table and ensure there is alignment in emergency response. Communication and transparency with the community is evident in their documentation, the Patient Experience Advisors (PEAs) inclusion and transparent communication with staff.

KHSC should be congratulated on the pro-active approach to COVID-19. The team formally opened the EOC in early January, however the planning for COVID commenced in late November 2019. What is also notable was the inclusion PEAs early in the discussion regarding family presence, communication to the community and other elements that would impact the community. The PEAs affectionately known as the 'Balzak Group' were instrumental in creating trust in the community in the daily/weekly decisions surrounding COVID, functioning as ambassadors.

Another clear example of a nimble EOC was decision making in real-time within the group that allowed for operationalization immediately of decisions. This was evidenced with the assessment/vaccine centre, ramping up/down of services, family restrictions, screening protocols to mention a few.

Shared was the pride in the collaboration of areas, resilience of leadership/staff, fortitude of the EM team and support from the executive team to invest in emergency management. There was a sense of pride in the work and commitment to do better for patients, families, and staff. Active succession planning is in play, and the portfolio is ensuring that historical and legacy knowledge is not lost with retirements.

Encouraged is for the Emergency Management area to continue to share their work across the organization and build upon the success for future events. Voiced were some concerns regarding regional/provincial alignment and direction in the management and response of emergencies. Encouraged is continue focus to foster a harmonized response. Also recognized is the number of new staff without CBRN and FIT training. Understood is COVID has been the main priority and once the organization is in the recovery phase, this will be resurrected as a priority.

Priority Process: People-Centred Care

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Compassion Respect Partnership Excellence and Innovation are values which foster the culture at Kingston Health Sciences Centre (KHSC). Two formers legacy hospitals, Kingston General and Hotel Dieu Hospital, came together in 2017. One can feel the philosophy of People Centred Care (PCC) as soon as they enter the organization. Knowing you will not be embarking on a journey alone but supported by a team of healthcare professionals who want you to have the best possible patient and family experience, truly makes a difference.

“Transforming Care Together” is the culture that comes to life within the walls of KHSC. The organization's website is easy to navigate and full of resources available to patients and families, like a digital handbook, videos about program services, and becoming a Patient Experience Advisor (PEA) to name just a few. PEAs are instrumental to ensure “Transforming Care Together” is successful. Embedding the lived experience voice of clients and families into every decision that impacts the patient experience is standard practice. They are members of committees, councils and working groups and partner on improvement teams across KHSC. PEAs are full members on all committees, including the Board committees. In 2020/2021 PEAs have volunteered over 2024 hours of their time, which is to be commended as we are still in a global pandemic and doing meetings in a virtual world.

PEAs are sitting at key decision making tables including the Regional Health Information System team and numerous Redevelopment Design Working Groups and Subject Matter Expert Groups. Additionally, PEAs are participating in the new Ontario Health Teams including Co-Chairing the FLA-OHT Community Council and sitting on the Transitional Leadership Collaborative. The Co-Chair of the KHSC PFAC sits on the KHSC Covid Clinical Operations Committee.’ Two PEAs are on the 1) Patient Care and Quality Committee, 2) People, Finance and Audit Committee and 3) Board Committee. This is innovative engagement and will be meaningful for both Board members and advisors alike, quality improvement initiatives within KHSC include a PEA ensuring the voice of patients and families is reflected in the project. PEAs are members of the KHSC Patient and Family Advisory Council (PFAC), South East Regional Cancer and Regional Renal PFACs which offers a breadth of experience and expertise who are passionate about patient engagement and partnerships.

PEAs played a key role in COVID-19 planning. In March 2020 just before the world shut down, former VP Elizabeth Bardon, and Angela Morin met with 8 committed PEAs at a local coffee shop and became known as the "Balzac Group", proactively identify patient and family priorities and inform decision making related to the potential impacts of a pandemic on family presence They were prepared and ready to lead the way and show how PEAs can still play an instrumental part in healthcare improvement. PEAs were involved in decisions regarding Family Presence and lent their voice to the Family Presence Exceptions Committee

who helped ensure that family seeking time with loved ones could have a fair and safe consideration. In a partnership with Queen's researchers, the Kingston General Health Research Institute, and members of the PFAC have helped to create a series of resources to improve patient education and access to virtual care. PEAs have had input in at least 20 committees, working groups, task forces and policy initiatives from Emergency Mental Health to Death Policy Review, not easy work for patients and families but meaningful. This is another example of the organization's authentic commitment to improving the patient experience.

PEAs are part of giving electronic feedback to patient education materials to help patients and families who will need these resources. PEAs transitioned from in-person to virtual presentations for the new Employee Welcome sessions at KHSC. Done virtually to accommodate COVID restrictions, PEAs can present to new employees and is co-presented with the staff member who leads patient and family centered care. Having staff and PEAs present together is well received by new employees of KHSC. Any quality improvement initiative occurring within KHSC will have a PEA participating and ensuring the voice of patients and families are remembered. KHSC is to be commended for the value they place on the patient voice. It is truly making a difference and the organization is encouraged to seek out the voices that are not often heard and those who would not normally be invited to the decision-making table. KHSC may wish to reach out to their community partners and collaborate on bringing in new Canadian or Indigenous voices to ensure they are being equitable, inclusive, and hearing from the diversity of people they serve. Staff play a key part in the patient experience by ensuring they are putting their care and safety first by partnering with them from developing care plans to transition to home safely. Patient safety tools like risk and fall identifiers and two patient identifiers, as well as and trying new ways of partnering with shift change at the bedside will strengthen patient safety and collaboration. KHSC is encouraged to build upon their great PCC work to spread patient safety and engagement at the bedside to all programs and services. KHSC is living the patient experience and is encouraged to continue to explore new and innovative ways to lead, partner and connect with those who want to make a difference. The contributions of PEAs are a gift, and it is important to remember that burn out of advisors is possible. Just like you look after your staff, remember to look after the people who share so much with their time, passion and lived experience. Make sure they are appreciated and safe. COVID has been hard on them too.

Thank you for your commitment to your patients and families, staff, and communities. Keep on seeking ways to be creative, be mentors to others and celebrate your successes.

It was a joy to see PCC woven throughout this organization. You truly are walking the walk and talking the talk. You will transform care one step at a time, together.

Priority Process: Patient Flow

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

The organization has met all criteria for this priority process.
Surveyor comments on the priority process(es)

There is a comprehensive and innovative approach to managing both internal and external flow in the organization. Daily weekday bed management flow and. capacity meetings are held and documented. A significant innovation from the impact of the pandemic has been the formalization of regular regional capacity and flow engaging multiple regional organizations from Oshawa to Prescott and as far North as James Bay.

A considerable number of beds and human resources have been invested ion LTC partnerships with Bayshore.

One other significant innovation is the development of the "Kingston at home" program which is a truly multidisciplinary program focussed on patient values and needs allowing for care to be provided in a home environment. The program is for up to 16 weeks of care and supported through the Ministry of Health.

Special note is made of the acknowledgment of the multidisciplinary approach to manage flow. There is broad engagement from all staff including health care support services that manage the vital role of keeping our health care facility safe and clean.

The organizational approach to managing and planning for wait lists is appropriate and ethically based. Team based models of care strategies have been appropriately implemented and redeployment of staff during the pandemic was planned to enable as little disruption as possible for staff and Queens trainees. A clear partnership and collaborative approach with the University was evident.

Work incorporating First Nations health care is in progress and is ongoing opportunity for all of us in the Health Care Community.

One area of opportunity voiced by staff is the lack of standardized flow process and protocols for the Level 2 ICU on D4. The substantial number of level 2 beds is set up very well for a closed ICU model. Given the urgency of human resources and the known provincial direction on this issue a timely opportunity to transition with engagement across all specialties is indicated.

Priority Process: Medical Devices and Equipment

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
9.7 Plans or processes for maintaining, upgrading, and replacing medical devices and equipment are followed.	

Surveyor comments on the priority process(es)

The MDRD has refreshed its leadership and implemented multiple process and quality improvements. These include innovative training and recruitment, "Tag" system of transparent and equitable work allocation, centralized reprocessing for GI endoscopy, incorporation of computer workstations to facilitate just in time education, and consistent use of SAFE reporting, root cause analysis, and staff follow-ups.

A strategic opportunity was implemented to facilitate a combined training/hiring process. Staff turnover has been reduced as a result.

There is evidence of extensive collaboration with the OR and regional partners through a MDR Committee and Regional Supply Chain Disruption Working Group.

Leadership engaged with staff, Professional Practice and Material Management in a trial and procurement of single use instrument wrap that was viewed positively.

Focus in MDRD on assuring equipment in high demand can be made available; and high priority of the MDRD to assure first case equipment availability with extra quality checks. Engagement with the perioperative team has facilitated acknowledgements of the importance and respect of the work performed in MDRD.

Ergonomically appropriate environment and equipment to prevent injuries and support staff.

There is an opportunity in medical devices to improve upon keeping an inventory of medical devices and their current expected lifespan and expected termination of support from vendors.

Clinical engineering is doing more cross training of staff and has implemented quality improvements in documentation.

Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Living Organ Donation

- Living organ donation services provided by supporting potential living donors in making informed decisions, to donor suitability testing, and carrying out living organ donation procedures.

Organ and Tissue Transplant

- Providing organ and/or tissue transplant service from initial assessment to follow-up.

Point-of-care Testing Services

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

Clinical Leadership

- Providing leadership and direction to teams providing services.

Competency

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

Episode of Care

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

Decision Support

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

Impact on Outcomes

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

Medication Management

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

Organ and Tissue Donation

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

Infection Prevention and Control

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

Diagnostic Services: Imaging

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

Diagnostic Services: Laboratory

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

Transfusion Services

- Transfusion Services

Standards Set: Ambulatory Care Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
1.3 Service-specific goals and objectives are developed, with input from clients and families.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Clinical leadership team for ambulatory care is a very dynamic and collaborative group. They acknowledge that they lead a diverse set of clinical ambulatory care clinics. Some clinics are directly aligned with clinical programs such as; renal, surgical and perioperative services, urgent care center, and mental health. The team has developed a roadmap to articulate services that are aligned with programs and those that remain directly under the auspice is of the ambulatory care clinical leader ship group.

There is a process in place through an intake form for departments and other clinical leaders to identify gaps in clinical services. The needs assessment is reflected in the intake form which is accompanied by an impact assessment. There is a physician manpower plan created that projects needs over a three year period. Approval of new clinics is dependent upon ministry approval to fund new ASP decision positions and the organizations capability to identify additional operating revenues and funding for capital equipment.

The clinical leadership team acknowledges that they do not currently have a strategy that is aligned with the corporate strategic plan and directions. They were working on an ambulatory strategy to streamline and optimize outpatient clinics just prior to the Covid pandemic. The team is encouraged to pick up their planning when they were able to to ensure that their limited footprint is optimized going forward.

The renal program is a Regional Program in the Ontario Renal Network. There are specific goals and objectives related to renal services under this structure. This is unique to Renal when compared to the MS clinic and Opthalmology. A great example is the Access to Kidney Transplantation and Living Donation Strategy (AKT)-Project Charter.

The team is committed to exploring partnerships and collaborative opportunities to provide outpatient services and other regional organizations were possible. In addition, they are looking to optimize the utilization of virtual care post pandemic.

The team demonstrates a culture of support. Especially within the individual clinical areas.

The clinical areas visited for tracer exercises included; the MS clinic, the ophthalmology clinic and renal .

