ACCREDITATION
AGRÉMENT
CANADA
Qmentum

Accreditation Report

Kingston Health Sciences Centre

Kingston, ON

On-site survey dates: April 22, 2018 - April 27, 2018

Report issued: September 21, 2018

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 2018. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

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

Confidentiality

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

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

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

A Message from Accreditation Canada

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

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

Your Client Engagement Lead 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 (Report)

The organization has succeeded in meeting the fundamental requirements of the accreditation program.

About the On-site Survey

- **On-site survey dates: April 22, 2018 to April 27, 2018**

- **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 Hospital Site
  2. Kingston General Hospital Site

- **Standards**

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

  System-Wide Standards

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

  Service Excellence Standards

  5. Ambulatory Care Services - Service Excellence Standards
  6. Biomedical Laboratory Services - Service Excellence Standards
  7. Cancer Care - 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. Mental Health Services - Service Excellence Standards
  13. Obstetrics Services - Service Excellence Standards
  14. Organ and Tissue Donation Standards for Deceased Donors - Service Excellence Standards
  15. Organ and Tissue Transplant Standards - Service Excellence Standards
  16. Organ Donation Standards for Living Donors - Service Excellence Standards
  17. Perioperative Services and Invasive Procedures - Service Excellence Standards
  18. Rehabilitation Services - Service Excellence Standards
  19. Reprocessing of Reusable Medical Devices - Service Excellence Standards

- **Instruments**

  The organization administered:

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

Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
 Population Focus (Work with my community to anticipate and meet our needs)	55	2	0	57
 Accessibility (Give me timely and equitable services)	114	1	1	116
 Safety (Keep me safe)	728	15	11	754
 Worklife (Take care of those who take care of me)	164	4	0	168
 Client-centred Services (Partner with me and my family in our care)	538	11	1	550
 Continuity (Coordinate my care across the continuum)	106	1	0	107
 Appropriateness (Do the right thing to achieve the best results)	1148	22	3	1173
 Efficiency (Make the best use of resources)	84	1	0	85
Total	**2937**	**57**	**16**	**3010**

Overview by Standards

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

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

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

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

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	50 (100.0%)	0 (0.0%)	0	36 (100.0%)	0 (0.0%)	0	86 (100.0%)	0 (0.0%)	0
Leadership	49 (98.0%)	1 (2.0%)	0	96 (100.0%)	0 (0.0%)	0	145 (99.3%)	1 (0.7%)	0
Infection Prevention and Control Standards	36 (90.0%)	4 (10.0%)	0	29 (100.0%)	0 (0.0%)	2	65 (94.2%)	4 (5.8%)	2
Medication Management Standards	73 (100.0%)	0 (0.0%)	5	63 (100.0%)	0 (0.0%)	1	136 (100.0%)	0 (0.0%)	6
Ambulatory Care Services	44 (95.7%)	2 (4.3%)	0	76 (97.4%)	2 (2.6%)	0	120 (96.8%)	4 (3.2%)	0
Biomedical Laboratory Services	71 (100.0%)	0 (0.0%)	0	105 (100.0%)	0 (0.0%)	0	176 (100.0%)	0 (0.0%)	0
Cancer Care	101 (100.0%)	0 (0.0%)	0	128 (100.0%)	0 (0.0%)	0	229 (100.0%)	0 (0.0%)	0
Critical Care Services	59 (98.3%)	1 (1.7%)	0	104 (99.0%)	1 (1.0%)	0	163 (98.8%)	2 (1.2%)	0

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Diagnostic Imaging Services	65 (97.0%)	2 (3.0%)	0	69 (100.0%)	0 (0.0%)	0	134 (98.5%)	2 (1.5%)	0
Emergency Department	69 (97.2%)	2 (2.8%)	0	105 (99.1%)	1 (0.9%)	1	174 (98.3%)	3 (1.7%)	1
Inpatient Services	56 (93.3%)	4 (6.7%)	0	79 (92.9%)	6 (7.1%)	0	135 (93.1%)	10 (6.9%)	0
Mental Health Services	48 (96.0%)	2 (4.0%)	0	91 (98.9%)	1 (1.1%)	0	139 (97.9%)	3 (2.1%)	0
Obstetrics Services	70 (95.9%)	3 (4.1%)	0	87 (98.9%)	1 (1.1%)	0	157 (97.5%)	4 (2.5%)	0
Organ and Tissue Donation Standards for Deceased Donors	54 (100.0%)	0 (0.0%)	0	95 (100.0%)	0 (0.0%)	1	149 (100.0%)	0 (0.0%)	1
Organ and Tissue Transplant Standards	86 (100.0%)	0 (0.0%)	1	118 (100.0%)	0 (0.0%)	0	204 (100.0%)	0 (0.0%)	1
Organ Donation Standards for Living Donors	66 (100.0%)	0 (0.0%)	0	117 (100.0%)	0 (0.0%)	0	183 (100.0%)	0 (0.0%)	0
Perioperative Services and Invasive Procedures	109 (94.8%)	6 (5.2%)	0	102 (93.6%)	7 (6.4%)	0	211 (94.2%)	13 (5.8%)	0
Rehabilitation Services	44 (97.8%)	1 (2.2%)	0	80 (100.0%)	0 (0.0%)	0	124 (99.2%)	1 (0.8%)	0
Reprocessing of Reusable Medical Devices	81 (93.1%)	6 (6.9%)	1	38 (95.0%)	2 (5.0%)	0	119 (93.7%)	8 (6.3%)	1
Total	**1231 (97.3%)**	34 (2.7%)	7	1618 (98.7%)	21 (1.3%)	5	2849 (98.1%)	55 (1.9%)	12

* Does not includes ROP (Required Organizational Practices)

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)	Unmet	0 of 1	0 of 0
Client Identification (Rehabilitation 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 (Critical Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Emergency Department)	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 (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
Information transfer at care transitions (Rehabilitation Services)	Met	4 of 4	1 of 1
Medication reconciliation as a strategic priority (Leadership)	Met	4 of 4	2 of 2
Medication reconciliation at care transitions (Ambulatory Care Services)	Met	7 of 7	0 of 0
Medication reconciliation at care transitions (Cancer Care)	Met	12 of 12	0 of 0
Medication reconciliation at care transitions (Critical Care Services)	Met	5 of 5	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Emergency Department)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Inpatient Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Mental Health Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures)	Met	8 of 8	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
Safe Surgery Checklist (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
The “Do Not Use” list of abbreviations (Medication Management Standards)	Met	4 of 4	3 of 3

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management Standards)	Met	4 of 4	1 of 1
Concentrated Electrolytes (Medication Management Standards)	Met	3 of 3	0 of 0
Heparin Safety (Medication Management Standards)	Met	4 of 4	0 of 0
High-Alert Medications (Medication Management Standards)	Met	5 of 5	3 of 3
Infusion Pumps Training (Ambulatory Care Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (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
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

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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Ambulatory Care Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Cancer Care)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Critical Care Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Diagnostic Imaging Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Emergency Department)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Inpatient Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Mental Health Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Obstetrics Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Organ and Tissue Transplant Standards)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Organ Donation Standards for Living Donors)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Rehabilitation Services)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Pressure Ulcer Prevention (Cancer Care)	Met	3 of 3	2 of 2
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 (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 (KHSC) has a new board configuration as the result of the merger of two legacy organizations. The merger was complicated by the nature of the organizations, as one has strong religious roots and the other is more pluralistic. It is evident from discussions with the governance and leadership teams that the philosophy of both legacy organizations has been well respected. The voluntary nature of the merger is evidence of the mutual respect the legacy organizations have for each other.

Discussions with community partners show that KHSC is respected and seen as a leader in the Local Health Integration Network (LHIN). The partners are very supportive of KHSC and grateful for its ongoing support. They gave many examples where KHSC provides leadership, such as with regard to the spring surge in patients.

Leadership is engaged and working toward prioritizing the work necessary to complete the merger. It is important to recognize that the organization is in a significant transition and many processes are new, having been in place less than a year. Reporting relationships are clear and well understood and the working relationship with the board appears to be excellent.

The human resource plan has good alignment with the proposed strategic plan. The merger is a time of much uncertainty for staff and this was recognized by the leadership team early on. The human capital team developed a purposeful focus on trust and communication through the pre- and post-merger period. Change management is all about communication, and not only did the human capital team develop a communication plan but they validated it with staff. This was confirmed by discussions with staff.

KHSC provides a broad range of services. It partners with hospitals in Ottawa and Toronto to provide tertiary and quaternary level care that it is not able to provide. KHSC provides service to Kingston and also is a tertiary care resource to a large part of eastern Ontario, as far north as Hudson Bay. Patients who were interviewed had been transferred in or were being prepared for repatriation to hospitals in smaller regional centres.

Patients are uniformly happy with their care. They feel they have good nursing care and attentive medical staff. Their questions are answered and they are treated with respect. All are aware of their plan of treatment. The only consistent theme for constructive feedback is the poor quality of the food.

There is good collegiality with teams and they all seem to work well together and support each other.

There is a good organ and tissue donation program and KHSC has initiated multiple initiatives to support donor families and the acute care teams supporting transplant. A tree populated in recognition of donors is displayed near the critical care area.

There is good evidence of engagement of families in the care of the critically ill. The critical care team has initiated a quality improvement process that includes family participation in the transfer of accountability between teams at sign over. This initiative addresses continuity of information transfer and care and is clearly family centred.

KHSC is in the early stages of developing a quality end-of-life policy and procedure. The organization is encouraged to continue this process to clarify how to define capacity. There is also a need to formalize the substitute decision making process. Some steps have been taken in this regard and KHSC is encouraged to continue the process. It is clear that the team has the skill set to take this on successfully.

There is little signage on or promotion of hand hygiene. Handwashing results are not openly displayed. In the operating room, health care workers were observed coming and going without washing. The laboratory area at the Hotel Dieu Hospital (HDH) is not ergonomically set up to maintain universal precautions or appropriate hand hygiene. Blood draws without gloves is the accepted norm and handwashing does not follow best practice. KHSC is encouraged to revisit its infection prevention and control policies and develop a plan to address these issues.

There is a strong focus on patient- and family-centred care on the clinical and support teams. This was validated in discussions with the patient engagement group, where support for KHSC is palpable. Patient advisors are engaged, knowledgeable, committed, and proud of their work.

Detailed Required Organizational Practices

Each ROP is associated with one of the following patient safety goal areas: safety culture, communication, medication use, worklife/workforce, infection control, or risk assessment.

This table shows each unmet ROP, the associated patient safety goal, and the set of standards where it appears.