Priority Process: Competency

All new staff are provided orientation to the organization through a general orientation process. They are required to complete annual mandatory training on key programs like fire and WHMIS. This is all available to staff through an e-learning problem called Kingston knowledge now. Employees are able to login and complete their mandatory e-learning.

Specific training for staff in ambulatory care is unique to the ambulatory care clinic in which they are working. There are a variety of strategies in place including conference attendance, e-learning module completion and team-based knowledge transfer and development.

It is recognized by the team that with the uniqueness of the clinical programs that it makes sense to cross train staff to at least 1 to 3 other clinics. This enables the organization to be flexible to respond to whatever clinic is running in the "hotel" space throughout the week. This innovative practice is encouraged to promote flexibility and efficiency.

Staff were able to identify additional training to support redeployment during COVID to clinical areas based on past clinical experience to find the best fit.

A competency matrix has been developed by the educator/manager to identify where staff have experiences from previous assignments, their current experience, and where they would like to work in the future. Again, this is a creative and innovative strategy to stabilize staffing in a very diverse clinical area.

Professional staff or credentialed through annual processes and privileges are approved by the board of directors.

There is recognition of need to have back up staff for relief for key individuals who are on vacation. A nurse practitioner has recently been hired by the ambulatory care program to provide back up support for

the educator.

In the renal program they have recently made the shift to an RN/RPN mix. This varies across modality from, PD, MCKC, Hemo and transplant. PD and MCKC are all RN and Hemo and Transplant are 75% RN and 25% RPN.

There is a six week training program for new nurses assigned to Hemodialysis with a 6 month check in. There are numerous upcoming in-services with a supper club that staff voluntarily attend. This has switched to virtual during the Pandemic.

Priority Process: Episode of Care

The ambulatory care department is a diverse set of ambulatory clinics. The clinical tracers were completed in the MS clinic, ophthalmology and renal.

Patients are booked directly into the clinic based on their clinical need. They are registered and wait for their visit while they are clinically distance. All screening for COVID occurs at the main entrance.

Standard assessment tools are used in all clinics and there was evidence of plans of care developed for each patient.

The best possible medication history is variable dependent on the ambulatory care clinic. Few designated clinics such as renal are targeted to ensure compliance with BPMH. Physician medication reconciliation training is mandatory for reappointments.

There was evidence of the use of two patient identifiers when administering patient care.

Patient interviewed in the ophthalmology clinic very positive about the level of patient engagement and quality of care delivered by the clinical teams. The feedback reflected that access to care was very timely and outcomes are very positive. This was echoed in renal clinic with additional satisfaction expressed with the ability to access team members easily to respond to questions. Clients express knowledge about their rights and responsibilities.

Priority Process: Decision Support

There was evidence of complete client records maintained and documented in a standardized Way in each of the ambulatory care areas were tracers were completed. However, the processes were unique in each of the ambulatory care clinics. An example of this is the use of Nephrocare (Fresenius) in use in the Renal Program.

The ambulatory care clinics combined a mix of paper-based documentation, physician dictation scanning

in to the Quadramed PCS program of key documents. Although the documents were complete and portrayed comprehensive clinical picture. The organization will benefit to the conversion to electronic health record with the implementation of Cerner in approximately two years.

The ambulatory program has recently created a manager of health information system in virtual care to provide leader ship to the diverse ambulatory care clinics in preparation for the transition to electronic health record and incorporating sustainable practices around virtual care.

Priority Process: Impact on Outcomes

In the ambulatory care clinics evidence-based guidelines are determined at the local clinical level with input from the clinical team.

Quality improvement initiatives are also clinic specific. There are a few indicators that are regularly collected and monitored at the ambulatory program level an example of this is clinic utilization with data collected and Monitored around no show appointments.

The Renal program has extensive data sets that are collected both at KHSC and at the ORN level. There are numerous reports available to assess outcomes including but not limited to; Incenter HD scorecards, HD QCI reports and an Ontario Renal Plan # Program Report which is a very powerful reporting tool.

The team openly knowledge acknowledges their desire to create a meaningful dashboard for the handle ambulatory clinics they oversee. The team has not had the capacity to establish this yet but they are strongly can encouraged in their pursuit of this important initiative. This is something that could be monitored by the ambulatory care subcommittee of the medical advisory committee. They have a vision to create report cards at the individual clinic and physician level to be able to monitor and report on performance.

Clinical incidents are identified and reported through CRL solutions. The team reports completing quality reviews with clinical incidence and identifying recommendations for improvement. Although the team did not report a recent critical incident they were able to outline their process and recommendations for a recent incident experienced in the program.

The ambulatory care programs are involved in research at the individual clinical level. Research projects are reviewed and approved by the research evaluation board. The departments become involved when there is an impact to resources, patient consent or demands on access to space. The team was able to say a number of important research initiatives they are engaged in.

There are a significant number of Research Projects underway of particular note was the recent presentation of the Renal Program of their work "Improving Timeliness of COVID Vaccination for Kidney Transplant Patients using a Dedicated Outreach Program.

Standards Set: Biomedical Laboratory Services - Direct Service Provision

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

Surveyor comments on the priority process(es)
Priority Process: Episode of Care

See Comments under Diagnostic Services Laboratory

Priority Process: Diagnostic Services: Laboratory

The laboratory staff are to be commended for their tremendous efforts in preparing for this survey, including the development of numerous standard operating procedures, and standardization of many processes.

Much of the Laboratory Services program has been assessed through the Institute for Quality Management in Healthcare. Assessment was limited to a small number of items not included in the Institute for Quality Management in Healthcare assessment.

Departmental objectives are set and drive decision making. The Laboratory is involved in numerous programs and efforts in support of the organization. The Quality Team is active in the Laboratory and there appears to be a well-developed Quality Management Program. Planning is in place to monitor resources and ensure efficient use. Utilization is examined and results are shared. The laboratory completed a Quality Management Review which is an excellent document to evaluate the status, adequacy, effectiveness, and efficiency of the current quality management program.

The laboratory is staffed. Consideration of succession planning, and human resource planning appears appropriate and ensures the organization is not at risk for disruption of services and unplanned changes in service provision. Education and training are in place and some competency assessments are in place. Academic activities are in place and support ongoing development. Training needs have been identified.

Staff are very engaged and there is an overall feeling of team amongst lab staff. In general, lab staff feel supported and are eager to learn. There is a sense that staff genuinely want to ensure they provide quality results. A customer satisfaction survey is in place to gather input from patients. Staff understands use of patient identifiers. Staff are client focused. Hand hygiene practices are understood and practiced by staff.

Processes involved with the introduction of modern technology and new equipment appear to be appropriate. Communication methods are in place to ensure laboratory staff, physicians and laboratory users are informed. In general, staff members are aware of policies and procedures. Equipment is in good repair and under appropriate maintenance schedules. The role of the safety officer is formalized and supported by a safety manual for the laboratory. The laboratory has limited physical space for existing operations. Planning for existing and future space needs should be actively pursued.

In summary, the laboratory has a sound quality program and is well positioned with a solid foundation to advance its comprehensive program into the future. The staff were very welcoming, eager to learn, and delightful to work with.

Standards Set: Cancer Care - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Cancer Care leadership team demonstrates a shared passion, commitment and clear vision for sustaining and advancing high quality care. The experience and outcomes for patients receiving cancer care is top of mind. They share a focus on supporting and developing teams providing care and demonstrate highly collaborative approaches to consistently integrating patient perspectives into care and service planning. The program direction includes strategies to facilitate care closer to home, to expand existing successful programs to additional patient groups, to achieve FACT accreditation, to engage and lead regional quality improvement priorities and to collaborate with the DI team to add a PET scanner as a needed diagnostic tool. There is evidence of strong external partnerships with Cancer Care Ontario, satellite care sites, and external care partners to enhance access to specialized care. The team demonstrates a high degree of resilience and innovation by adapting models of patient care to accommodate risks and restrictions resulting from the pandemic. Safety, timely access to assessment and priority treatment have been key considerations. The leadership team is acutely aware of workload stressors exacerbated by human health resource challenges and the prolonged impact of the pandemic. They have effective strategies in place to enhance employee wellness and they continue monitor risks and to explore new strategies.

Priority Process: Competency

Policies, procedures and documented tracking of education, training and certification for specialized care practices and procedures are in place. Team are committed to sharing information through formal and informal educational opportunities and through extensive publication. Comprehensive educational programs are in place for radiotherapy and systemic therapy staff and patients. Areas of focus include radiation safety, chemotherapy administration certification, occupational health and safety standards, infection prevention and control practices, infusion pump safety, in addition to relevant corporate safety priorities. There is a strong commitment to support ongoing professional development in particular to support the expansion of new treatment modalities. The Cancer Care program is preparing for FACT Accreditation to enable Autologous transplant procedures. There is clear evidence that learning associated with the care of patients undergoing allogenic transplants is already taking place through the experience of caring for patients who have undergone transplant at other sites and from planned educational opportunities. Staff demonstrate a strong desire and commitment to continuous learning and leadership demonstrates commitment through funded continuous learning/certification opportunities. Extensive patient educational programming and material if easily accessible across all areas of care. Patients expressed satisfaction and appreciation for learning opportunities.

Priority Process: Episode of Care

There is evidence of strong patient engagement in developing their plan of care across all areas of care. Patients are educated about treatment modalities and provided with information to make informed choices in collaboration with expert guidance. Systemic therapy and radiotherapy protocols are validated through multiple safety and planning processes and are developed using best evidence. Patients are provided with information to establish treatment expectations in terms of duration, efficacy, side effects, diagnostic tests, and other essential information. A Primary Nurse Navigator role is in place to support patients through sometimes complex care paths. Throughout pandemic circumstances, the Cancer Care team has continued to use standardized provincial priority ranking to ensure equitable access and optimal outcomes They are committed to collaboration with provincial cancer care centres and KHSC has prioritized cancer surgery and diagnostic testing to prevent out of window wait times for essential care. In addition, the Cancer Care team has continued to build and leverage partnerships with satellite treatment partners in part to achieve their aim of providing care closer to home and in part to expand capacity during the pandemic. Their innovations have been positive for patient care and have been externally recognized through awards. Specifically, by providing compounded medications from KHSC Pharmacy to satellite care centres, systemic therapy can be provided closer to home in hospitals who cannot compound medications. An innovative program in which admission can be avoided by providing Methotrexate as day treatment improved patient experience and made efficient use of resources, becoming a standard of care.

The team is aware of and regularly uses the KHSC ethical decision making framework and resources. They provide compassionate person centered palliative and end of life care by collaborating with and supporting patients to choose and access the KHSC and external resources available to them.

Priority Process: Decision Support

Policies and procedures are in place to meet required standards for health information documentation and compliance audits are in place. The Cancer Care program uses a hybrid (digital and paper) model for documenting clinical care. The digital platforms enable CPOE to enhance medication safety practices. In addition they support external data sharing and required reporting. An innovative IT system for planning and mapping complex and often frequent patient encounters for radiotherapy has enabled timely access, improved efficiency of resource utilization, safety and patient experience. Cancer Care IT systems are also used to effectively coordinate ambulatory chemotherapy and to match care needs with staffing levels and expertise. Privacy policies and practices are in place and monitored. Staff educational programs on privacy are accessible and tracked. The Cancer Care team have dedicated decision support resources to support necessary synthesis of data for clinical decision making, quality improvement and research.