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Communication	
Client Identification Working in partnership with clients and families, at least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them.	· Perioperative Services and Invasive Procedures 12.3
Patient Safety Goal Area: Infection Control	
Hand-Hygiene Compliance Compliance with accepted hand-hygiene practices is measured.	· Infection Prevention and Control Standards 8.6

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)
In the midst of a complex voluntary merger the board and leadership team are commended for their participation in the accreditation process. The board and leadership team have done a remarkable job continuing the leadership of the legacy organizations while moving to a fully integrated organization. The board is commended for its commitment to governance development and education. The board has a formal work plan that is monitored regularly and reviewed annually. Community partners identify a sense of a positive change in culture within the organization and they welcome more outreach into the community. They recognize the excellent level of support and strong partnership with KHSC. They also recognize KHSC's focus on quality and are very supportive of these efforts. They encourage KHSC to look at improvements in discharge summaries, adoption of a fully electronic record, and the timeliness of data sharing.

Priority Process: Planning and Service Design

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization used an extensive process to engage stakeholders in developing the values statement. An excellent communication plan was used throughout the planning process, including the development of the mission statement. The organization is encouraged to continue this process once the plan is approved.

The organization is commended for using advisors extensively throughout the organization.

It is recognized that the organization is in transition. It is encouraged to merge policies from the legacy organizations on the rights and responsibilities of patients, when it is reasonably possible.

The organization is in the process of approving a new vision and strategic plan that are in keeping with the legacy organizations while reflecting the newly merged organization. This is noted with approval.

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)

KHSC is commended for identifying merger savings and reinvesting in priority areas. The new operating budget process is a distributed model and appears to be sound.

A Strategic Operations Committee is now being used to formulate the operating budget.

Operational savings have been used to fund increases in the capital budget.

KHSC uses a criteria-based capital budget process to prioritize equipment purchases in keeping with strategic priorities.

Budgeting for occupancy pressures is identified as an area to improve.

There are two payroll systems and two patient billing systems. KHSC is encouraged to move to one system for each of these.

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 conducts extensive annual health and safety audits and uses the results to develop quality improvement plans to address predetermined areas of focus.

There is good alignment with the proposed strategic plan.

There was a purposeful pre- and post-merger focus on trust and communication, with a consistent theme of communication and transparency. Town hall meetings were used successfully and these were followed by written communication in an effort to promote transparency.

The organization is commended for developing a human resource principles document for non-union staff, in the event that there is a change in employment.

The organization recognizes the importance of personal development plans and the value of providing employees with feedback on a regular basis. However, personal development plans are about 50 percent complete and it is very important to provide staff with more regular feedback.

While there is an immunization policy and associated procedures, the immunization rate remains low. The organization is encouraged to look at opportunities to increase the rate.

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 organization is well resourced with respect to quality improvement. It is encouraged to disseminate risk management approach and contingency plans organization-wide.

The organization is encouraged to complete the harmonization of the patient safety incident management system and the medication reconciliation policy and process.

The team identifies that more work needs to be done to review and update the disclosure policy.

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)

This is a very engaged team.

KHSC is commended for providing support for ethical decision making. There is very good ethical review of research projects.

The organization is encouraged to proceed with the incorporation of patients or families in the ethical review process.

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)

KHSC is commended for its comprehensive communication approaches to day-to-day operations, supporting initiatives, outreach to the community, and proactive engagement of staff, physicians, volunteers, and the public regarding integration.

The organization demonstrates evidence of compliance with privacy legislation including the Personal Health Information Protection Act. Reports on privacy and freedom of information are made regularly to the senior leadership team and board. Robust systems are in place to protect the organization from cybersecurity threats.

KHSC uses multiple methods to share information with staff, physicians, and volunteers internally through CEO town hall meetings, the Leaders Forum with communication tools to disseminate information, a robust intranet, and a weekly online news blast. Communications team members are part of all significant organizational initiatives from the outset to help plan appropriate and effective communications strategies to engage and inform stakeholders.

Communication with physicians is centrally coordinated through the chief of staff.

Technology is leveraged wherever possible to support communication efforts. KHSC also uses multiple social media channels to communicate externally. Communication integration efforts are made regionally through a forum for the six hospitals across the LHIN. Throughout the strategic planning process, multiple methods were used at various times to engage stakeholders and ensure input.

Priority Process: Physical Environment

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

There is a maintenance division at each facility that benefits from open communication and resource sharing. The maintenance staff are very knowledgeable and committed to what they do.

Kingston General Hospital (KGH) has completed several facilities initiatives since the last accreditation on-site survey in 2012, including isolation rooms in the emergency department (ED), changes in the neonatal intensive care unit to include the sink areas such as countertops and hands-free faucets, fridges added at each care space, and improved flow of clean and dirty materials, to note a few. It is apparent throughout the facility where flooring has been replaced, like in the obstetrical unit.

HDH has also updated equipment and completed initiatives such as upgrading the ambulatory care clinics which included two 20-room clinics, developing urgent care, revamping and expanding the front entrance, and adding a backup generator. Patient advisors were involved in the revamp of the front entrance. HDH requires a new operating room air handling unit.

The Brockview Café at HDH provides food service for patients in the peri-anesthesia care unit. The millwork is in a state of disrepair and needs to be replaced to provide sanitary conditions for meal preparation. The corkboards need to be removed as they do not meet infection control standards. In addition, the carpet in the peri-anesthesia care unit needs to be removed, to permit enhanced cleaning of the patient care environment and reduce the risk of infection.

Both hospitals have very good preventive maintenance programs.

Representatives on the accessibility committees include patient advisors. HDH has a number of bariatric-accessible spaces, and bariatric chairs are available in waiting rooms and in exam offices for patients' comfort and safety.

There is awareness and understanding of regulations and laws. The facilities work closely with the Ministry of Health and Long-Term Care to ensure they comply with facility standards and regulations.

Strong maintenance programs are well supported with expert resources. Staff education and training is provided. The organization is working toward doing as much on-site maintenance as possible to ensure systems are available.

The buildings are old and some are historic, but most areas at both facilities appear well maintained and clean. The clinical areas at the HDH for the most part are uncluttered.

There is some concern regarding the ED at KGH, as there are patients in the corridors, equipment everywhere, and worn floors that do not appear to be clean. The laboratories are small, cluttered, and pose a risk to staff doing their work. The organization has tried to do what it can to implement technology to accommodate these limited spaces.

Phase 2 redevelopment at KGH is expected to address many of the infrastructure issues. There are five-, ten-, fifteen-, and twenty-year plans for HDH.

Security services are visible and appropriately involved in many of the organization's activities throughout the facility. Staff at KGH use Vocera voice-activated communication that also acts as a safety device to call security. Areas with restricted access are well marked and security services assigns limitations on staff and physician identity cards. Unnecessary access is monitored and tracked. There are surveillance cameras throughout the facility.

Maintenance activities are very sensitive to patient care. They collaborate regularly with the infection control staff to limit patient and staff exposure to dust, fumes, or other contaminants. All construction follows the guidelines to maintain patient, staff, and visitor safety.

Waste disposal is satisfactory and the facilities have a strong relationship with an external contractor that provides incineration services and disposal. The facilities are part of the Greening Health Care coalition and are engaged in several initiatives to protect the environment.

An energy retrofit at KGH in 2012 resulted in considerable savings.

An environmental sustainability coordinator was hired at KGH to address areas where efficiencies may be realized, including heat, power, waste recycling, and water, to note a few.

The physical plant is supported by an electronic preventive maintenance program that includes the maintenance of technical and plant equipment, beds, and overall facility operations.

An initiative at KGH includes vents and duct care where an external vendor uses robots to inspect the duct work on a regular basis. This reduces the frequency of replacing microbic (HEPA) filters that are very expensive.

A new air handling system was implemented in 2017 at KGH to service four operating rooms.

All rooms where surgical and invasive procedures occur have 20 air exchanges per hour. The operating rooms, isolation rooms, and fume hoods are monitored by an external company for adequate air exchanges and are meeting the requirements.

The physical plants include sufficient backup systems to support electrical, water, and heat failures. There are two backup generators at both facilities that respond to failure in less than ten seconds.

The plant systems are a blend of old and new, but all are monitored and maintained to enhance life expectancy.

Housekeeping, laundry, and dietary staff are well informed on workplace hazardous materials information systems (WHMIS), infection prevention and control activities, and adverse event reporting. Management for these services is privately contracted and managed through Compass.

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)

Protection services has been in place at both facilities since 2006 and is responsible for emergency preparedness planning as well as security. The members from protection services are knowledgeable, committed, and possess a broad array of expertise.

The Joint Emergency Preparedness Committee has representatives from KGH and HDH. The committee includes representatives from protection services, leadership, the unions, and staff.

The KHSC emergency preparedness plans are up to date and extremely well developed as a result of hazard analyses and actual incidents. There are many examples of exercises and actual events and debriefings. For example, the hospitals participated in a multi-truck accident in 2017 that involved a chemical spill on the 401. That experience led to protection services doing presentations to other groups on what they learned. This is a good example of an integrated effort to ensure patients receive expert and timely care.

The organization uses an all-hazards approach to emergencies. Evacuation exercises occur annually. KGH is a 24/7 operation and the evacuation is a horizontal move directed by the Kingston fire department. Med sleds are available at KGH for transport from the operating room should an evacuation be necessary. HDH is not normally an overnight operation but does participate regularly in code drills.

Live fire drills occur monthly at both sites, with documentation and debriefing. The drills focus on the patient care areas. All patient care areas have sprinkler systems. Silent drills are carried out during the night at KGH, to ensure all staff participate and know what to do in the event of a fire. REACT is used and staff know what it is and how to use it as a result of their training.

Education about preparedness is delivered via e-learning. Fire safety in-services are held. These are mandatory for all staff and are supported in their performance review. Staff are assigned emergency code modules to be completed annually as part of their performance development.

The hospitals collaborate with a broad range of stakeholders when planning and exercising the emergency plans. Code red and green are tested frequently. Exercises for code brown, orange, yellow, and black have been completed.

In compliance with the Ontario Fire Code, the annual fire inspection at KGH by the Kingston Fire and Rescue began on March 1. It takes about two months and identifies fire code violations. Recommendations have to be addressed to remain compliant with the standards. Work is being done on the fire system at HDH.

Recognition is given to the implementation of the “call-em-all system" (VOIP) call-back system at KGH. This approach is monitored and tracked for response time and numbers. HDH has a newly implemented call system that can be used for codes and emergency assists.

At its last on-site survey on 2012, KGH was encouraged to undertake regular re-certification for all executives to complete emergency operations centre (EOC) training, to ensure they understand their roles and the role of the EOC during an incident. The executive team are now receiving education and training around emergency planning.

Staff at both sites know to dial 4444 for emergency codes, which goes to the switchboard. The organization and committee have worked to standardize what they can as a number of staff go between the sites.

There is a strong connection and partnership between the organization and the municipality for emergency planning and exercises, including the mayor and council, the fire department, the police, and emergency medical services. Having the director of protection services sit on the committee has helped build stronger community collaboration.