Priority Process: Impact on Outcomes

The Cancer Care team is passionate about achieving optimal outcomes and is committed to continuous quality improvement. They are leaders in generating new Cancer Care knowledge through clinical research. As a result they have initiated relatively unique treatment modalities that achieve treatment goals with fewer unintended consequences than some existing treatments. For example, the Brachytherapy program is revealing very effective, more targeted radiotherapy that results in fewer treatments and less damage to surrounding tissue and therefore fewer complications for patients during and after treatment. There is opportunity to expand the use of this radiotherapy modality through training/fellowship programs.

Leadership and clinical care teams are highly engaged in quality improvement initiatives. In addition to radiotherapy and systemic therapy QI programs and collaborative provincial data sharing, the KHSC team is assuming a leadership role in establishing a regional quality improvement platform known as Queens University Improving Cancer Care (QUICC). Initial regional improvement priorities will likely focus on cancer care issues pertaining to vulnerable community populations. This is one of many examples of KHSC Cancer Care engagement and leadership within the region and province to enhance partnerships, capacity and quality outcomes.

There is evidence of many departmental quality and safety initiatives, which include patient experience advisors are authentic partners. There is a comprehensive set of quality indicators that blend KHSC priorities, Cancer Care program priorities and priorities specific to individual departments or units. Staff are encouraged and supported to be engaged in QI projects.

Of note, the Cancer Care team has been aware of quality (access) and safety (exposure) risks to patients receiving cancer treatment throughout the pandemic. They have developed processes to support patients to bypass higher exposure risk areas like the ED by creating safe but tailored screening and access routes. There are a number of strategies that have been implemented to support patient connection with important family members and other supports when their presence has been restricted. Nevertheless

staff have expressed moral distress over how these necessary limitations are experienced by patients undergoing stressful treatment. Leadership teams have supportive strategies in place for team members.

The diagnostic and surgical assessment programs are an excellent example of the sophisticated way the Cancer Care team leads and collaborates with internal and external partners to develop innovative programs to improve clinical and experiential patient outcomes. By effectively coordinating complex diagnostic testing patient journeys, they have demonstrated significantly reduced referral to treatment times, reduced frequency of visits for patients and overall improved patient satisfaction. The programs measure all dimensions of quality and have extensively published program outcomes. Plans are in place to expand the model to different disease sites. The nurse navigator role has been acknowledged by patients and team members as highly valued and critical to the program success.

Priority Process: Medication Management

Safe medication management practices for systemic therapy are a focus throughout areas providing Cancer Care at KHSC. Nurses are supported to be certified in chemotherapy administration and the rate of completion is tracked as a unit level quality indicator. There are guidelines, standard order sets, educational programs and safeguards like infusion pump guardrails and independent double check practices that are all reviewed regularly. They are reliably integrated into practice. Systemic therapy practices are in alignment with organizational policies and procedures for High Alert medications.
Cancer Care is the only department in which COPE has been fully implemented as a mechanism to enhance safe medication ordering. There are dedicated workspaces intended for use by staff engaged in calculations or other medication management practices that require uninterrupted concentration.
The safety reporting system (SAFE) is an integral part of learning from errors and near misses related to medication safety. Front line staff are universally aware of they system, have easy access and regularly report incidents.

Standards Set: Community-Based Mental Health Services and Supports - Direct Service Provision

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

The HDH outpatient mental health program has strong leadership that will continue to drive the innovation, research, and program improvements for the community. The physician/director dyad have been able to make substantive changes in the program since assuming their roles in the last 12-15 months. There is a strong quality improvement lens to improving patient services, building community partnerships with other agencies, and leveraging the proximity of the university to drive research opportunities.

Since last accreditation there have been many exciting improvements including the recent approval of one million in funding to plan and develop a new Eating Disorders Day Treatment Program which will be based in the community. Like other program initiatives, this will be partnered with clients, former clients, patient experience advisors (PEAs) and with Peterborough hospital to design a regional approach. This funding was secured by leadership through leveraging of metrics, understanding the community needs and strong track record for mental health recovery of their clients.

With COVID the leadership team was able to pivot quickly onto a virtual platform and have zero downtime for services. This was voiced as an extremely proud moment for many of the clinicians as they felt they

were able to continue care for those most in need and ensured recovery of patients.

The chief of psychiatry is a champion of collaboration amongst the team, and this can be evidenced with all the research and education initiatives within programming. Leadership is very comfortable with data and use information to drive change and innovation. There is a close alliance/partnership of medicine and leadership to develop innovative care models.

An opportunity for the leadership team will keep a close eye on fatigue, pace of change and sustainability of project implementation. Staffing continues to be a challenge across the organization, and fatigue prevalent, so this will need to be considered when planning for implementation.

An opportunity for the organization is to consider a different model for ethics. While there is a bioethicist that addresses all clinical needs, this is a person dependant model. Consideration of an ethics committee or hub and spoke model for ethics may be a better way to ensure continuity of consultation, trending of information and ensuring broader based resource.

Priority Process: Competency

The programs within the outpatient services are highly functioning and provide layered services for clients. The team includes psychiatry, nurse practitioners, nursing, occupational therapy, social work and other clinical or clinical support services.

Educational opportunities are provided for the team which creates excitement and passion to improve services. Reviews are completed annually/bi-annually depending on the staff member (e.g. union vs non-union), while physicians have a different model of evaluation that is managed by the chief of the service. Goals are identified annually for staff to achieve, and there are multiple check-in's with management to ensure goal completion.

Staff report they feel very safe and supported by leadership and have not experienced workplace violence in any form. There is clear understanding of how to report concerns, and where to seek support. The team has interestingly thrived through COVID through their shared vision of keeping programs open, and supporting each other in formal and informal ways.

Priority Process: Episode of Care

There has been a tremendous amount of work that has been conducted within the outpatient mental health and addictions programs at HDH over the past 4 years. The success of this work can be attributed to new leadership, dedicated staff and strong partnerships with the community/patients/families/Patient Experience Advisors.

The programs at HDH mental health have a very wide catchment area and can be accessed through medical referral (physicians/programs) or self-referral from clients. Noted by clients, families and community partners were delays in access and no single point of contact. Over the past 2 years, the

program implemented a centralized intake process ensuring a single point of contact for patients. This quality improvement initiative minimized the re-telling of information which could trigger clients, duplication of services and/or loss of referral. Since inception the initiative has improved satisfaction of clients, reduced presentation to the Emergency Department or UCC by 8% and reduced inpatient admissions to MH units by 10%. The centralization not only allows for referrals to be managed efficiently, but there is also an attached intake process whereby clients are screened for suicide risk, homelessness, and coordination of services. The success of the program has resulted in scalable expansion to child/youth services to find similar success.

Another success through program improvement has included the inclusion of psychiatry across many programs and agencies that allows for the matching of services to care needs. Where traditionally there was a consultation model with longer wait times, the program created the Emergency Psychiatric, Assessment, Treatment and Health (EmPATH). This direct and expedited referral to urgent psychiatry services assists with ED avoidance and supports appropriate care. Clients referred into service are typically seen within 2-3 weeks with intake triage within 3 business days. The pathway as resulted in less mental health patients going to the ED or UCC for services and more appropriate care for crisis intervention.

The close affiliation with Queen's Psychiatry has also allowed for integration of research into programming. Over COVID the development of online psychotherapy tools for common mental health disorders (e.g., anxiety, bipolar, depression) assisted with managing need and the temporary closer of in person visits. Over the past two years with CIHR funding the results have been promising with more young persons, or adults needing to travel long distances using the online tools to assist with recovery. The challenge will be the ongoing funding of these types of initiatives as they are reliant on grants. KHSC will need to explore how to receive permanent funding for a service that continues to grow and demonstrate success.

The detox program has also seen momentous changes over the past 4 years with the addition of a nurse practitioner. This new role has assisted in providing holistic care of both medical and psychological care. This role has assisted in ED diversion with simple medical needs being met by the NP and/or referred to other programs outside of the ED. The program is in process of planning standardized care and order sets for ED physicians to assist in the management of addiction should patients be seen in the ED.

The strength of all programs can be directly attributed to the skillful staff who are strong advocates for their clients. They are the backbone of the program and partake in community and regional events to de-stigmatize mental health and addictions. They have strong clinical skills and are constantly looking to improve process for the betterment of care and clinical outcome. There is always a focus of reintegration back into the community and ensuring clients have all the support they need to be successful. Staff articulated how proud they are to work for their clients, each other, and the community. They feel their services are 'top notch' and care is wrapped around the client. Staff felt their contributions to care (clinical and clinical supports) change people's lives and the hope is to continue to grow, and strengthen collaborations across programs, especially in the ED.

The challenge this team may have is the pace of change and sustainability of process given the resources and potential need for more staffing.

Priority Process: Decision Support

All HDH outpatient services have strong policies and process regarding health information, privacy, release of information (ROI) and access to health records.

Presently, records may contain information not only regarding the client, but also their family which has the potential for conflict when ROI is involved. Organizationally, there was an exploration to establish clear protocols using the bio-ethicist, privacy officer and HIM officer to understand how best to release information to clients, SDM's and families as it relates to minors. The thoughtful process ensures that clinicians are always notified when a ROI is requested for a minor and/or SDM to ensure appropriate consent. As well, HIM connects with clinicians if the file has information that is sensitive in nature (e.g. about the family dynamics, or person in the family) that may trigger the client and/or family before it is released. A great deal of effort has been put in place to standardize the process, and ensure thorough understanding to discuss 'refusals of ROI' with families.

The outpatient services has an electronic health information system that will be fully integrated in the new HIS when launched. This will allow for a more seamless flow of information from inpatient to outpatient units. While waiting for the organizational HIS, there is awareness of information flow and ensuring complete records.

Priority Process: Impact on Outcomes

The outpatient programs use evidence based guidelines and leverage a variety of different protocols to support their clients/families.

The 'Heads Up' program is one example of an evidence based program that has accountability through the Early Psychosis Intervention Ontario Network (EPION). Fidelity assessments are done periodically and the entity is highly regulated regarding processes and protocols. The 'Heads Up' program has undergone fidelity testing twice and been successful both times.

In addition to the standard treatment programs, there is room for customizability for clients to meet their needs and the needs of their families. Feedback is formally and informally gathered to make improvements to programming and care.

Standards Set: Critical Care Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
4.2 There is a process to communicate with admitting and referring team members and family physicians about their respective roles in the client's care.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
10.1 Oral communication is facilitated or alternate means of communication are used when the client is unable to communicate orally due to ventilator use, physical condition, or other reasons.	
Priority Process: Decision Support	
13.4 Clients are able to access information in their records, including electronic medical/health records, in a routine, client-centred, and timely way.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	
Priority Process: Organ and Tissue Donation	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Intensive Care Unit has through the pandemic proven beyond any doubt that quality processes, standards of work, communication, and collaboration both internally and externally is exceptional.

Significant ongoing work is being done to enhance the current environment to retain staff and educators to facilitate recruitment of very limited Human Resources. This includes tracking of all turnover for causation, implementing scheduling changes to facilitate autonomy/flexibility, creation of hybrid positions between ER and ICU. Significant support and education for redeployed staff was assured. Recruitment of respiratory therapists was enabled with the development of an RT assistant role.

Othe innovation nations included RN/MD lead PICC line insertions, an airway checklist, proning protocols, multiple simulation projects, and the implementation of an antimicrobial stewardship program.

Quality committees for adult and NICU incorporate patient advisors focussing on feedback from patients and families. Standard metrics are followed and reported. Trends of SAFE reports are reviewed.

Safety huddles are he'd at least daily and a standard quality board is now utilized across the organization, Further work on standardized quality process for each unit is ongoing.

Waiting room resources for families have been significantly upgraded.

A bundled consent document is in final phases of development to facilitate both the consent process and to help families understand the concepts and consequences of an ICU patient.

The NICU is on the verge of updating outdated infrastructure. Strong leadership! Engaged staff in a difficult and high stress environment. Patient family focus on improving the experience with incorporation of text messaging and pictures in real time that have clearly been impactful for distanced parents and CoVID.

Obsessive adherence ot client identifiers especially with implementation of a new innovative feeding program. There is very clear evidence of compassionate patient oriented care.

Opportunities.

A standard policy for end of life care incorporating end of life process for compassionate and ethically sound end of life care would be helpful as we navigate and mitigate risks associated with sensitive issues including withdrawal of life support, organ donation, and MAID. An example has been forwarded to the ICU leadership team.

Level 2 ICU capacity at the KGH site is very geographically advantaged to facilitate a closed ICU model of care. Provincial direction supports this approach. There was clear indication that this was a dissatisfiee to our nursing staff and is an issue to appropriately address with engagement of the multiple specialties involved.

It is not unusual for family physicians to remain engaged in the care of ICU cases and in particular patient value can be advanced in some cases with assurances to the family from the family physician that all advocacy for the patient is being appropriately managed. Incorporating this process within a quality end of life policy may be of benefit.

Priority Process: Competency

All standards have been met

Priority Process: Episode of Care

Standard alternative mechanism such as a white board are in use to facilitate communication however advanced technology and tools are available to more consistently provide the opportunity for even the most difficult cases who have difficulty communicating as a result of there illness. Opportunity exists to significantly improve upon this through defined process and protocols.

Priority Process: Decision Support

The client access to charts requires a paper requisition and is something to addressed with the introduction of future EMR.

Priority Process: Impact on Outcomes

All standards are met

Priority Process: Organ and Tissue Donation

All criteria are met

Standards Set: Diagnostic Imaging Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Diagnostic Services: Imaging	
1.3 The team meets at least annually to review information collected from clients and medical professionals to identify strengths and areas for improvement in service needs, and make changes accordingly.	
Surveyor comments on the priority process(es)	
Priority Process: Diagnostic Services: Imaging	

The diagnostic imaging team serves both inpatient and outpatient services across a large regional catchment area. They serve a population of more than 650,000 and are the tertiary care centre. Internally, the ED is the largest internal customer, and the department has strived to creative innovative models of care with key areas (e.g., cardiology, neurology, surgery) and interventional radiologists to wrap care around the patient. The focus since the last accreditation cycle was to maximize throughput, expand CT hours of operation, re-structure staffing to have greater redundancy (e.g., hybrid roles of dual specialization X-Ray/CT) and ensure that specialty services such as MRI/CT/Ultrasound were maintained during closures.

Since last cycle there has been a 36% increase in the number of radiologists to serve the 230,000 and 12,000 IVR procedures. The program has two interventional radiologists and have implemented significant quality improvement initiatives to maximize the number of procedures (100% increase in procedures) completed annually. CT has seen a 500% improvement in throughput with QI initiatives with staff/radiologists proud of their impact to their community.

The department has strived to create strong partnerships across the organization. There are several MOUs in place with cardiology, neurology, surgery to partner with interventionists with specialists. Novel for the program has been the introduction of the ‘aneurysm coiling ' a designation from the Ministry of Health. Historically patients would need to travel large distances to be able to receive care (e.g., Ottawa Hospital). Aligned with the mandate of care closer to home, the program launched conducting 30 per year.

The vascular ultrasound MOU has also been quite successful whereby this partnered approach has assisted in the avoidance of higher risk surgery, riskier interventional procedures, and better patient care. Patients are well prepped and comfortable in the explanations of pre/post op care.

The cardiology MOU has also resulted in better patient care closer to home. Historically, patients were required to go to Ottawa to undergo a CTA and come back for local care. A cardiac imaging group with radiology was created with the goal to have access to cardiac CTA locally, reduce wait lists and improve continuity of care. this MOU was layered on several QI initiatives to ensure the collective support team

could implement easily (e.g., education on beta blockers, medical directives for nursing, CME for family medicine). Since implemented there has been a significant impact on care for residents and better health outcomes.

A strength of the program is their education of technicians and radiologists. There is a well-designed educational program for technologists to have dual expertise that allow for a more flexible and nimbler workforce. The education is embedded across both sites with coordinators, and the emphasis is on recruitment of future talent.

The program is new in research with a planned focus in expanding partnerships with residents and securing fellowships for speciality DI. In 2019 the program hosted a national CME event called 'MRI in the 1000 islands' which had delegates across Canada. The department is expecting their first fellowship in neuroradiology in July of 2022 and a subsequent women's imaging fellowship the next year.

The department has also embarked on an exciting global health initiative with the University of Nairobi on international exchanges to build infrastructure, educational training, development of curricula and an international community of practice.

Patient Experience Advisors (PEAs): There are many examples of the patient partnership within diagnostic imaging. The organization authentically partners with PEAs, and clear that this is within the DNA of KHSC. Two key initiatives were partnered over the past 4 years. The first example was way finding. As the buildings are historic with additions to the original build, wayfinding was challenging. The PEAs provided guidance and support to the initiative to assist those seeking services.

A second example is the new Breast Imaging Kingston (BIK) center that recently opened. The PEAs were part of the planning, design, build, implementation, and ongoing improvements to provide breast imaging services to the region. What was apparent was the equal voice at the table. The BIK is a state-of-the-art service providing unique interventions not seen across other areas in Canada (e.g., prone biopsy unit) and will attract international fellowships/radiologists to practice at KHSC.

Impact of COVID: The team was nimble and able to leverage the downtime in Wave 1 for specific procedures to repair or install new equipment (e.g., MRI 1.5T and 3.0T equipment), plan virtual care options and implement QI initiatives to ramp up services quickly and improve throughput. Within the MRI services, protocols were put in place for PUI/COVID positive to ensure safety for staff and other patients. Introduced during COVID was the ability to scan patients with pacemakers which historically was not done. The team was able to implement the model of care, provide education, audit results during COVID which should be commended. This modification of service allows for a whole sector of the population to receive care where not previously possible.

Staff voiced their pride in their teamwork, the ability to 'keep the show running' despite COVID, floods or staffing shortages. The leadership team is strong on both the medical/operations side and will no doubt continue to innovate.

Opportunities

1. Annual surveys from regional providers to better understand the needs of the program
2. Ongoing review of space limitations and the need to ensure diligence on where supplies are stored (at HDH)
3. Pace of change of initiatives to ensure staff can implement and sustain at a non-frenetic pace.

Standards Set: Emergency Department - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.9	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
2.11	A universally-accessible environment is created with input from clients and families.	
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		
Priority Process: Organ and Tissue Donation		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The clinical leadership team for the emergency department is a very cohesive and collaborative team. They are supported by a program dyad structure with a physician program Director and an Administrative program Director.
They meet as a team regularly on a weekly basis to identify and resolve real time issues that are challenging the Program. The Program operates the Urgent Care Center at the HDH and the ED at the KGH. Together the Programs serves over 91,000 visits per year.

They have an emergency medicine annual plan and quality improvement plan that aligns with the organizational strategic plan and annual planning processes. Many of these plans also are aligned with the Provincial Pay for Results program.

There are processes on an annual basis to submit requests for operating budget and capital equipment needs to support the program.

The program is in the process of reviewing its Program Council terms of reference.

Throughout the pandemic they have increased their external partnerships especially with community mental health, public health unit, safe injection sites and local city fire and police.

They have increased their partnership with Providence Care for: rehab, access to complex continuing care and seniors' mental health to support flow through the emergency department. There have been efforts to support direct admissions from the emergency department to Providence care to address patient flow.

The organization runs and 80 bed transitional care unit at Bayshore to facilitate movement of patients from the Emergency and Inpatient units to improve patient flow. Approximately 30 of those beds are restore and reactivation and 50 are allocated to ALC and long-term care. The Emergency Department infrastructure, space, congestion, and cleanliness challenged. This creates difficulty for the clinical team to perform its best.

Priority Process: Competency

Approximately 8 to 9 months ago the emergency department introduced a new model of care. The new model included a mix of RN, RPN, and nurse support assistants and patient care assistants. They have also included increasing the Ward Clerk unit on nights. This has been an important change for the organization to assist with addressing the staffing issues but more importantly informed by model changes designed to better align scope of practice with patient care needs and acuity.

At the UCC staffing is a mix between RN and RPN. They used the three factor framework just like in ED at KGH, to determine scope of practice. There is a clear understanding of scope of practice. They describe working collaboratively as a team between Physicians, RNs and RPNs when acuity increases to ensure that patient care needs are met.

Performance evaluation for unionized staff members is completed annually for non non-unionized staff is every two years. The program acknowledges they are somewhat behind us they have been responding to the global pandemic.

Physicians are orientated through on line documentation, on site tours and opportunities to participate in buddy shifts. Physicians move between UCC at the HDH and ED at KGH. Nursing staff are dedicated and hired to one site or the other and don't typically move between the two sites.

New staff benefit from individualized orientation. The clinical learning specialists engage with them to determine beyond the general orientation whether they need 12 to 24 additional buddy shifts.

There is evidence of education and monitoring of competencies with support from the Clinical Nurse

Educator for UCC at the HDH site. There is a specific file for each nursing staff member to document advanced skills and learning needs.

The team leadership is focused on supporting their teams. They meet weekly with the staff through Virtual meetings to provide updates and address issues. The leadership team is committed to focusing on Team Wellbeing. They are committed to listening better and providing incidental staff supports such as pet therapy.

The team has relationships with Queen's University and St. Lawrence College School's of Nursing to support a Clinical Extern Program. There is also engagement of students from other Allied Health Science Programs. These students assist with such care activities as ADLs and mobility supports.

Priority Process: Episode of Care

The episode of care is very well coordinated at both the ED at the Kingston General Hospital as well as the urgent care centre (UCC) at the HDH.

Patients who present by ambulance to the Kingston General Hospital (KGH) are very quickly offloaded by the emergency department team following an appropriate handoff from EMS. There is a dedicated offload nurse supported by additional funding. The offload nurse is available for periods of time throughout the day.

The emergency department at the Kingston General Hospital has access to a full array of diagnostic modalities. At the urgent care centre the team has access to the following modalities; x-ray, CT, ultrasound, portable x-ray, and you bladder scanner. Both sites fully utilize point of care ultrasound.

There is information for the general public on the Kingston Health sciences Centre external website for patients to pick the "right place at the right time". There is information on the website to guide patients to decide between presenting at the Kingston General Hospital emergency department or the urgent care centre at HDH. This is intended to prevent situations where patients and families present at the wrong location. The urgent care centre at the HDH is open from 8 AM to 8 PM with capacity to keep the unit open till 2300 if necessary depending on patient status and condition.

There are approximately 3 to 5 patients per day may require transfer from the UCC to the ED at KGH. There is a enroute program established to coordinate patient transfer between the two sites. Patients are flagged and tracked with respect to their transfer in EDIS. There is a process establish for communication of clinical handoff and transfer of care between physicians and nurses at both sites. Patients are either transferred by EMS or through non-urgent patient transfer. There is a well established and documented urgent care centre guidelines including appropriate criteria for non-urgent patient transfer services. There is a documented Medical Transport Record in place that forms a permanent part of the health record.