The work that has been done by protection services in conjunction with the Joint Emergency Preparedness Committee is very impressive and training and presentations are provided for staff and the community. There is an excellent working knowledge of what to do in the event of an emergency.

There is good collaboration between the two sites when incidents occur. Efforts are made to prevent overload on one site by maximizing resources and to ensure emergency is always available to those who require the service.

A debrief is done following an event that impacts both facilities, with additional debriefs for the teams that are most impacted.

Priority Process: People-Centred Care

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

Unmet Criteria	High Priority Criteria
Standards Set: Ambulatory Care Services	
1.7 Barriers that may limit clients, families, service providers, and referring organizations from accessing services are identified and removed where possible, with input from clients and families.	

Surveyor comments on the priority process(es)

The client- and family-centred team feel included in the organization. Members feel that their concerns have had an impact on decisions at KHSC, although they express that communications with KHSC could be improved and they are frustrated with the lack of movement on signage recommendations.

The team feels that patient advisors are used at all levels of the organization.

Parking is inconsistently applied. This was confirmed by the client engagement team.

There is insufficient signage in the eye clinic to guide visually impaired clients.

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 has been a remarkable improvement in and focus on patient flow, due to a concerted effort at all levels of the organization at both sites. Despite increased activity in the ED, flu season, and an increase in patient acuity and complex discharge planning, the team decreased ED wait times significantly, from 49 to 26.5 hours, and reached an 853-bed saved in four months. This was an interdisciplinary achievement driven by reviewing monthly data at the ED Program Council and listening to patient advisors, patients, medical leaders, internal and external stakeholders, LHINs, and staff on how to set and reach this goal.

An admission transfer unit and section F were created in the ED to increase capacity and assist with fast-tracking patients (CTAS 4 and 5) and flow. A corporate huddle is held daily at 9:45 to identify system barriers, and work is done on discharge planning as a team at both sites. Having dedicated patient flow coordinators who manage direct admits to medicine and directing bilirubin follow-up for neonates directly to the ward have also decreased pressure on the ED.

Nurse practitioners focus on managing fast track and complicated chronic diseases and complex discharge planning in the ED, and services such as medicine and surgery meet daily to assess patient readiness for discharge. This has built momentum in creating capacity to admit in a timely manner.

Leveraging IT systems, the team expanded access of the emergency department information system (EDIS) to other wards and sites to increase awareness and create a sense of urgency at all levels. Having clear surge protocols, including pediatric, has brought teams together to collectively support each another, given that KHSC does not have the ability to divert to other receiving hospitals at this time. The team recently used the same day admit area to decant ED-stable patients for the St. Patrick's Day surge. With support from HDH urgent care, the plan was very successful and is being further explored.

The HDH urgent care centre working station needs to be reconfigured to enhance patient flow and minimize the risk of staff injury. This is a high-volume area and high traffic makes it difficult for staff to perform their duties effectively, causing further delays.

From a patient- and family-centred care perspective and for patient flow, it is suggested that the organization consider a fast-track system for ED returns or readmissions requested by ED, so they are flagged on arrival to be seen in a timely manner and avoid being in the queue. Another option that was brought forward by the medical team is to look at ways to create another or expand the MSAP clinic to accommodate ED returns for frequent treatments.

Time-to-transfer is being tracked and has significantly changed since the amalgamation. This is a quality indicator that the team has been working on and it is encouraged to continue the quality improvement process.

Priority Process: Medical Devices and Equipment

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

Unmet Criteria		High Priority Criteria
Standards Set: Diagnostic Imaging Services		
8.7	All diagnostic imaging reprocessing areas are equipped with separate clean and decontamination work areas as well as separate clean storage, dedicated plumbing and drains, and proper air ventilation and humidity levels.	!
Standards Set: Reprocessing of Reusable Medical Devices		
3.3	Access to the MDR department is controlled by restricting access to authorized team members only and being identified with clear signage.	!
3.5	Appropriate environmental conditions are maintained within the MDR department and storage areas.	!
3.6	The MDR department has floors, walls, ceilings, fixtures, pipes, and work surfaces that are easy to clean, non-absorbent, and will not shed particles or fibres.	!
3.7	The MDR department is clean and well-maintained.	!
8.2	The reprocessing area's designated hand-washing sinks are equipped with faucets supplied with foot-, wrist-, or knee-operated handles, electric eye controls, automated soap dispenser and single-use towels.	
8.8	Appropriate and properly maintained PPE is worn in the decontamination area.	!
11.3	All flexible endoscopic reprocessing areas are equipped with separate clean and contaminated/dirty work areas as well as storage, dedicated plumbing and drains, and proper air ventilation.	
11.8	Flexible endoscopic devices are appropriately stored following manufacturers' instructions in a manner that minimizes contamination and damage.	!

Surveyor comments on the priority process(es)

KGH uses flash sterilization infrequently but more often than most hospitals. It is encouraged to follow through with an assessment of the reasons flash sterilization is used to reduce and eliminate its use. This could be incorporated into a quality improvement plan and project.

It was noted that bags of clean gowns at KGH were stored under a sink in the ED and next to a garbage can, and bags of gowns were frequently left sitting on the floor outside patient rooms on inpatient wards. In the ED surge unit, dirty linen and garbage were very close to clean supplies. Space is an issue and the staff are doing their best to provide excellent care in less-than-ideal surroundings; however, it important to remember basic principles of keeping soiled laundry away from clean supplies.

The ceiling in the medical device reprocessing department (MDRD) at KGH is porous and does not meet standards for cleaning. The new MDRD administrative lead has extensive experience in medical reprocessing and taking the formal course and attaining certification in this area is in her personal professional development plan.

While the dress code in the kitchen states that hair should be covered, it was noted that the manager in the kitchen was not wearing a hair net.

The reprocessing room for endoscopes at KGH is cramped and humid, with poor air quality that does not meet the standard. The technician cleaning the endoscopes was not wearing a plastic apron and indicated that because of the heat in the room, cleaning staff often use yellow gowns instead of the plastic aprons. Given the poor air quality in the room it is understandable that staff might not want to wear the designated personal protective equipment, but they are being exposed to the risk of infection.

New ergonomic sinks and workstations for decontaminating dirty equipment have been approved in KGH capital budget. Implementation of this equipment will reduce the risk of back injury to staff.

At HDH, the ultrasound sound probes are reprocessed and stored in the same room. The ceiling in the room is porous and therefore cannot be cleaned properly. This area does not meet standard.

Access to the MDRD at HDH is not controlled. Visitors to the department need to be properly gowned and wear boot covers. The air quality and circulation in the MDRD is poor and does not meet standard. It is not apparent that a terminal cleaning is done in the MDRD. The MDRD has not been painted in years and is generally not well maintained. Also, staff use the sink in the bathroom as a handwashing station. The handwashing station needs to be independent of the bathroom and have a hands-free sensor or foot, wrist, or knee-operated handles.

While the cleaning of endoscopes at HDH is very well done, the ceiling tiles in the room where the endoscopes are stored are porous and cannot be cleaned properly.

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.

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

Standards Set: Ambulatory Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
6.5	The number of clients who fail to present at scheduled appointments is monitored and strategies to improve attendance are implemented with input from clients and families.	
7.13	Clients and families are provided with information about their rights and responsibilities.	!
7.14	Clients and families are provided with information about how to file a complaint or report violations of their rights.	!
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

Renal

KHSC is the regional centre for renal care for the South East LHIN, including all its community satellites.

Since the last on-site survey, the units expanded the renal area to include clinic space, to improve access and better meet patient needs in one centralized area. This provides seamless care and continuity throughout the patient's journey.

KHSC meets and exceeds Ontario Renal Network goals for independent dialysis, going from 13 percent to 25 percent, and efforts are underway for continued improvement. There is a concerted effort to meet patient needs, with no wait times in other modalities such as operating room, diagnostic imaging, and laboratory services. The kidney transplant program has recent expanded to include living and deceased donors, ensuring that more patients are receiving a transplant rather than being on dialysis.

The nursing and medical model meets patient and community needs by providing continuity of care at satellite sites, regular leadership presence, and standardized policies. With regard to future strategic planning for the renal unit, a dedicated focus will be needed on home dialysis growth (30 patients to 100 currently) as well as on a sustainment plan to ensure patients can be and are safely cared for in their home environment in the longer term. The team is commended for its low infection rates, nimbleness to change, and staff engagement.

HDH ambulatory care units (respiratory, urology, gastrointestinal)

The teams are commended for their dedicated efforts to maintain and sustain the provision of specialty primary, tertiary, and quaternary care, as well as for being teaching and research units. As a result, the HDH ambulatory care teams have built strong relationships internally and externally with family general practitioners and other hospital sites.

Changes in leadership and governance have made one person accountable for organizing and supporting the specialties, enhancing communication, and having a strong voice in future planning and innovation. This is seen as positive. Teams have streamlined access to services, decreasing wait times in many modalities such as endoscopy, the lung diagnostic assessment program, and the pain clinic, and expanded specialty services such as a spine clinic that is starting in May and the newly offered cystoscopy/biopsy procedure in the urology cancer clinic.

HDH tracks flash sterilization in its safety tracking systems. Items are reviewed at program councils and equipment has been purchased to avoid flashing.

The staffing model was reviewed three years ago, stabilizing the clinic skill mix and building capacity to further expand clinical expertise in each area. Future space is a common concern in all areas, given growth projection and expansion of services with an aging population. New innovations such as robotics and creating interdisciplinary teams such as in the lung diagnosis clinic with medical oncology, radiation oncology, and respiratory working collectively will require a functional space design.

Priority Process: Competency

Staff are dedicated and very engaged in providing the best patient care at both sites. They are receptive to performance opportunities and work well as a collective and cohesive team.

Training is standardized and opportunities are offered and supported. Given the many changes in leadership that have occurred, both sites are encouraged to continue with the completion of staff performance evaluations.

The HDH site may require a needs assessment in spiritual care support, particularity for the interstitial lung disease clinic when patients are diagnosed with lung cancer and seen by medical oncology and radiation oncology on the same visit. Extra immediate support may be required.

Priority Process: Episode of Care

The medical team in nephrology has access to palliative care services at the clinic and recently hired a lead who is cross trained in nephrology and palliative care to better meet patient needs. The Ontario Renal Network has recognized KHSC for its local achievements by dedicating an access coordinator to be the go-to person for coordinating patient and medical needs such as fistula, vascular access in interventional radiology, and home dialysis.

A satellite site was recently closed, requiring patients to be cared for at the hospital. An interview with a patient indicated that this closure has had a negative financial impact due to parking costs that were not required at satellite sites, extra trips to the bank to pay with coins, feeling vulnerable being exposed to potential hospital-acquired infections, and losing a sense of being part of a “family.” From a patient- and family-centred care perspective and based on growth projections and Kingston’s aging population, further exploration is needed to see how KHSC could accommodate local needs in the Kingston/Belleville area to expand the satellite sites.