The teams were able to demonstrate collection of the BPMH as well as medication reconciliation.

The consistent use of two patient identifiers was observed by the surveyor.

Patient incidents are reported through the "Safe" report system. When incidents occur they are reviewed whether they are a critical incident or not. Disclosure to patients and families are completed as appropriate and recommendations for improvement are documented and followed up.

Both teams have established a process to develop integrated responsive care plans for patients who frequent either the emergency department or the UCC. These care plans are regularly updated and available online through EDIS for the care team to access. There is contact information available for the responsive case manager and information about the community agencies supporting these patients.

There is evidence of Patient Rights and Responsibilities posted in the departments at both sites.

Patients were interviewed at both the ED and the UCC consistently cite that they receive excellent care. They believe their condition, diagnostic and health information is communicated to them appropriately from the care team. They communicate the confidence they have in the organization despite experiencing longer wait times at the Kingston General Hospital.

Priority Process: Decision Support

All patients are screened through the process to determine if they are presenting with Covid symptoms. Patients presenting with potential COVID are isolated and put on IPAC precautions until they are cleared. Once they are screened they present at triage where electronic CTAS is completed. During this process their at home medications are documented.

The team uses an emergency department information system (EDIS) provided by Wellsoft. This includes infection prevention and control screening and assessment which determines if any precautions should be implemented. The UCC and ED teams use the same system so that they can access patient information irrespective of which site they are at. This is very important and supports patient information when a patient needs to be transferred from one site to another. Lab values are integrated into the EDIS and critical lab values are flagged in the system and the laboratory team will also call to the unit. Diagnostic results are accessible through the PCS system.

The EDIS enables documentation of progress notes such things as falls risk assessment and suicide assessment are included in the EDIS. the majority of ED and UCC teams document in the EDIS with the exception of paper referrals for consult.

The EDIS enables CPOE for the Professional staff and documentation by nursing staff.

There is evidence of reminders for staff in clinical areas to reinforce privacy of patient health information. There are mechanisms in place for patients to access their health record.

Priority Process: Impact on Outcomes

The emergency department at KGH and the urgent care centre at HDH have extensive data to monitor their performance across a number of metrics.

They are part of the pay for a results program which is a provincial initiative in the province of Ontario. They capture and monitor data on such metrics as EDLOS for both admitted and non-admitted patients. They also monitor time to physician initial assessment an inpatient bed. Pay For Results data is monitored weekly.

Their ambulance offload time is also monitored closely. These are just a few of the metrics available to this team. They have a SharePoint site that is accessible to leaders to complete different types of analysis.

The team monitors data to assess patient flow key metrics like number of no bad admits on a daily basis is critical to assist with identifying blockages to improve processes to affect better patient flow. The teams utilize a bed management dashboard. There are daily management team meetings to assess risks/pressures and identify daily strategies.

They also monitor safety incidents the top three categories are violence/threat, falls and medication/IV fluid. Patient incidents are reported through the "Safe" report system. When incidents occur they are reviewed whether they are a critical incident or not. Disclosure to patients and families are completed as appropriate and recommendations for improvement are documented and followed up.

Priority Process: Organ and Tissue Donation

There are well established and documented procedures for organ and tissue donation at KHSC and provincially.
The Charge Nurse in the Emergency Department is involved in identifying potential donors and connecting with the Trillium Gift of Life Network (TGLN) Coordinator. There is a TGLN coordinator dedicated to KHSC. Data is provided back to the organization from TGLN to report performance at regular intervals. The data also provides performance information from other organizations.

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

Unmet Criteria	High Priority Criteria
Priority Process: Infection Prevention and Control	
2.10 Applicable standards for food safety are followed to prevent food-borne illnesses.	!
Surveyor comments on the priority process(es)	
Priority Process: Infection Prevention and Control	

The IPAC team is a very collaborative and competent interdisciplinary team. The IPC program has been regularly reviewed and resources have been added to support this team throughout the pandemic. Some good examples include setting up a model that included team leads ensuring there were resources dedicated to IPAC and PPE audits and supporting IPAC leadership for renovation construction and redevelopment as a few examples. The team continues to reassess and re-evaluate through each wave of the Pandemic and is turning its attention to sustainability structures.

This team has been enhanced by a number of IPC professionals and benefits from significant qualified IPC physician leadership through their Medical Director role. There is an interdisciplinary committee that reviews and evaluates the structure and oversees the delivery of services.

Throughout the pandemic work has been done to create a regional hub and spoke model. This has helped to ensure that there have been consistent approaches to IPAC with the coordination of three separate Public Health Unit's as well as a number of other hospital corporations. There is an IPAC regional table to coordinate a pandemic response to new MOH directives and policies announced.

The team demonstrated documentation of patient screening process and recording keeping of patient status in the Emergency Department Information System (EDIS). IPAC has access to this system to review patients and ensure appropriate precautions are put into place. They can also monitor test results to adjust precautions, as necessary.

The team uses RL solutions surveillance software to monitor key metrics. This application is interfaced with ADT and PCS to ensure a comprehensive up to date view of all patients. This system supports surveillance on all organisms that the team tracks. They were able to access organization support from IT and Decision support to generate daily reports at Midnight to facilitate mandatory Ministry reporting.

There is excellent coordination between environmental services, facilities management and IPAC to respond to codes (floods), remediation and facilities planning. The team complies with CSA standards for design and construction. There are IPAC sign off is required at 33% 66% and 99% of project completion.

The organization has implemented a number of new policies and procedures in place to ensure correct handling of biomedical waste. They ensure that they are separating waste at the source and ensuring it is stored in compliant containers there is a dedicated refrigerator and storage area staff are trained and dangerous good certification and they have instituted new methods for safe transport biohazardous waste throughout the facility.

Along with directive 6 in the province the organization has established a COVID vaccination policy. The policy and position around mandatory Covid vaccination for staff have been integrated into their regular occupational health and immunization policy. All staff are required to be vaccinated on hire. The definition of vaccine continues to be two doses. There is demonstrated compliance with the policy including Progressive discipline for staff and suspension of privileges for professional staff.

Hand hygiene education is mandatory and is provided as part of orientation with annual recertification required through the electronic learning management system.

The Frequency of hand hygiene is now being monitored through "i auditor software". The infection control practitioners audit hand hygiene during daily rounds they also use techniques such as glow germ measures and "paint" during orientation to also observe and teach the importance of the quality of hand hygiene. The team is creatively using wall clings to post hand hygiene rates in clinical departments.

The team has recently initiated a green sticker program to indicate when equipment is cleaned it is called " Green is Clean ". There is evidence of this program in place to easily identify clean equipment and storage areas at the KGH site. The team is beginning implementation at the HDH where there was evidence of stickers in the soiled utility storerooms but not yet used on clean equipment. The team is encouraged to complete implementation of this creative initiative.

The team has close linkages to medical microbiology and is one of four labs in Ontario providing genomic sequencing.

The organization has contracted with Compass Group Canada for the management of retail, food, cleaning and portering. However, all these staff are Kingston Health Sciences Centre employees.

There is evidence of commitment to flooring upgrades at Kingston General Hospital to address issues in medical device processing department. The carpeting identified in clinical areas during the last survey at the HDH site has been removed and replaced with linoleum.

There are clear and comprehensive processes for outbreak management with a checklist initiated to ensure that all best practices are in place for outbreak management.

The team completes an annual SWOT analysis to inform their annual plan and quarterly deliverables. They have a four-year quality improvement plan visioning document. This is available to all the team on a shared file or drive and there are quarterly reviews of progress and updated.

shared file or drive and there are quarterly reviews of progress and updated.

The Director of infection prevention and Control is a member of the patient safety and quality committee.

The IPAC program engages patients and families to inform their program design. There is a patient advisory rep on the on the IPAC committee.

There is evidence of effective staff, patient, and visitor screening at all sites. The team has partnered with IT to create a screening program for staff that automates screening.

Hand Hygiene is readily available at POC. As well as CAVI wipes for cleaning equipment.

Standards Set: Inpatient Services - Direct Service Provision

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

Surveyor comments on the priority process(es)
Priority Process: Clinical Leadership
The interprofessional leadership teams of inpatient care areas demonstrate strong teamwork and a shared desire to support staff to be successful in planning and delivering high quality care. The design of service delivery care priorities, models and spaces for inpatient services is done in consideration of strategic priorities, populations needs and is uniformly co-designed with patients, staff and external care partners. Inpatient leadership teams demonstrate strong skill in collaboration, communication and engagement to optimize available internal and external resources for care and service delivery. A specific focus on external partnerships has been effective in preventing longer waitlists, managing ALC days and in enhancing patient satisfaction despite unavoidable pandemic impact. There is evidence of continuous evaluation of service delivery and associated improvement initiatives. The leadership teams are focused on employee wellness and have a number of strategies implemented to address pandemic related stressors and ongoing retention factors.
Priority Process: Competency
There is strong evidence of effective team work across inpatient services. Relatively new leadership teams demonstrate a high degree of collaboration and commitment to supporting clinical teams to provide safe and effective care. With continuous changes associated with pandemic circumstances in combination with expanding complexity in clinical services there is attention paid to interprofessional

education through formal and informal delivery models. A large number of resource materials are accessible to staff and there are targeted priorities that have been enhanced by focused interprofessional working groups that have engaged patient advisors to target meaningful improvement and educational initiatives. Individual and team recognition is pervasive across all inpatient areas. Several innovative ways to integrate meaningful ways to acknowledge others were observed as standard components of daily workflows. There is a focus on preventing and effectively managing workplace violence that includes innovative strategies to anticipate and prevent escalation of harmful behaviour in patients at risk. Teams demonstrate a high degree of clinical competence including skill and commitment to person centred care.

Priority Process: Episode of Care

Each inpatient unit demonstrates high quality, evidence based and person centred care. A pervasive focus on quality and safety is evident with clear strategies for improving organizational safety priorities (Med Rec, Pressure injury prevention, falls prevention, patient identification, hand hygiene). In addition, inpatient clinical teams are empowered and encouraged to identify unit or population specific improvement initiatives which are tracked and shared during standardized huddle board discussions. There are numerous examples of innovation with opportunities to share improvement ideas between inpatient units. There is evidence of consistent application of standardized prevention strategies for safety priorities. Visual cues and standardized communication is consistent to identify patients at risk. Patient preferences and individual care needs are top of mind for all staff and they are well documented in the health record and by using communication tools like patient white boards.

There is a universal awareness of the KHSA framework and resources for ethical decision making and staff can readily identify how and when they are used. Clinical teams are knowledgeable about and attentive to special practices and processes for palliative care, end of life and for patients choosing MAID.

There is evidence of respectful and compassionate care across all inpatient care units. Patients expressed their satisfaction with the level of information provided by the interprofessional teams and appreciation for their active engagement in developing care goals. Staff are committed to providing education to patients and families and have implemented new ways to do so during pandemic restrictions. There is evidence of innovative strategies in place to optimize independence of care with necessary supports in anticipation of successful readiness for discharge. Effective discharge planning processes are in place with a high degree of patient and family engagement. Roles accountable for coordinating internal and external resources to support patient transition from inpatient units has been defined.

Teams are engaged in clinical research as primary investigators and by supporting patient enrolment and data collection.