Patients on the dialysis unit are empowered to guide their own care and be actively involved. It was impressive to see a patient set up the machine and be able to comprehend and explain the different volume measures on the screen and identify variations and notify the nurse. Staff are well versed in the specialty area and remain up to date with best practices.

During interviews, patients at both sites said they are not informed or aware of their rights and responsibilities. They also talked about the cost of parking; HDH being less costly influences their decision to go there, rather than basing their decision on getting the best care at the most appropriate site. Standardizing cost may support patients and families in getting to the appropriate site.

At HDH, all clinics have dedicated space to accommodate general practitioner urgent referrals or walk-ins. There are a significant number of clinic cancellations and no shows. Many appointments are booked months or even years in advance, making it difficult to adhere to dates and times. Reminders are made in certain areas one week prior, but no other reminders or confirmations are made closer to the date. A deeper dive into the data is suggested.

There is excellent teaching and patient- and family-centred care in all clinic areas. Staff are very collegial, professional, and caring in their approach. Endoscopy was recognized for best performance in the region for its dedicated efforts to meet quality wait time metrics, and the lung diagnostic assessment program clinic shortened its time from diagnosis to first treatment by 25 days. Close attention is required to support the pulmonary function laboratory, due to elevated wait times of up to nine months, and in the sleep lab over one year. The medical manpower need exceeds the current supply, and thus long-term sustainability and recruitment is crucial for these areas.

Priority Process: Decision Support

NephroCare is the IT system used in renal. Staff find the system easy to use and very comprehensive. It has built-in safeguards with alerts and reminders for staff. However, the system does not interface with ED so notes are not available if patients present in ED. Further analysis is needed to ensure access to the patient chart and how this current IT system will integrate with other electronic medical record systems in the future.

At HDH, protecting patient privacy is a standard practice in all areas. There is a conscious effort to ensure patients are cared for in a conducive environment and with discretion. The electronic medical record systems are the same at both sites, for continuity of care. The organization is encouraged to consider having central scheduling to avoid patient confusion and multiple contacts for clinic services.

Innovative technology such as robotics is an area of interest for medical staff. The endoscopy booking clerks are commended for the great strides being made to manually maintain and track, via Excel, fecal occult blood testing and first-degree endoscopy bookings. Looking into a long-term solution to facilitate data entry may be an area for the organization to explore.

Priority Process: Impact on Outcomes

Patients are active participants when it comes to equipment selection. From a quality and safety perspective, all patients are started on dialysis at a KHSC site when they originally start, to ensure they can safely transition and are medically stable to be supported at satellite sites. A new quality initiative on dalteparin has involved staff, pharmacy, and medical staff.

At HDH, the endoscopy team received national recognition as one of ten training programs in skill-enhanced endoscopy training and train-the-trainer. There is a quality measures report card specific to physicians for quality improvement performance and global rating systems. The organization has been very nimble in adjusting to Ministry of Health and Long-term Care and LHIN quality improvement initiatives. Spine is the most recent upcoming quality improvement work that will be housed in the community with a direct link to health care teams, starting in May.

Standards Set: Biomedical Laboratory Services - Direct Service Provision

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

The organization has met all criteria for this priority process.

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

The team is engaged and passionate about laboratory services. It is a high-functioning team that works well together.

The team is commended for the high level of compliance with the Ontario Laboratory Accreditation process.

Following concerns expressed by a patient advisor regarding test result delays, the laboratory manager invited the advisor to tour the lab to better understand the process.

The laboratory has a scorecard to set targets for response times. Most response times are within targets and there is a plan to address the outliers.

All tests that are referred out are sent to accredited laboratories.

The team provides a comprehensive orientation to the laboratory services.

The team's competency is assessed following a new staff member's orientation and on a regular basis thereafter. Each team member's performance is evaluated in an objective, interactive, and constructive way. Compliance is at 90 percent.

The team has regular access to continuing education and professional development opportunities related to laboratory services.

The team has sought client feedback to determine ways to improve accessibility for clients with limited mobility, visual, or hearing abilities.

The team has access to standard operating procedures that are applicable to the activities it carries out. An electronic document control system would be beneficial.

The existing physician order entry system is old and needs to be updated to enable utilization management.

While it is recognized that the team has done everything possible to mitigate risk due to space issues, the lack of appropriate space remains a risk to both clients and staff.

The team recognizes the need for more clinical engagement with respect to utilization management, to ensure appropriate use of resources.

The team is encouraged to do more consultation on examination types and the use of laboratory services, including the frequency of testing and the type of sample required.

The team has identified issues with labels and continues to work on improving this.

In the HDH phlebotomy areas, hand hygiene is inconsistent at best, and universal precautions are not followed. There appears to be very little signage or promotion of hand hygiene in the organization. Handwashing results are not openly displayed. In the operating room health care workers were observed coming and going out of the operating room without washing.

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 oncology program has had a 15-member Patient and Family Advisory Council for nine years. Patient advisors describe themselves as "being involved in everything" and gave examples such as quality improvement initiatives, Kaizen events, policy and protocol development, resource and pamphlet development, and even being co-investigators in a study. This program is clearly advanced in patient and family activation and should serve as an example to other programs and organizations.

Oncology has developed a partnership with the mental health and addictions program to ensure timely access to support patients holistically. Oncology has developed satellite clinics in smaller communities across the South East LHIN to provide systemic therapy closer to home. Initiatives with emergency services as well as a number of divisions within internal medicine that include education sessions and incorporating palliative symptom scales have increased early referrals for supportive and palliative care.

The entire oncology leadership team is trained in LEAN. Processes are mapped and reviewed regularly with the goal of improving value for patients and staff. Examples were described of changes made to

processes and protocols based on ongoing quality improvement efforts. The systemic therapy clinic uses one type of infusion pump.

Priority Process: Competency

Required certifications for various team members in each service area are clearly defined. Ongoing education and professional development is organized and made available to staff. Clearly defined training is provided for each of the services (that include stem cell transplant, systemic therapy, and radiation therapy) to ensure consistent application of evidence-informed patient care pathways.

The radiotherapy service is meticulously organized with leads for each area. This highly complex service has committed leaders who are engaged in working with all staff to create an expert, safe, and well-organized environment. Nurses in the systemic therapy clinic are well trained and demonstrate expert knowledge of infusion pump use and safety protocols. They perform double checks of all required high-risk procedures and medications.

The teams in all service areas (inpatients, stem cell, systemic therapy, and radiation therapy) are commended for their close collaboration and cohesive team environment that supports a healthy and safe work environment.

Priority Process: Episode of Care

Clearly defined, standardized care pathways that are based on the best available evidence guide the initiation of each treatment type in oncology. Protocols have been established with referral services and the ED to provide treatment for emergencies such as febrile neutropenia in a timely manner, including off-hours and weekends.

Patients and families describe receiving teaching from clinical staff and being provided with information regarding proposed, optional, and investigative treatments. They describe a very positive experience throughout their cancer journey with regard to their relationships with staff and physicians.

The is evidence that medication reconciliation is completed on admission and discharge. The oncology ambulatory services where treatments are delivered conduct medication reconciliation, and nurses double check high-risk medications such as chemotherapy.

As a result of increased falls the oncology program, led by the charge nurse, developed a falls prevention poster for patients and families called Avoiding Falls in Hospital and a separate poster for staff called Reducing Patient Falls (Using teach back methods to educate patients and families). The program is commended for analyzing the falls data and as a result developing this quality improvement initiative to help patients, families, and staff reduce falls.

Use of two person-specific identifiers was consistently observed in all services in oncology. There are processes to share information in a timely manner between referral sources such as primary care

providers and partner providers of care. Care is coordinated through interdisciplinary clinics as well as coordination of treatment appointments when possible for patients who are receiving simultaneous radiation therapy and chemotherapy. The organization has different information and booking systems for these services which makes for cumbersome, manual processes. Integrating these systems would create significant efficiency.

The oncology program operates a triage service to address patient concerns in a timely manner. The radiation therapy service has developed a rigorous pathway for treatment regimens that includes several failsafe checks by numerous staff at each stage of the process including imaging, measurements for immobilization devices, precision mapping, treatment calculations, and phantom testing before the patient receives treatment.

Priority Process: Decision Support

The oncology program adheres to consistent practices regarding obtaining, documenting, storing, exchanging, and retrieving patient information.

Priority Process: Impact on Outcomes

The radiotherapy team has a high-functioning Quality Assurance Committee. The team abides by regulatory requirements. It is evident that the team's culture is always focused on quality improvement. Numerous examples were provided of quality improvement initiatives, including LEAN Kaizen events to improve quality, safety, and value.

KHSC collects and reports on the wait time indicators required by Cancer Care Ontario. Pathology wait times are significantly better than the provincial target. Surgical wait times are close to the provincial target, while systemic therapy wait times for both referral-to-consult and consult-to-treatment are considerably below provincial expectations.

The oncology program director reports health human resources challenges. The organization is encouraged to put focused efforts into a sustainable health human resources strategy as well as to continue to improve processes to improve efficiency to achieve the desired wait times for this patient population. The teams in systemic therapy, radiation therapy, inpatient care, stem cell therapy, and the breast assessment program all provided examples of testing quality improvement initiatives that were later implemented.

Priority Process: Medication Management

KHSC has established guidelines to safely prepare and handle cancer therapy medications. Teams from pharmacy through to administration to patients were observed to adhere to the guidelines.

KHSC uses Cancer Care Ontario’s oncology patient information system (OPIS) system for systemic therapy. Chemotherapy preparations are double checked at various stages in the process, including on receipt of the order, once the preparation is completed, and prior to administration to the patient. During the

on-site survey a patient reported to the nurse that their physician indicated that they would be receiving additional fluid during their next treatment. Following a double check by two registered nurses, the administering nurse paused before initiating the treatment, paged the physician, confirmed the intention, and obtained an order to proceed from the physician. This demonstrates a culture of safely managing changes in systemic therapy.

Guidelines for pharmacy to prepare and dispense chemotherapy are outlined and followed. A system of multiple verification is evident and a safe environment has been created for staff in the physical plant of the chemo preparation area. Appropriate personal protective equipment is available.

The radiotherapy team is commended for the rigorous planning, design, process development,and multiple quality assurance checks in the protocols for equipment and software use, as well as for the ongoing development of standardized methods to prepare extremely precise radiation treatments for each patient.

Standards Set: Critical Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
9.21	There is a process for initiating palliative and end-of-life care, as required.	
10.2	A process which meets legal requirements is followed to support decisions about providing, forgoing, or withdrawing life-sustaining treatment in partnership with the client and family.	!
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		
Priority Process: Organ and Tissue Donation		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

There is a strong, collegial leadership team.

Priority Process: Competency

A culture of support and continuing education extends collaboratively across teams.

Priority Process: Episode of Care

There is a well-developed and collegial team in critical care. A version of a quality committee is established and meets regularly and a patient safety specialist is engaged with the team. There is not a well-defined quality improvement process; however, there are forums to discuss issues with staff and facilitate quality improvement and change management, enable debriefings on difficult issues, and celebrate team success. There is strong clinical leadership.

A policy for quality end-of-life care is in early development.

An innovative approach to facilitate quality transfer of accountability between teams has been implemented, using the family as a source of information. This is truly unique work and the team is commended for it.

Priority Process: Decision Support

There is good communication among teams and programs in a complex environment.

Communication is enhanced with an innovation that includes family participation in the transfer of accountability process.

Priority Process: Impact on Outcomes

Quality improvement is engrained in the culture of the intensive care unit. A dedicated specialist in safety and ethics works closely with the team in a supportive role.

Data support is good.

Developing a process for quality improvement is needed to further enhance the already solid team.

Priority Process: Organ and Tissue Donation

The organ and tissue program has a client-focused, high-performing team.

There are good outcomes and ongoing research and quality initiatives. Innovative support mechanisms are implemented for all team members.

Standards Set: Diagnostic Imaging Services - Direct Service Provision

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

The imaging services department consists of a committed and knowledgeable team that works collaboratively between KGH and HDH. Team members are dedicated to the patients and work to better meet their needs and those of the families. The team has a "can do" attitude and is very proud of the variety of services offered, their team, and the range of expertise available.

There are many students including residents and technologists. This leadership structure was integrated in 2010 when the radiologists began working at both sites.

Information and data are collected to ensure the services offered meet patient needs, and changes are made to better accommodate patients and meet their needs in a more timely manner. Examples include the bone mineral density and diagnostic mammography that were moved to HDH. As services are realigned, the team could consider centralized booking of appointments for better control of scheduling and patient flow.

Most of the KGH technologists have a specific speciality. At HDH, they can be trained on up to two modalities.

In April 2017 the team started offering endovascular thrombectomy for patients who have had a stroke.

Challenges include the fact that there are two rooms for interventional procedures but three are required. Space is an issue the team deals with every day. Following procedures, the recovery area needs to be closer. Nurses are provided for recovery of these patients.

The team is very proud of the two new CT scans and the room setups, and feel that they are able to provide better, safe care to patients.

At KGH, there is a problem with getting patients to the service area on time. The team feels that having their own porters as part of the team would rectify the problem and solidify the importance of timely transport.

The growth in service is faster than can be managed with the present staffing.

HDH has a porter to ensure patients are where they need to be for service delivery. The team finds this makes a huge difference to meeting time lines for appointments. This may be something to monitor and standardize at both sites for maximum efficiencies.

The team has introduced an operations analyst to focus on process and patient flow. True capacity and back logs are measured, with a focus on reducing wait times and improving patient flow. Some creative initiatives regarding the daily huddles have been implemented that KGH staff find very beneficial.

HDH staff have a senior huddle every Wednesday, and there is a great visual calendar for meetings, huddles, and important events. The operations analyst will also be working with HDH staff to review patient flow in booking and maximize appointment availability.

A representative from imaging sits on the Patient and Family Care Committee, and a patient advisor is involved in planning and design or when new projects occur at both sites.

The examination techniques include general radiology, interventional radiology, magnetic resonance imaging, ultrasound, computed tomography, and nuclear medicine. A pamphlet outlines the services and includes a patient satisfaction survey.

Patients who have been injected with radioactive substance still do not have a separate waiting room; this was noted in the 2012 on-site survey as well. There is a larger waiting area for these patients, but it is not separate from the other patients. The team is encouraged to continue to identify this as an issue and a risk to patients.

Performance reviews are completed every two years.

Two identifiers are used for patients at both sites.

The Falling Star falls prevention strategy is used and all patients are assessed for their risk of falling. It is suggested that the team might consider having patients at risk for falls wear coloured arm bands for easy identification.

Continuing education is available through e-learning and includes training in workplace hazardous material information systems, hand hygiene, privacy and confidentiality, review of the emergency codes, and other professional requirements. There are lunch-and-learns and participation in WebEx.

Imaging services has a strong quality improvement program that is well understood by staff. The results are broadly shared and changes are made where necessary.

The team is encouraged to continue to integrate policies, procedures, and processes. This team has a solid foundation and is integrated in many ways, as staff work and meet together, and the radiologists move between the sites. There is also a strong leadership team that possesses the working knowledge required to keep things moving.

Standards Set: Emergency Department - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
4.11	Education and support to work with clients with mental health and addictions are provided to team members.	
Priority Process: Episode of Care		
9.14	Clients and families are provided with information about their rights and responsibilities.	!
9.15	Clients and families are provided with information about how to file a complaint or report violations of their rights.	!
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		
Priority Process: Organ and Tissue Donation		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The ED leadership team has been actively involved with the redevelopment planning phases and program planning. They regularly review the data to inform and guide decisions.

The ED has resources dedicated to exploring root cause analysis with regard to ED wait times, length of stay, left without being seen patients, and ambulance off-loads. This has been a collective effort across the organization at all levels.

Emergency planning is at the forefront at both sites on how to collectively support one another. The teams are commended for their creativity and innovative ideas as well as for their level of engagement regarding program planning, space, tabletop and equipment layout exercises, and supporting staff and medical teams in the decision-making process.

Board and governance structure changes have energized the team members and they feel supported by these organizational changes. The ED's goal is continuing to reduce ED wait times and patient flow bottlenecks, particularly focusing on targeting CTAS 4 and 5, and how to better support the growth in mental health and addictions patient populations.

Priority Process: Competency

Education and support to work with patients with mental health and addictions is provided to team members, but they will need further training.

Staff and volunteers have concerns about security, particularly on the night shift when fewer staffing resources are available and there is less security on shift to cover the large ED area. The team is seeing an increase in patients with mental health and addictions and is finding it is becoming more complex to keep patients and staff safe in such a crowded and busy ED.

Staff appreciate the support to enhance their training, as donated by the physicians specifically to support professional growth and as supported by the organization.

The ED has a standard communication tool for handover and for inter-unit/inter-hospital transfers through the EDIS. The ED team members have recently been recognized for their contributions to KHSC's most improved emergency wait times in Ontario.

Priority Process: Episode of Care

Clear signs are visible on entry to the ED. Patients are self-directed to sit and wait to be called for triage or they are supported by volunteers. There is no mechanism to establish who arrived first, which often causes discontent when patients feel they are being bypassed. A robust system is in place to triage patients using CTAS. After the initial triage assessment those who are waiting for service are advised to check back within a designated time and told who to contact if their condition changes.

Patient rights and responsibilities were recently reviewed by both sites and patient experience advisors, and a declaration of values was created and is being rolled out. This is posted at the KGH ED but not at the HDH urgent care centre. Patients and families interviewed at both sites were not aware of nor provided with this information. There is insufficient evidence to show how patients and families are to file a complaint or report a violation of their rights. This process is not communicated or posted and no written documents were provided to the patients and families who were interviewed.

With regard to suicide risk assessment, a change is needed to ensure policy reflects practice at both sites. Policy #06-50, Suicide Risk Assessment, states preparation for mental health programs should include ED. The date on the policy is "new" but the authorizing signature is the previous CEO.

A patient identification process is in place, such as the use of armbands to identify patients in the ED. It was impressive at the urgent care centre to see the added patient- and family-centred care engagement, such as asking a personal question at registration on how the patient would like to be addressed (i.e., Pat or Patricia).

With regard to medication management at the urgent care centre, patients sitting on chairs in the hallway have ready access and are in close proximity to an unlocked fridge containing medication that could cause significant harm. This fridge needs to be locked at all times. The medication cart in the resuscitation room is unlocked and is located where patients can easily access it. A patient who uses the HDH site frequently would like a larger wayfinding sign giving directions to the eye clinic when exiting the sixth floor elevator, as it is difficult to see the sign, especially for those with poor eyesight.

Decluttering the ED environment at KGH, such as by not storing clean supplies on the floor, would help environmental services properly clean floors and avoid infectious disease transmission.

Both sites have ripped patient and staff chairs that cannot be cleaned, breaching infection control standards of cleaning and disinfection and potentially causing hospital-acquired infections. More hand hygiene rub dispensers are required, especially at point of care, as is additional hand-hygiene awareness and teaching. The use of gloves is significant but little hand-hygiene practice was witnessed.

Priority Process: Decision Support

EDIS has recently been expanded outside the ED so other units at both organizations can see ED status.

There is seamless communication and information transfers between sites. There is a formal process for internal and external disclosure of patient information.

Priority Process: Impact on Outcomes

Both sites have reviewed extensive data with regard to patient flow and how to best align services and quality improvement initiatives.

The ED team uses LEAN methodologies to enhance efficiency and performs extensive plan-do-study-act cycles to monitor progress. The goals and objectives for both sites are aligned, with a focus on building capacity for volume and aging and special needs of patients.

Priority Process: Organ and Tissue Donation

Clear guidelines are established and there are policies on organ and tissue donation for the ED and Trillium Gift of Life. The ED team contacts the intensive care unit for neurological determination of death. Once identified, the patient is often transferred to the intensive care unit until organs can be retrieved, as the team is now doing both live and deceased organ transplants.

Spiritual care is available to patients and families.

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

Unmet Criteria			High Priority Criteria
Priority Process: Infection Prevention and Control			
2.8	Environmental services and the IPC team are involved in maintaining processes for laundry services and waste management.		!
2.10	Applicable standards for food safety are followed to prevent food-borne illnesses.		!
7.7	Safety engineered devices for sharps are used.		!
8.3	Team members, client, families, and volunteers have access to alcohol-based hand rubs at the point of care.		!
8.6	Compliance with accepted hand-hygiene practices is measured.		ROP
	8.6.1	Compliance with accepted hand-hygiene practices is measured using direct observation (audit). For organizations that provide services in clients' homes, a combination of two or more alternative methods may be used, for example: • Team members recording their own compliance with accepted hand-hygiene practices (self-audit). • Measuring product use. • Questions on client satisfaction surveys that ask about team members' hand-hygiene compliance. • Measuring the quality of hand-hygiene techniques (e.g., through the use of ultraviolet gels or lotions).	**MAJOR**
Surveyor comments on the priority process(es)			
Priority Process: Infection Prevention and Control			

With permanent administrative and medical leads, the IPAC team has become stable with experienced staff and rigorous policies and procedures that protect the patients of KHSC. The very few outbreaks of infection at KHSC is testimony to the effectiveness of the IPAC program. This team is often called upon to be a resource to other hospitals in the LHIN.

The Brockview Café at HDH provides food service for patients in the peri-anesthesia care unit. The millwork is in a state of disrepair and needs to be replaced to provide sanitary conditions for meal preparation. The corkboards need to be removed as they do not meet infection control standards. In addition, the carpet in the peri-anesthesia care unit needs to be removed, to permit enhanced cleaning of the patient care environment and reduce the risk of infection.