Priority Process: Decision Support

There are established policies and procedures for documentation within the health record and adherence to standards is monitored with a key focus on essential safety elements (e.g. medication transcription, BPMH and Med Rec). Improvement initiatives are implemented as required. Policies, procedures and

practice pertaining to privacy legislation are in place. Staff training about privacy is provided and regularly evaluated. There is a process in place for patients to access their health information that is known by staff and communicated to patients both verbally as needed through other mechanisms including the KHSA website and written information available to patients and families. The planned electronic HIS shared by 6 regional partners will greatly enhance consolidated information across care locations, improve access to patients, reduce safety risks associated with manual transcription and may free time for staff to focus on other care priorities. Staff express anticipated benefits and recognition of necessary future changes in workflows and processes to match the HIS.

Priority Process: Impact on Outcomes

Inpatient services teams are applying evidence informed protocols and care plans in consideration of unique patient differences and preferences in the context of expanding complexity and scope of services. Clinical teams are highly engaged in improvement of clinical outcomes, patient experience and safety. Standardized unit huddle boards contain current, relevant outcome indicators that are used for tracking progress on local improvement initiatives. Many improvement initiatives have been initiated by or with patient advisor input. Improvement aims are a blend of KHSA organizational priorities and departmental initiatives identified from SAFE report trends, safety event reviews, staff and patient/patient advisor insights. There is evidence of creativity and innovation within a large number of initiatives. Participation at huddles includes information sharing from education leads, IPAC and other stakeholders. The organization and teams will benefit from enhanced measurement and reporting opportunities following the implementation and optimization of the HIS.

Standards Set: Medication Management (For Surveys in 2021) - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Medication Management	
13.11 Medication storage areas are regularly inspected, and improvements are made if needed.	
Surveyor comments on the priority process(es)	
Priority Process: Medication Management	

The KHSC pharmacy department and medication management practices are led by a knowledgeable, committed leadership team and a department of over 110 team members. Oversight for policies, procedures and formulary is provided by an effective and appropriately representational committee structure in addition to defined operational role accountabilities. A few examples of very solid practices and resources to ensure safe medication management include the High Alert Drug reference guide, standardized medication rooms across both sites, and targeted improvement initiatives based on organizational strategic priorities and from SAFE report analysis. Pharmacists have a strong presence in all areas of care and are considered essential team members.

Pharmacy has led an interprofessional improvement strategy for Medication Reconciliation. A working group engaged stakeholders to identify standardized approaches and area specific approaches based on process mapping and awareness of most informed professional resources. Overall improvement has been sustained and is now monitored by the Medication Safety Committee. Because there isn't a standardized approach to BPMH and overall, Med Rec, and map of accountabilities across the organization would complement the well-planned strategy.

KHSC pharmacy has safe and effective processes for compounding hazardous sterile and non-sterile products. They have extended that service to provide chemotherapy agents to Satellite Cancer Care sites to support care closer to home while expanding cancer care capacity.
Of note the Pharmacy Practice Council has been working to expand the role of pharmacists to their full scope of practice. This initiative optimizes safety, effectiveness and efficiency of medication management and frees time for other professional team members. In addition, it may serve as an important retention and recruitment strategy in a competitive state for human health resources. The pharmacy team audits safety practices and integrates audit processes into pharmacy residency programs.

KHSC pharmacy has provided impressive regional pandemic leadership and support for both vaccine distribution/administration and now distribution of antiviral agents. Both initiatives have had significant impact on workload and equipment/storage requirements. The leadership team has been attentive to supporting staff resilience. The storage impact has resulted in a few suboptimal storage locations of

supplies in the pharmacy department. Overall, the pharmacy and medication management areas appear clean, well organized, have restricted access. They are standardized in terms of equipment and general layout. There is a plan to add Omnicell dispensing cabinets in the few remaining medication rooms where they have not yet been installed at the HDH site.

In addition to their role in supporting medication management in care areas, pharmacists are engaged in research and in navigating complexities for access to new, specialized and differently funded medications. The pharmacy team will benefit significantly with the implementation of a regional HIS. It will facilitate standardized CPOE, seamless access to patient information, standardized Med Rec, reduced workload, and enhanced safety associated with transcription. The leadership team is engaged in early planning and anticipating changes to processes and workflows.

Standards Set: Mental Health Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
2.7 The physical environment is safe, comfortable, and promotes client recovery.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The leadership team is new within Mental Health and Addiction services. Apparent is how well the team functions together even though they have been together for less than 15 months. Staff indicated prior leadership within the programming was not as supportive, with this new leadership team authentically listening to their staff, understanding the challenges, and inspiring growth professionally/personally. The Chief of Psychiatry is also new to the program, however, has made visible changes in a brief period and evident is a clear leadership dyad with the Director of the program. Both Chief/Director dyad are committed to innovation, making change, and supporting staff through the journey of program improvement.

The clinical leadership teams leverage data to guide decisions in programming and staffing levels. There is clear passion to drive improvement and make changes not only for the program but into the community. Leadership understands the gaps within the community and services that will augment positive outcomes and has pivoted to meet the emerging needs.

There is a strong partnership with universities and colleges (e.g., Queens, RMC, St. Lawrence College) to support students, as well as strong partnerships with other community agencies to assist patients discharged into the community. The program's leadership has created a novel care pathway between

school wellness program to the hospital to provide seamless transitions based on the levels of care required for students. Up to 40% of wellness centre visits in universities are issues with mental health and/or addictions. The EmPATH clinic has provided a strong bridge between intensive psychiatric care ad outpatient services. Since the program was implemented, there have been substantive increases in referrals with an average of 70-75 referrals a month. Most area seen within 48 hours, however with increasing volumes based on the success of the program, wait times are increasing. This has been made possible with the new leadership model and community outreach.

COVID presented challenges to programming throughout the waves and IPAC restrictions, however the program was able to pivot quickly and provide group programming virtually. In a brief period and ensuring all privacy requirements were met, group activities were resumed ensuring the needs of the community were met. Leaders are very aware of their staff and health human resource to ensure programming needs. COVID continues to be a challenge with increased needs in the community, and a workforce that is fatigued.

The leadership team supports innovation, research, and quality improvement within the program. There have been many examples of QI including development of clinical guidelines for patients with dementia, standardizing roles within the occupational therapy team, and improving the welcome package for all families.

As the leadership is committed to the program and evolving care to remove stigma, augment the patient care experience, and support the team to reach their fullest potential.

Priority Process: Competency

The team has focused and standardized training that suits the program well. All new hires undergo Non Violent Crisis Intervention training to ensure safe interactions with patients with a history of violence. More recently a new program was developed the 'Workplace Violence Prevention Program' which expands on the NVCI principles to ensure a safe working environment and appropriate management of patients.

There are clear guidelines on restraints (physical and chemical) as well as seclusion guidelines that uses the least amount restraint and long-term harm. The program has reached out to partners to learn and best approach management of clients/patients in crisis.

Workplace violence prevention is a priority for the team and all staff where VOCERA badges to ensure their safety. As well in their high observation areas, security is present to assist in de-escalation. All areas are only accessed through badges and risk of elopement is low.

Staff report feeling safe when providing clinical care, there are structures/processes to keep them safe and leadership support when an incident occurs.

Priority Process: Episode of Care

Over the past 18 months the organization has been actively developing new programming to address the increase in community need of services. Across various programs the rise in volumes have ranged from 10% to 100% increase. Most notably, to address some of these needs, has been the implementation of the 'nurse navigator' in the ED to assist in linking mental health patients to community resources, identify needs and reduce the Length of Stay for inpatient stays. Noted was the ED typically has 10% of their visits associated with Mental Health & Addition issues which requires different types of care to address the crisis. The nurse navigator has contributed to a reduction of time from assessment to admission, and/or linking the patient to social work services to discharge with support into the community. The impact has been positive with the implementation through the pay for results, enabling the use of funding to add additional resources to the program.

Leadership in the past two years has dedicated more staffing within the program (e.g., Nurse Practitioners, Behavioural Science Technologist) to provide more fulsome care and greater connections in the community. As the new tower is constructed through the redevelopment strategy, this will enable more beds attached to the unit to allow for Emergency Psychiatric assessment.

The program is committed to making the patient experience safe and supportive through the co-design of new space in Connell One area. Four clinical rooms within the space allows patients to feel supported, oriented, and safe while assessments/interventions are in progress. A Patient Experience Advisor (PEA) assisted in the co-design of the space to ensure the needs of the community were met.

Transitions are managed through an active handover process with community partners or programs attached to the outpatient areas. The 'Heads Up' and 'ITTP' support patients transitioning into the community. The programming has a robust staged approach (e.g., LOA) to discharge to be able to monitor success. The psychiatry and clinical team closely monitor this to ensure success in transitions.

The program since the last accreditation cycle has also implemented the OPOC survey to guide feedback and subsequent quality improvements initiatives. While the response rates are good, there is a homogeneic element of the respondents; all identify as Caucasian and English speaking. There is a focus moving forward to integrate equity, diversity, and inclusivity within programming to allow for more individuals of diverse backgrounds to participate in the surveys. As well to create safe passageways for vulnerable and equity seeking groups in the community to access services for care.

The 'Stand Up to Stigma Campaign' is an example of how the program is addressing concerns of patients and providers. The campaign is a compilation of topics using a story-telling platform to humanize the experience of 'stigma'. The topics are accessible on you-tube and are aimed to generate dialogue amongst people regarding their own beliefs and how they might be able to change their own practice. The program will continue this important work to shift the conversation in the community, hospital, and academic environments. Encouraged is that there is increased awareness across the organization or leverage other platforms (e.g., LMS) to deliver these stories to deepen understanding of stigma.

ROP's were met, however the suicide assessment has opportunity for improvement with more consistent completion of the tool to ensure proper documentation of physician notification.

There are many exciting and innovative initiatives the Mental Health program are involved in. Outlined below are a few the staff mentioned that have promise to make meaningful change.

1. Exciting for the program is the development of the Dynamic Appraisal of Situation Aggression (DASA) aimed at predicting aggression within programs. This has been piloted successfully and has been evaluated to have scalability and will have an education component in the internal LMS system for staff. Leveraging a heat map framework, this should contribute to decreasing workplace violence incidents. Encouraged is to share findings with other organizations to assist in reducing workplace injury.

2. The inpatient program has a strong strength-based service that tailors the therapy to focus on everyone's ability. There is a focused approach on the intersectionality of competency and enjoyment of activities of patients to assist them in managing their disease process. Recommended is the program evaluate the program and share with other organizations.

3. Music Therapy study that will introduce centralized music to improve the calmness for patients to reduce the number of code whites and patients exhibiting higher levels of anxiety. The research is partnered with one of the staff psychiatrists and if successful will be one of many initiatives involving music.

When asking the staff what they were most proud of what resonated very clearly was the essence of teamwork, family, and reliance on each other for support; especially during COVID. Another theme that emerged was quality improvement and innovation. The teams expressed how they enjoyed being able to try different models of care and the executive supporting the program curiosity to improve patient care. Finally expressed was the team's new leadership environment and sense of psychological safety in how they can work together and comfortably live in collaborative tension when discussing challenges in the program. While a young leadership team, evident is the trust staff have in their leadership and the collegiality amongst the leadership to improve patient care.