Clear plastic bags filled with clean yellow protective gowns were frequently noted to be sitting on the floors. In the intensive care unit there was a barrier cart with a receptacle for the gowns to keep them off the floor. Barrier carts would be of value for patients on isolation.

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		
3.10	Education and training are provided on how to identify palliative and end-of-life care needs.	!
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
13.2	Policies on the use of electronic communications and technologies are developed and followed, with input from clients and families.	
Priority Process: Impact on Outcomes		
16.1	Information and feedback is collected about the quality of services to guide quality improvement initiatives, with input from clients and families, team members, and partners.	
16.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
16.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
16.5	Quality improvement activities are designed and tested to meet objectives.	!
16.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
16.10	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
16.11	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	

16.12	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The program leadership team collects input from patients and families through surveys prior to discharge. In addition, there is a patient representative on the Program Council and a patient or family representative on the Joint Interprofessional Practice Council, both of which contribute to service planning, development, and changes.

Cross-department and program collaboration to support the needs of patients with complex health issues is evident.

A recent reorganization on the tenth floor, which is shared by the pediatric and medicine short stay inpatient units, resulted in a more effective use of space.

Priority Process: Competency

Infusion pump training and education is provided on hiring, when new pumps are brought into service, and on an ongoing basis to ensure safe practice.

KHSC has completed an analysis and developed an action plan on the need for education and resources with regard to identifying patients who would benefit from palliative care or who need a better understanding of terminology (e.g., advance care planning, goals of care); determining the consent and substitute decision making process; and speaking with patients and families about end of life, to improve interprofessional orientation and training regarding palliative and end-of-life care. The organization is encouraged to follow through with this action plan to foster collaborations across programs.

Opportunities for team collaboration include Program Council meetings as well as staff-led Joint Interprofessional Practice Councils. Staff gave examples of being recognized by leaders for their accomplishments, such as specialty certifications and other professional achievements and designations.

The interdisciplinary inpatient teams appear to work well together. The pediatric team in particular is extremely cohesive and supportive of each other. This clearly has a positive impact on the delivery of care to patients and families.

Priority Process: Episode of Care

Standardized assessments and documentation are done electronically in emergency services. These are accessible and transferred to inpatient units. There is excellent collaboration across regional hospitals to ensure the appropriate level of care and access to specialty treatment when required.

A number of standardized clinical assessment tools (e.g., Confusion Assessment Method [CAM], Canadian Health Outcomes for Better Information and Care [C-HOBIC], and Pediatric Early Warning System [PEWS]) are routinely used. Staff collaborate clearly and respectfully with patients and families to ensure they understand findings and treatment options and are making informed decisions about care.

The best possible medication history is frequently completed in the ED as preparation for admission, along with medication reconciliation by the admitting physician or team pharmacist.

Patients at risk for falls or with a history of falls are discussed at morning rounds. A standardized system called Falling Star, has visual cues/pictures that are added to the kardex, patient's chart, wall desk outside the patient's room, and the head wall of the patient's bed.

A number of guiding documents are available on the intranet to support the prevention of pressure ulcers. Skin integrity assessments are completed and documented as part of ED services for patients who remain for more than 20 hours, upon admission to inpatient services, and routinely on each shift. The organizational approach is evidence based and uses the Braden assessment scale. No overarching policy framework could be found. KHSC is encouraged to develop a guiding policy for pressure ulcer prevention. In addition, as part of corporate quality initiatives, setting targets with a systematic approach for evaluation would help inform services and the organization regarding success.

Patient identification is confirmed using at least two identifiers. Numerous standardized order sets have been developed for specific patient populations and are in use. Venous thromboembolism prophylaxis is implemented.

A standardized patient transfer checklist guided by the situation, background, assessment, recommendation (SBAR) technique is completed, and a nurse-to-nurse verbal report is given by phone prior to admissions and transfers.

Priority Process: Decision Support

The KHSC senior leadership team is collaborating with the South East LHIN and partner organizations to invest in the development of a regional health information system.

Transfer of patient information between services occurs from physician to physician and between nurses on admission and transfer, using an SBAR approach and, in the case of pediatrics, PEWS. KHSC would benefit from adopting a standardized transfer of accountability tool that could be used consistently across the organization to ensure all pertinent clinical and safety information is consistently shared verbally and in writing at each patient transition.

No policies could be found in the documentation provided or in the policy section of the KHSC intranet to guide staff, physicians, and volunteers regarding appropriate use of electronic communications, technologies, and personal digital devices.

Priority Process: Impact on Outcomes

KHSC has a pediatric surge plan checklist and a medicine overcapacity protocol to guide clinical teams when overcrowding occurs. Off-service patients are grouped together when possible to facilitate physician MRP care as well as nurse exchange and support as required to ensure expertise to safely manage patient care.

The organization has created a culture of safety whereby staff routinely report safety incidents in the SAFE reporting system. Incidents are reviewed by relevant individuals and teams as appropriate for follow-up.

Service and program feedback is sought through patient satisfaction surveys. Clinical quality reviews are conducted when serious occurrences happen, and these reviews inform some practice and policy changes. Program and service level issues are discussed at Program Council meetings; however, coordinated, systematic collection of data regarding service quality is inconsistent and does not appear to be well understood or adopted by the teams.

Safety and quality indicators are collected for falls prevention, pressure ulcer rates, and hand hygiene, to name a few. However, staff could not clearly articulate distinct quality improvement initiatives or services, or program-level quality and safety priorities. KHSC has a number of initiatives and collects important quality and safety data; the organization is encouraged to develop program-level quality and safety goals that are measured and evaluated, and to inform the teams if desired outcomes are achieved.

Standards Set: Medication Management Standards - Direct Service Provision

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

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

In addition to the Pharmacy and Therapeutics (P&T) Committee, KHSC has a Medication Safety Committee that uses the standards from the Ontario College of Pharmacists, the National Association of Pharmacy Regulatory Authorities, and Required Organizational Practices from Accreditation Canada to guide medication management. The Medication Safety Committee is interdisciplinary and includes a patient advisor.

KHSC has a clear high-alert medication policy that outlines high-alert medications. The policy is available on the intranet. There is clear labelling and separation of high-alert medication in the pharmacy and the units.

KHSC has an Order Set Committee. Each service has a standard admission order set. Changes are made through the Pharmacy and Therapeutics Committee, approved by the Medical Advisory Committee, and communicated through the medication management system as well as through emails specifically labelled P&T Changes to ensure clinicians are aware.

Documentation, storage, access, and processing of investigational and study medications are clearly separated from regular operations.

Staff use the SAFE reporting system to report medication errors. Pharmacy has a weekly sharing session where medication-related incidents are reviewed and a follow-up plan is developed and acted on.

With the exception of the OPIS in cancer care, KHSC does not have computerized physician order entry.

KHSC has clear guidelines and protocols for the safe management of low molecular weight heparin. KHSC has clearly outlined policies guiding the prescription, handling, administration, and disposal of waste narcotics. Safeguards are in place in the pharmacy with multiple checks to account for all narcotics. On the units, the Omnicell dispensing units have safety protocols to ensure proper accounting of all narcotic use. The pharmacy narcotics area and medication rooms on the units are all monitored through security cameras. Senior technicians complete medication audits every 12 hours and document and report any discrepancies to the unit charge nurse. Clinical managers receive monthly reports on any deviations in narcotic use.

Temperature-sensitive medications are kept in monitored fridges and freezers that are connected to alarm systems to alert pharmacy staff of any fluctuations. The on-call pharmacist is paged when an alarm is triggered.

Significant improvements have been made in the pharmacy in recent years to improve organization, labelling, separation of functions, and appropriate and safe storage in areas with durable and easy-to-clean surfaces such as stainless steel where possible. Standardized documentation is in place to facilitate completion of a best possible medication history for patients being admitted through the ED by pharmacy technicians, as well as for pharmacists and physicians to complete and document medication reconciliation upon admission. Standardized systemic therapy protocols are used in the oncology service.

KHSC has a “Do Not Use” list of abbreviations which is posted in locations for clinical teams to reference, and printed on the back of order sheets. The oncology pharmacy is well organized with safety infrastructure including anteroom and negative pressure preparation areas with appropriate hoods. KHSC is commended for already having made capital investments to install appropriate ventilation systems to meet National Association of Pharmacy Regulatory Authorities standards. Staff working with higher-risk medications were observed to use appropriate personal protective equipment. The Omnicell automatic dispensing units are set up with biomarker (finger print) access, to ensure proper identification and documentation of those accessing the units.

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		
7.14	Clients and families are provided with information about their rights and responsibilities.	!
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
13.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
13.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

This is a strong, committed, and integrated team. A patient advisor on the team represents the needs of the patients and their families. The advisor is part of a group that developed a new pamphlet called Information for Patients and Families, available in English and French. It is very informative and outlines the services provided, privacy and confidentiality, patient safety and wellness, the admission process, group activities, passes off the unit, discharge planning, items to bring, and other helpful information.

The mental health leaders, staff, and physicians have a strong collaborative working relationship with community partners. Engagement in service planning and patient services is evident.

The team listens to the patients and their families to better address their needs and makes changes to improve outcomes. The team is very interested in the patient and family perspective. A number of planning days, including a youth planning day, have been held in an attempt to better meet their needs.

Staff at KGH and HDH are under one leadership structure and work collaboratively to meet the needs of patients and families.

A charge nurse is available seven days a week to provide coordination and leadership to the team. There is concern with the charge nurse carrying a caseload on the weekends, as they juggle a number of roles to provide leadership to four units.

At KGH, there are four acute care units: the general inpatient unit for adults, an intensive observation area, the intensive transitional treatment program, and the child/adolescent unit. There are also two beds designated in the ED that are staffed by a mental health nurse with security support.

Staff at KGH use Vocera, a communication tool that is also used as a emergency device to page security.

Heads Up at HDH is an early psychosis intervention program serving south eastern Ontario. This is an outpatient program that targets youth and adults ages 14 to 35 years. The team is very committed and knowledgeable and is focused on the patients and their families.

The team has a patient advisor actively involved in planning and design.

The team was awarded the KHSC Team Award for Knowledge and is very proud of that accomplishment.

The team collects data to evaluate, support, and guide services. It would benefit from an electronic health record to collect and monitor data in real time.

The team works to support children even after they become adults, providing an urgent consult clinic, an eating disorder clinic for youth and adults, and cooking programs. The primary goal is to eliminate the barriers to accessing mental health services.

The team surveys clients on a regular basis to assess the needs and determine if programs are still required or need to be refocused.

Priority Process: Competency

Staff are provided with professional development opportunities through online learning modules; compassion and fatigue meetings to discuss workload; lunch and learns; and training on non-violent crisis intervention, restraints, and hand hygiene.

Staff have access to an ethicist at a monthly meeting and this is well received. They appreciate being able to discuss the many ethical challenges that arise in mental health.

Staff do not use infusion pumps on any of the units or in the emergency designated rooms; therefore, education and training are not required.

The units receive a number of students from Queen’s University, St. Lawrence College, and Laurentian University.

At KGH, daily safety huddles occur with the staff. Safety is a top priority for the team. KGH has a pamphlet called Violence Prevention at KGH, A Guide for Patients, Families, and Guests. It outlines the importance of creating a respectful and safe environment for all.

Both facilities participate in the workplace violence prevention program and use SAFE reporting (incident reporting) when required.

If an incident occurs, there is an immediate debrief with the staff who were involved, the charge nurse, and the manager. A larger debrief with all staff is done later.

Heads Up at HDH is a regional team of social workers, nurses, occupational therapists, and psychiatrists who help people in south eastern Ontario recover from psychosis. A patient and parent who were spoken with are very happy with the program, the support provided, and the timely access to services. The patient also appreciates that the staff make him feel respected and they really listen to and hear him.

Priority Process: Episode of Care

At KGH, the entry to mental health is bright and cheerful with pretty art work. The units are secured with limited access.

There is an adult unit, a child and adolescent unit, an intensive observation area, and an intensive transitional treatment program. These mental health units are relatively new.

The child and youth unit is very bright, warm, and well organized, with plenty of natural light and a wonderful view of the lake.

Omnicell is used for medication dispensing. The medication room is well organized and clean.

There are two mental health beds designated in the ED with a dedicated mental health nurse, psychiatry resident, psychiatrist, and security and crisis workers.

There is no clear information on the rights and responsibilities of patients and their families. Nothing is posted and patients indicate that they are unaware of it. This is apparently being worked on.

Medication reconciliation is done while the patient is in the ED and maintained on the unit using the Omnicell automated medication dispenser.

In the ED, the electronic chart (EDIS) is copied to paper for transition to the unit. All documentation on the unit is paper except for the imaging and laboratory reports.

A consult liaison team liaises with patients on other units who have mental health needs but who also require acute care. The consult liaison team has a psychiatrist but not a designated nurse. A designated nurse would be beneficial for continuity and transfer of care.

Transitional care teams are also available. The team has access to a chaplain who is very committed to the patients and the staff.

The patient advisor role will be beneficial in better meeting the patient needs.

Telehealth (over the network) is provided to patients who live far away, eliminating travel. There is a Ronald MacDonald House called Almost Home where families can stay. There is also a house near HDH for First Nations families.

The team is reviewing and revitalizing mental health services which includes defining goals and objectives for the service areas, identifying quality and safety initiatives, and evaluating the services.

The area where the Heads Up program is provided is very bright and welcoming. The flow-through for patients from registration to being seen is timely. A patient indicated that they appreciate the phone call the day before as a reminder of the appointment.

Priority Process: Decision Support

Patient documentation is up to date, well maintained, and completed on paper. Patients in the designated beds at the ED at KGH have electronic charts.

Staff have timely access electronically to diagnostic reports, laboratory, and diagnostic imaging results through the picture archiving and communication system.

Staff are conscious of protecting patients' privacy and maintaining confidentiality. All patient information is confidential and protected. There is a process for patients to access their information.

At KGH, staff would like to have more time to spend with patients one-on-one, in an attempt to improve outcomes. That is also an area patients would like to see improved.

The Heads Up program has good documentation and the information available can be readily shared with the patients and family, with patient consent.

Priority Process: Impact on Outcomes

The team is integrating the patient advisor onto its committees and in planning future patient services.

Safety risks are identified and addressed. Staff carry out daily safety huddles and work closely with security to maintain ongoing patient, visitor, and staff safety. Patient safety incidents are reported through SAFE reporting and this information is used to make improvements where appropriate.

There is no evidence of a procedure to select evidence-informed guidelines. When one is developed, it is suggested that input be sought from patients, families, teams, and other partners.

There is a solid quality improvement program with collection, tracking, monitoring, and trending of indicator data. This information is used to make improvements. Quality improvement results and learnings are shared with staff, other teams, patients and families, and community partners.

The Heads Up program at HDH would like to have more timely access to metrics to better guide services. There is a quality improvement program in place but team members often research outside metrics to support recommendations they put forward.

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		
3.7	Education and training are provided on the safe use of equipment, devices, and supplies used in service delivery.	!
5.1	The workload of each team member is assigned and reviewed in a way that ensures client and team safety and well-being.	
Priority Process: Episode of Care		
7.14	Clients and families are provided with information about their rights and responsibilities.	!
7.16	Clients and families are provided with information about how to file a complaint or report violations of their rights.	!
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 department has a fairly new leadership team which has contributed to a shift in culture, and a positive shift in unit morale and medical engagement. The new governance structure is described as strong, supportive, engaged, and attentive to patient, medical, and department needs.

Service design data (BORN) have recently been reviewed due to the redevelopment project. Provincial data through the Champlain maternal newborn regional program are also reviewed. Goals are established regionally in partnership with Belleville, Brockville, and Smiths Falls. Other partners include Women's Health Care providers.

From a patient flow perspective, the unit has a seamless layout providing all pre-, intra-, and post-natal services on the fifth floor. Patients are familiarized with the unit early in their care, which supports effective transitions and patient flow.

Resources have been streamlined and cross-trained to provide flexibility to follow the patient through from labour, delivery, and recovery to the operating room if a C-section is required, combined obstetric and postpartum nursing.

The space has recently been modified to install water delivery tubes in the labour, delivery, and recovery room. A bariatric population will be supported at KHSC.

Priority Process: Competency

The environmental cleaning staff work force on both the obstetrical and pediatric unit is not sufficient to meet demand, causing significant delays in getting a patient transferred to the unit or accessing the operating room suite in a timely manner. No environmental cleaning backup support is available in surge or peak times during the day.

Leadership meets two to three times a week to discuss issues that are brought forward and deal with them in a timely manner to avoid escalation.

Staff performance reviews are 80 percent complete and are reviewed every two years.

With regard to assessment of residents, recently the Queen's department evaluation head agreed to have nurses perform a 360-degree evaluation on residents who are on rotation.

A process review is suggested for the sterile supply room located in between the two operating rooms. There was personal clothing on top of sterile supplies and tape on the operating room walls. Operating Room Nurses Association of Canada (ORNAC) standards need to be reviewed with regard to flipping sterile supplies onto a sterile field and pre-setting and opening sterile equipment in advance of a case.

Priority Process: Episode of Care

The standardized procedure to prioritize and schedule planned C-sections allows for unscheduled inpatient and emergency cases as required, although planned C-sections are often delayed. The delays are related to insufficient cleaning staffing being pulled between labour, delivery, and recovery and operating room cleaning suites. Cross-training environmental staff to cover break and lunch would help with delays in accessing the operating room suites.

There is no visible documentation to show that patients and families are made aware of their rights and responsibilities or the process to file a complaint. The team uses First Nations liaison nurses and midwifes to accommodate Aboriginal needs and special requests. The team is looking at providing access to laundry on the unit for patients and families in the neonatal intensive care unit or who are on long-term stays. A protocol is being created to address the bariatric population; this will be a local asset.

Demand and wait time access to gynecology services is significantly high. It is also growing and will continue to do so based on projections, so further growth expansion planning may be required.

Regarding infection control, many surfaces are wood (cabinets, shelving) or cork boards that are porous and difficult to clean and disinfect. Recliner chairs are torn and covered by blankets making them difficult to clean. The organization is encouraged to increase awareness on hand-hygiene practices and point-of-care access to increase compliance, and to consider putting alcohol-based hand rub dispensers in and outside soiled utility rooms.

Priority Process: Decision Support

The team uses a teletracking system to communicate with teams. Data are gathered and abstracted from BORN, the electronic regional IT platform. The data are reviewed by the Program Council.

Logistically, the process to collect money at time of delivery to cover the cost of "plugs and nets" for the new tubs in the labour and delivery unit could be revised. Staff feel uncomfortable handling free money and feel that the timing to request money at the delivery stage is not patient centred.

Priority Process: Impact on Outcomes

The units have dedicated time and effort to reviewing data, road shows, and using quality improvement evidence-informed guidelines to set the strategic direction.

The most recent evidence-based practice is the installation of water tubes in the labour, delivery, and recovery room. This was created in collaboration with a patient advisor and midwives, and from patient feedback.

Current quality improvement work involves patients' nutritional needs during labour. The team is commended for embedding morbidity and mortality reviews at the regional level and for being nimble and proactively engaging patients, families, leadership, staff, and community partners with the growing needs of the obstetrics and pediatric populations.

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

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

KHSC works in collaboration with Trillium Gift of Life Network (TGLN) and follows all standard operating procedures.

Priority Process: Competency

The TGLN coordinator is an employee of TGLN and not KHSC, and TGLN is accountable for training and performance review. The coordinator is well oriented to KHSC and educates staff in the hospital regularly about the gift of life program.

Priority Process: Episode of Care

The TGLN coordinator obtains complete information about potential donors.

Priority Process: Decision Support

TGLN and KHSC comply with all legislation that applies to organ donation and retrieval.

Priority Process: Impact on Outcomes

The program functions well and meets all standards and guidelines.

Priority Process: Organ and Tissue Donation

KHSC works closely with the recovery team and TGLN to ensure the deceased donor is suitable for recovery, the recovery is done appropriately and in a dignified manner, and the family is thanked afterwards.

Numerous examples were given as to how families are thanked, such as including the name of the donor on a donor wall.

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	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Organ and Tissue Transplant

A standard approach to assessing patients for organ donation has been developed by the TGLN and is followed by KHSC.

Wait lists are monitored and updated regularly as patients receive a transplant or are taken off the list because they have died or become unsuitable for transplant. Patients are kept informed at least every six months as to their position on the wait list.

Priority Process: Clinical Leadership

KHSC has a renal transplant program that arose out of a need to offer transplant services to patients on dialysis.

KHSC also does stem cell transplantation but no other solid organs. Appropriate policies and protocols have been developed to support this program.

Priority Process: Competency

Staff are trained to support this program and have access to ethics and spiritual care to assist in providing guidance and psychosocial and spiritual support.

There is true sense of team supporting this program.

Priority Process: Episode of Care

There is a comprehensive assessment of patients to ensure they are suitable for transplant. Patients and families are kept informed as the assessments are done and are encouraged to participate to the extent they wish.

Priority Process: Decision Support

The program meets all regulations with respect to document management.

Priority Process: Impact on Outcomes

Outcomes for transplant patients are carefully monitored.

There is an electronic adverse event reporting mechanism that tracks and documents adverse events. These are then reported on a monthly basis and followed up by the quality program staff.

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	
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: Living Organ Donation

The living donor consent is extensive and ensures detailed sign off. The donor is given many opportunities to decide not to donate and undergoes counselling to ensure they are not being coerced into donating their kidney.