Priority Process: Decision Support

The program is still primarily reliant on a paper health record in their inpatient areas. KHSC is in process of adopting an electronic health record that will assist in finding information within the chart and ensuring all required activities (e.g. falls risk assessment, suicide assessments)are force functioned to reduce human error.

The charts are organized to assist the reader through sections, however for longer term patients the charts have been thinned out and would be challenging for gathering information without the additional step of requesting the chart from Health Information.

Patient care goals are clearly identified in the chart and done in partnership with patients and/or their families.

Priority Process: Impact on Outcomes

The leadership team collects metrics and information to drive programming and annual objectives. Workplace safety and behavioural incidents are closely tracked and acted upon with quality improvement initiatives.

Safety metrics are a clear priority for the program. One example is the program responding to challenges with traditional methods of gathering two client identifier using wrist bands. With the particular population not feeling safe to wear wristbands as a method of identification, KHSC reached out with CAMH to explore how their model of identification can be adapted safely within the program. This meets the needs of the program, ensures patient safety and respects the unique experiences of those admitted to service.

Standards Set: Obstetrics Services - Direct Service Provision

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

Surveyor comments on the priority process(es)
Priority Process: Clinical Leadership

The obstetrics clinical leadership team is very interdisciplinary and collaborative. They are led by a physician and administrative program director dyad. This model has been employed for around 10 years and has served the program well. The program steering committee sets goals for and objectives annually. These are aligned with the corporate goals and objects and annual plan and Quality Improvement Plan.

The Program council includes a Patient Experience advisor who participates actively to provide a patient/family perspective on such items as the external website as well as being actively involved in the design planning for the major redevelopment project.

The Program has weekly meetings to review the needs and the demands on the units. They make resource reallocation changes dependent on workload. There are annual operation and capital budgeting processes and a process to acquire equipment quickly if needed that is referred to as the "STAT Capital" process. The team often implements new initiatives as
Pilot project employing PDSA cycles to ensure that resources are deployed as efficiently and effectively as possible.

The program has developed effective partnerships with organizations such as as the Indigenous health counsel to inform program and service design. They also have established an important partnership with

Lennox and Addington General Hospital, which is 40 minutes away, the team operates a number of outpatient clinics and performs that's acute scheduled genecology and urology procedures at that site. This is an "informal" arrangement and is not a formally documented collaboration or partnership agreement.

They also collaborate with important organizations like family and children services in the community and the thrive program to support high-risk patients.

Priority Process: Competency

The Obstetrical Program has a very traditional model of care with a separate Labor and Delivery Unit from the Antepartum and Post partum unit. The team works to ensure that care delivery is seamless with comprehensive processes in place during transitions. The team looking forward to redevelopment and the opportunity to modernize care delivery with migration to an LBRP model of care. In order to support the transition the team is currently cross training all staff to be able to work and be competent in both Labour and Delivery as well as postpartum.
To date about 75 percent of staff are trained to work on both labour and delivery and post partum.

There are very comprehensive documentation and evidence of infusion pump training. New staff are training through elearning modules and subsequently there is a mandatory annual review that is completed. Staff were able to access the quick reference guide on KHSC "Knowledge Now" system.

Professional staff are credentialed under the Obstetrical Department Head. The Board grants privileges annually for the Professional staff.

Staff interviewed on the unit report that they have regular performance and cite a 2 year frequency.

In Labor and Delivery there is mandatory training and recertification every 2 years for neonatal resuscitation (NRP) and Fetal Heart Surveillance (FHS) has just recently been added.

The team does not formally participate in MOREOB training but they have developed their own in house program called OPIPS for simulation training for situations including; breach birth, prolapsed cord and shoulder distocia.

Priority Process: Episode of Care

Laboring patients present directly to the unit and are assessed and triaged based on priority. The Labor and Delivery unit is a locked unit. There are designated spaces for triage and a number of LDR rooms on the unit. Post partum patients are recovered for at least 1.5 hours and then transferred to a post partum unit.

There is evidence of appropriate clinical information documented to support transfer of care for patients moving from Labour and Delivery to Post partum and vice versa. These are paper forms that are retained

in the health record.

The unit has a mini OR suite with two C/S operating rooms. There is good signage and the potential for access is mitigated by ID swipe passes to the ORs and scrub room.

The Obstetrical Program has a very traditional model of care with a separate Labor and Delivery Unit from the Antepartum, Post partum unit. The team works to ensure that care delivery is seamless with comprehensive processes in place during transitions.

Kingston Health Sciences Center Obstetrical Program has a BMI policy and procedure in effect. This is to ensure both staff and patient safety. They use BMI to determine if a mother is a higher risk and the limit for the program is set at 50. If a mother is at BMI over 40 the mother is placed into a room with the appropriate lifting equipment.

The Program supports water deliveries with a number of rooms with birthing tubs. There was evidence of clear instructions for cleaning the tubs between patients.

Midwives are essential part of the care team as are Family Medicine physicians who still provide Obstetrics and Gynecology. There are clear consult and transfer of care guidelines to facilitate consult and transfer to specialist care.

The teams supports and works with patients and families to accommodate birth plans. Partners were welcome on the unit supported through careful screening processes.

THere is evidence of compliance with the safe surgical checklist when performing C/S. The team monitors data and performance specific to this quality and safety standard operating procedure.

All instruments and trays are sent to MDR for reprocessing and there is no flash sterilization deployed on the obstetrical unit.

There is demonstrated compliance with the collection of the BPMH and medication reconciliation. Also the surveyors observed evidence of the utilization of the falls prevention program.

There are whiteboards in all patient rooms to communicate care team members and components of the plan of care. They are used to exchange information between their patients and the team around preferences. They also clearly depict who is the support person(s) for the laboring mom.

On-call Obstetrical staff are available on the unit 24/7. Anesthesia is dedicated to the unit during the days. Evenings, nights and weekends are available through on-call services.

Priority Process: Decision Support

The obstetrical team and Program Council have good access to data to monitor performance in their program. They participate in the BORN program and monitor their performance on six KPI's relative to their peers. They monitor hand hygiene rates and are currently 90% compliant as well as infection rates post C-section. The team is very proud of their performance on this metric as they are currently the lowest in the province for infection rates post caesarean section. These are just a few of the metrics they monitor.

Data gathered from patient care is accurately documented in the health record.

During the tracer there was evidence of key documents to assist with patient transfers. In particular there is a specific GYN patient transfer report as well as in obstetrical patient transfer report this supports the flow of accurate information as patients are potentially transferred between these two units either postpartum or antepartum prior to movement to obstetrics for labour and delivery.

Priority Process: Impact on Outcomes

Women's and children's program have a complete program metric report that they monitor on a regular basis. This includes data trending for key performance indicators associated with volumes and clinical activity, patient satisfaction, financial metrics, and status of health human resources.

The team engages in the Kingston General Hospital patient and family led feedback forum. Period there is an entire guidance document to support this process including what to do in advance of the forum and after the forum with key tips for facilitators, patients, and families. This is an important mechanism to engage patients and families with the team to share experiences that will have an impact on program outcomes.

The team indicates that they have a regular process to report and review patient safety incidents. All significant incidents have a program quality review whether they are deemed a critical incident or not. The team was able to provide a specific example to demonstrate compliance.

There is evidence of a significant amount of research work in this Program to support advancing practice locally and in the field of Obstetrics.

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

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
7.2 There is a policy regarding maximum consecutive work hours.	
7.3 The policy for maximum consecutive work hours is adhered to.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	
Priority Process: Organ and Tissue Donation	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)
Priority Process: Clinical Leadership

The organ and tissue transplant program is well established. There is strong clinical and academic leadership. The governance structure supports donation and transplantation and consciously works in an ethical means to respect privacy of donors and recipients within the same organization.

Quality metrics are monitored in a collaborative transparent way with Trillium Gift of Life and KHS is recognized by Trillium for excellence in practice.

A very well informed patient advisor is engaged in quality improvement with the organ donation and transplantation program.

From a regional perspective the program exceeds provincial standards for donor consent. Significant

community work has gone into this through education, faith based community sessions, social media,

Significant work has been established for mitigating potential disappointments for families of donors and recipients when the donation is unable to proceed.

Celebrating success is well done in a respectful manner.

Priority Process: Competency

There is a significant educational support for organ and tissue donation and recipient management.

A policy on maximum work hours was absent.

Priority Process: Episode of Care

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Priority Process: Decision Support

All standards are met

Priority Process: Impact on Outcomes

Multiple patient focussed quality initiatives have been implemented.

The regional rate for enrolment through the Ministry to consent fro donation is at 50 percent, much higher than the provincial av rage of 35%. Significant common city engagement has occurred through multiple platforms including social media have facilitated this important change and outcome. In addition faith and culture sensitive education sessions were held.

Priority Process: Organ and Tissue Donation

Evidence exists to meet all criteria

Standards Set: Organ and Tissue Transplant Standards - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Organ and Tissue 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: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
18.4 Clients are able to access information in their records, including electronic medical/health records, in a routine, client-centred, and timely way.	
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 and Tissue Transplant

Evidence is provided for all standards

Priority Process: Clinical Leadership

Evidence is provided to meet all of these standards.

Significant work has been established and process implemented to facilitate growth of the live donor program.

Priority Process: Competency

All standards are met

Priority Process: Episode of Care

Evidence supports meeting all of these standards.

Priority Process: Decision Support

Multiple initiatives have been implemented for improving living donor procedure. The Access to Kidney Transplant program is an example of an initiative introduced at KHSC to improve upon its current successes.

Priority Process: Impact on Outcomes

Evidence supports meeting all of these standards

Standards Set: Organ Donation Standards for Living Donors - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Living Organ Donation	
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: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
18.7 Clients are able to access information in their records, including electronic medical/health records, in a routine, client-centred, and timely way.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Living Organ Donation

Evidence supports these standards

Priority Process: Clinical Leadership

Evidence supports all these standards

Priority Process: Competency

Evidence supports meeting all standards

Priority Process: Episode of Care

Evidence supports these standards

Priority Process: Decision Support

All standards are met.

Priority Process: Impact on Outcomes

All standards are met

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

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
21.4 Clients are able to access information in their records, including electronic medical/health records, in a routine, client-centred, and timely way.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	
Priority Process: Medication Management	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Kingston General Hospital operating room is clearly in need of major plant upgrade with a new build planned within 8 years. Significant work has been implemented to facilitate modern procedural care including a new hybrid OR and an OR utilizing robotics. Robotic surgery is clearly a patient focussed initiative resulting in expansion of minimally invasive surgery. Patients are home faster with fewer complication.

The Perioperative program is highly integrated and engaged with regional partners to facilitate use of community hospital operating resources for traditional tertiary care procedures. As an example minor spine surgery is now being performed in Smith Falls.

Exceptional work has been done to improve the culture of safety and respect in the operating room

environment. Identifying inappropriate behaviour with an "If you permit you promote" theme is foundational for providing a safe environment and supports quality of care. The refreshing acknowledgement that culture must be corrected in order to retain medical staff is appropriate. Implementation of cultural changes to improve the environment for new recruits is ongoing. The principle of refreshing the environment first as a retention strategy for both new recruits and educators of new staff is being trialed.

The patients are cared for in a compassionate manner. Staff are engaged in safe process to identify the patients personal and medical needs.

The nursing, surgery, and anesthesia clinicians communicate well in care transitions. There is clear evidence of collaboration with community partners to help meet patient needs through the expansion of services ices to other regional centres or private clinics.

The medical team has developed a multi disciplinary perioperative quality committe and has engaged in multiple projects including surgical site infection rates, skin preps, transfusion rates, start times, musculoskeletal injuries in staff, hand hygiene, and wardrobe audits.

Priority Process: Competency

Exceptional work has been done to improve the culture of safety and respect in the operating room environment. Identifying inappropriate behaviour with an "If you permit you promote" theme is foundational for providing a safe environment and supports quality of care. The refreshing acknowledgement that culture must be corrected in order to retain medical staff is appropriate.

Priority Process: Episode of Care

The patients are cared for in a compassionate manner. Staff are engaged in safe process to identify the patients personal and medical needs.

The nursing, surgery, and anesthesia clinicians communicate well in care transitions. There is clear evidence of collaboration with community partners to help meet patient needs through the expansion of services ices to other regional centres or private clinics.

The medical team has developed a multi disciplinary perioperative quality committe and has engaged in multiple projects including surgical site infection rates, skin preps, transfusion rates, start times, musculoskeletal injuries in staff, hand hygiene, and wardrobe audits.

Priority Process: Decision Support

In patients can review there own record if a staff person is present to review it with them. No web access is available. A new health information system to be installed in 2 years should correct this issue.

Priority Process: Impact on Outcomes

A quality committee has been established and partnerships with NSQIP and ERAS are established. There is a culture of change towards more minimally invasive procedures associated with better outcomes.

Priority Process: Medication Management

All of these standards are clearly met

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

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

The organization has met all criteria for this priority process.

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

The Point of Care Testing (POCT) program is well developed and integrated into clinical practice. Laboratory staff have a breadth of knowledge and expertise regarding Point of Care testing.

Oversight of the POCT is appropriate. A quality management/improvement program has been initiated. There is an interdisciplinary committee in place to oversee this program and ensure improvements. Standard operating procedures are in place. The organization has written procedures to store, handle, clean, and disinfect POCT equipment.

POCT is in place for glucose, blood gases, urinalysis as well as some other additional testing. Staff performing POCT receive appropriate training. Documentation of orders and test results is appropriate, and staff are aware of associated practices. Informed consent and positive patient identification are completed.

Procurement and inventory control is formalized. Reporting is appropriate. The ability to integrate results from POCT for glucose meter devices into the electronic patient record is in place. Integration is not available for all POCT and this should be considered in future to improve safety and efficiency.

Overall, this is a well-managed program that is overseen by a dedicated and knowledgeable group.

Standards Set: Transfusion Services - Direct Service Provision

Unmet Criteria	High Priority Criteria

Priority Process: Episode of Care

The organization has met all criteria for this priority process.

Priority Process: Transfusion Services

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Episode of Care

See transfusion services comments

Priority Process: Transfusion Services

Transfusion laboratory staff have a breadth of knowledge and expertise. The team collects information about the demand for transfusion services including service volumes, wait times, client perspectives, and trends in service needs. A Transfusion Committee is in place and meets regularly.

Staff are aware of policies and procedures. A quality assurance system is in place with various planned activities that provide confidence that all procedures/processes that influence quality are monitored to ensure they are working as expected. Quality control is adequate. An orientation program is established for new staff. A formal program to maintain team members' competence is evident.

Transport of units is appropriate. Nursing staff appear knowledgeable in policies, procedures and processes related to transfusion. Two patient identifiers were consistently utilized. The process to verify units of blood on the nursing floor prior to administration includes independent reviews by two clinical staff.

Procedures to identify and monitor system problems, biologic product deviations, recipient adverse reactions, and to ensure that adequate corrective action is implemented are in place. Look back procedures are in place and record handling is appropriate. The laboratory has processes for identification, evaluation, and documentation of adverse events and follow up action

The laboratory has appropriate linkages in place with the Canadian Blood Services and regional partners for the provision of blood bank needs.

Instrument Results

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

Governance Functioning Tool (2016)

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

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

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

- Data collection period: April 20, 2021 to May 8, 2021
- Number of responses: 19

Governance Functioning Tool Results

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1. We regularly review and ensure compliance with applicable laws, legislation, and regulations.	0	0	100	95
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	0	0	100	96
3. Subcommittees need better defined roles and responsibilities.	84	5	11	75
4. As a governing body, we do not become directly involved in management issues.	5	11	84	88
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	94

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
6. Our meetings are held frequently enough to make sure we are able to make timely decisions.	16	5	79	96
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	0	100	95
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	0	16	84	92
9. Our governance processes need to better ensure that everyone participates in decision making.	63	11	26	69
10. The composition of our governing body contributes to strong governance and leadership performance.	0	5	95	92
11. Individual members ask for and listen to one another's ideas and input.	0	0	100	95
12. Our ongoing education and professional development is encouraged.	5	0	95	84
13. Working relationships among individual members are positive.	0	5	95	96
14. We have a process to set bylaws and corporate policies.	0	0	100	94
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	97
16. We benchmark our performance against other similar organizations and/or national standards.	11	5	84	74
17. Contributions of individual members are reviewed regularly.	0	11	89	63
18. As a team, we regularly review how we function together and how our governance processes could be improved.	0	21	79	78
19. There is a process for improving individual effectiveness when non-performance is an issue.	0	33	67	59

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	5	21	74	78
21. As individual members, we need better feedback about our contribution to the governing body.	53	5	42	45
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	0	0	100	77
23. As a governing body, we oversee the development of the organization's strategic plan.	0	5	95	95
24. As a governing body, we hear stories about clients who experienced harm during care.	0	0	100	76
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	0	0	100	89
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	5	5	89	88
27. We lack explicit criteria to recruit and select new members.	89	11	0	80
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	0	21	79	89
29. The composition of our governing body allows us to meet stakeholder and community needs.	0	5	95	90
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	0	6	94	92
31. We review our own structure, including size and subcommittee structure.	0	0	100	88
32. We have a process to elect or appoint our chair.	0	0	100	92
33. Patient safety	6	22	72	83
34. Quality of care	6	6	89	85

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2021 and agreed with the instrument items.

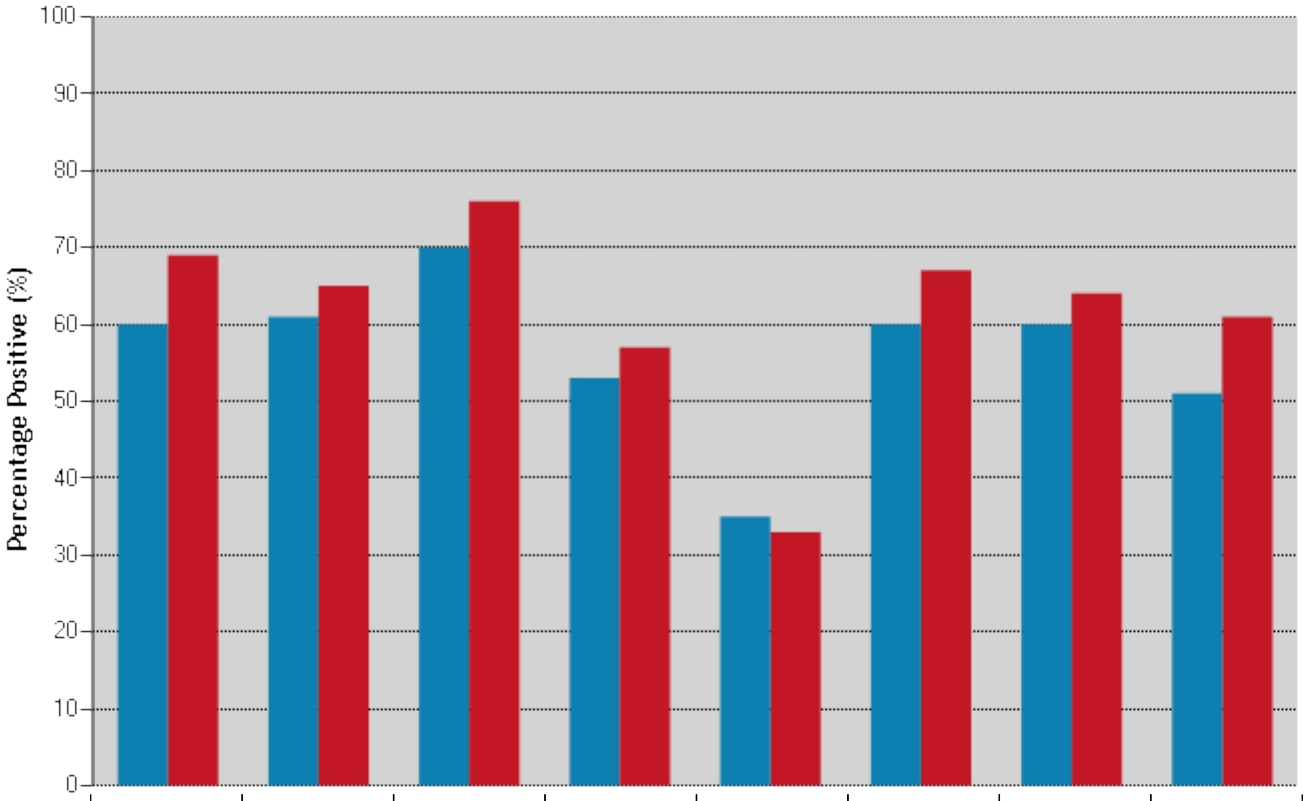
Canadian Patient Safety Culture Survey Tool

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

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

- Data collection period: October 26, 2020 to November 15, 2020
- Minimum responses rate (based on the number of eligible employees): 352
- Number of responses: 720

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



	Organizational (senior) leadership support for safety	Supervisory leadership for safety	Unit learning culture	Enabling Open Communication I: judgment-free environment	Enabling Open Communication II: job repercussions of error	Incident follow up	Stand-alone items	Overall Perceptions of Client Safety
	60%	61%	70%	53%	35%	60%	60%	51%
	69%	65%	76%	57%	33%	67%	64%	61%

Legend

Kingston Health Sciences Centre

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2021 and agreed with the instrument items.

Worklife Pulse

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

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

The organization used an approved substitute tool for measuring the quality of worklife. The organization has provided Accreditation Canada with results from its substitute tool and had the opportunity to identify strengths and address areas for improvement.

Client Experience Tool

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

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

> Respecting client values, expressed needs and preferences, including respecting client rights, cultural values, and preferences; ensuring informed consent and shared decision-making; and encouraging active participation in care planning and service delivery.
>
> Sharing information, communication, and education, including providing the information that people want, ensuring open and transparent communication, and educating clients and their families about the health issues.
>
> Coordinating and integrating services across boundaries, including accessing services, providing continuous service across the continuum, and preparing clients for discharge or transition.
>
> Enhancing quality of life in the care environment and in activities of daily living, including providing physical comfort, pain management, and emotional and spiritual support and counselling.

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

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

Appendix A - Qmentum

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

As part of the Qmentum accreditation process, client organizations complete self-assessment questionnaires, submit performance measure data, and undergo an on-site survey during which trained peer surveyors assess their services against national standards. The surveyor team provides preliminary results to the organization at the end of the on-site survey. Accreditation Canada reviews these results and issues the Accreditation Report within 15 business days.

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

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

Action Planning

Following the on-site survey, the organization uses the information in its Accreditation Report and Quality Performance Roadmap to develop action plans to address areas identified as needing improvement.

Appendix B - Priority Processes

Priority processes associated with system-wide standards

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

Priority processes associated with population-specific standards

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

Priority processes associated with service excellence standards

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

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