Donors are given clear instructions on follow-up when they are discharged from the hospital and are followed at set intervals to be certain there are no adverse issues.

Priority Process: Clinical Leadership

KHSC has had a deceased donor renal transplant program for a number of years and felt it could offer a living donor transplant program that would benefit patients on the waiting list. The team identified the volume of need in the community, its capacity to provide the service, and the alignment with the teaching requirements of the urology Fellowship training program. The team advocated to develop a living donor program and followed all the necessary steps to develop policies and protocols to offer this service.

A living donor who donated a kidney and her husband who was the recipient were interviewed. They spoke very highly of the program, and their experience confirms that the protocols developed and described by the team work as intended.

Priority Process: Competency

Staff in the intensive care units and the ED are trained by the TGLN coordinator who contacts each staff member on a regular cycle for a refresh of the standards and protocols.

Priority Process: Episode of Care

Living donor recipients are carefully monitored after the operation and are given careful instructions of what to do if they are concerned about a change in their health. They have contact numbers and are seen in the ED by nephrology if there is a concern.

Both the living donor and the recipient undergo extensive testing to ensure both are healthy and suitable for the surgical procedures. A donor was reassured that if she was unsure whether she wanted to proceed, she could back out and be given an alibi as to why she was not a suitable donor.

Priority Process: Decision Support

The program meets all standards for documentation and document storage. Kingston is a relatively small city and staff are very aware of the importance of privacy.

Priority Process: Impact on Outcomes

Feedback from living donors and recipients is obtained to look for opportunities to improve the service.

Renal transplant patients are closely monitored for clinical outcomes on both a short- and long-term basis.

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			
6.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.		!
8.3	Team members are recognized for their contributions.		
Priority Process: Episode of Care			
12.3	Working in partnership with clients and families, at least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them.		ROP
	12.3.1	At least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them, in partnership with clients and families.	**MAJOR**
20.16	There is a process to follow up with discharged day surgery clients.		
Priority Process: Decision Support			
The organization has met all criteria for this priority process.			
Priority Process: Impact on Outcomes			
23.5	Guidelines and protocols are regularly reviewed, with input from clients and families.		!
25.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.		
25.5	Quality improvement activities are designed and tested to meet objectives.		!
25.6	New or existing indicator data are used to establish a baseline for each indicator.		
25.7	There is a process to regularly collect indicator data and track progress.		

25.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
25.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
25.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
25.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	
Priority Process: Medication Management		
15.3	Every medication and solution on the sterile field is labeled.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The operating room at KHSC has seen a number of managers and interim managers over the last few years and as a result day-to-day running of the operating room has suffered; however, many changes have already been made under the new manager. Despite the manager having been on the job for only about four months, staff report positive changes and that areas for improvement have been identified.

Priority Process: Competency

Performance reviews are routinely done and up to date on the surgical inpatient wards. Nurses and cleaning staff in the operating room and post-anesthesia care unit report very infrequent performance reviews. The nurses are aware that the new manager has performance reviews on her work plan and expect to have them done this year.

While most staffing areas of perioperative services report opportunities for growth, there are pockets of staff who said they did not have opportunities for growth but would like to have them. It is expected this will resolve in the next few years if stable leadership can be obtained.

Staff consistently stated that there are no opportunities to be recognized for exceptional work or contributions. The nurses in the post-anesthesia care unit report they have just started having weekly huddles and they appreciate the support of the new manager. There is an Honour Your Caregiver program that recognizes staff when a letter is received that mentions the staff member's name and is accompanied by a cash donation. The majority of staff seem to be unaware of this program.

Priority Process: Episode of Care

Consistently following the policy of using two person-specific identifiers is important to reduce the risk of injury to patients. The operating room at KGH is completely compliant with the requirement for two person-specific identifiers. Two medication administrations were noted where the nurse checked the name band but did not ask the patient their name or birth date. Two patients were aware that the nurses did not always ask them their name or birth date, and one said the nurse used two identifiers the first time during the day but not the rest of the day.

Anesthesiology takes the patient to the post-anesthesia care unit and does transfer of accountability (TOA). The operating room nursing staff do not go to the post-anesthesia care unit and do not provide TOA. The standards do not specifically state that TOA has to be done by both anesthesia and nursing; however, it is a practice in other health care facilities to conduct nursing-to-nursing TOA, in addition to anesthesia-to-nursing TOA.

Priority Process: Decision Support

KHSC appears to meet all requirements for documentation and retention of patient care information, and privacy.

Priority Process: Impact on Outcomes

KHSC makes good use of order sets to standardize care, reduce transcription error rates, and promote best practice.

Information and feedback from patients is obtained on the surgical wards and is influencing planning and change. Operating room services are just starting to collect information on measures of operating room use to create a basis to develop a quality improvement project. The operating room program has not had a strong focus on quality improvement over the last few years. This is in large part due to frequent turnover in administrative leadership. The new manager clearly understands the principles of quality improvement, and, with newly appointed physician leads, it is anticipated that this program will soon develop a number of quality improvement initiatives.

KGH has not developed a robust quality improvement program in the operating room area. The HDH perioperative area demonstrated a very nice quality improvement initiative in managing orthopedic short-stay joints.

Priority Process: Medication Management

The operating room at KGH follows standards very strictly, with the notable exception of one instance when a medication on the sterile field was not labelled. There should be no exceptions to this standard.

Standards Set: Rehabilitation Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
7.13 Clients and families are provided with information about their rights and responsibilities.	!
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

Rehabilitation services for children and youth ages 0 to 18 years (up to 21 years if they are still in school) are provided at HDH. There are 21 such treatment centres across Ontario.

The program was started in the 1980s and was recently revamped and rebranded with input from staff, parents, and the community.

The name was changed to KidsInclusive from Childhood Development Centre and colour was added to the name and logo which adds warmth and draws attention. The website was rebranded and it is impressive. Working is being done to implement a parents' portal for easier access to client information in real time.

The team prides itself in being a leader in supporting children facing limitations and challenges while excelling in parent engagement.

The program is for all children and youth facing physical, communication, and developmental challenges.

The program is funded by the Ministry of Children and Youth Services. There are many internal and external partnerships including schools, day care, acute care, and neonatal.

This is a strong, knowledgeable team that collaborates regularly to meet client needs. Parents are very complimentary of the services received. Staff interaction with two clients was observed to show compassion and attention to helping them reach their goals, which was impressive.

Priority Process: Competency

The team is interdisciplinary and knowledgeable. Team members collaborate on a regular basis internally and externally on behalf of the clients.

The team consists of physiotherapy, occupational therapy, therapy assistants, speech language pathology, social work, IT, systems navigator, and administration. There is also access to audiology and ophthalmology.

A representative from the team sits on the Best Practice Committee that represents the 21 centres across Ontario.

Staff participate in e-learning and have access to ongoing continuing education to support their areas of expertise.

Staff have held off-site retreats with parents to review various issues and initiatives. The team is very proud of its family engagement efforts to support the clients.

There are many student placements, including physiotherapists, occupational therapists, therapy assistants, medical staff, social workers, and speech language pathologists.

Priority Process: Episode of Care

Clinical services offered by KidsInclusive include developmental pediatricians, infant and child development program, occupational therapy, physiotherapy, psychology services, social work, speech language pathology, therapy assistants, and a number of specialized clinics like the First Step screening clinic, outreach clinics in Brockville and Smith Falls, the neuromuscular team, the school age team, the feeding clinic, and the seating and mobility clinic.

Group intervention programs are also offered, including Ready to Play, Tools for School, Tumble and Play, swim program, life skills, friendship camp, Lets Learn Language, and Sign With Me.

KidsInclusive has an impressive website that outlines its services and programs. The team hopes to develop and implement a portal for parents to use to access client information in real time.

Parents are very complimentary and appreciative of the staff and the services they receive, seeing the staff as knowledgeable, interactive, and helpful. They include the family along the way and are very committed to the clients and ensuring they reach their goals.

Clients and families appreciate the two free parking spots at HDH that are available to them by the door.

Client rights and responsibilities are being worked on across the organization; however, the declaration of patient values is understood and shared with families. It is shared in the patient and family guide at HDH.

Over half (61 percent) of KidsInclusive clinical visits occur in a community setting, while 39 percent occur at HDH. The team tries to take the service to the patient as much as possible. Two outreach clinics are offered on a regular basis.

All active clients have a care plan where the patient and family are active participants. The team prides itself on its parent engagement.

The team's patient advisor stated that she admires the team and the organization as they truly "walk the talk." They do what they say they are going to do to support and advocate for the clients.
The patient advisor acts in this role both for KidsInclusive and for the NICU; the patient advisor is also a member of the Lanark Leeds Grenville Special Needs Steering Committee, which is Co-Chaired by KidsInclusive."

The KidsInclusive electronic health record, GoldCare, includes most children's treatment centres in Ontario. This system allows the team to collect real-time metrics to evaluate their services and care. The team also has access to the electronic Children's Health Network.

The team is considering an agency portal as part of the circle of care, to ensure information among the team can be shared and to reduce duplication in the assessments and the questions asked.

The team does not do medication reconciliation. In the acceptance letter, the client is asked to bring a list of their medications from the pharmacy to the first visit.

The team has implemented and had approved through quality improvement a falls prevention strategy for clients. The policy and procedure includes GoldCare, the electronic health record. If a client is at risk of a fall, then an alert comes up to notify staff. This process is for children to prevent accidental falls, not general falling which may be normal for them. If a child is injured as a result of a fall, a safe report is completed; if not, then a safe report is not required.

Staff are trained on the use of mechanical lifts and other equipment. The beds go high and low, there are soft places to fall, and all clients are required to wear seat belts while in the wheelchair. Staff ensure they are beside the client for support when activities are underway and they take every precaution to protect the clients from injury.

The team has access to many resources for best practices, including the committee for the Ontario Association of Children's Rehabilitation Services, Rogers House for pediatric end-of-life care, and CAN Child which is a research group out of McMaster University.

Priority Process: Decision Support

Each client has an active care plan and an up-to-date chart. The electronic chart is GoldCare, a system that is used by most treatment centres in Ontario. This data source enables the team to collect real-time information about wait times, service targets, and client visits, and this is used to populate a quarterly dashboard that staff use to evaluate their work.

The team has many internal and external partners including Early Expressions, schools, Family and Children Services, Maltby/behaviour supports, acute care, and community living.

The team also does parent satisfaction surveys, Measure of Processes of Care, that measures client experience.

Priority Process: Impact on Outcomes

There is a team representative on the Best Practice Committee for the treatment centres across Ontario, funded by the Ministry of Children and Youth Services. This group reviews evidence-based guidelines to help the services and ensure the best and most up-to-date information is provided.

There is a solid understanding of ethics and the process for ethical research.

The team uses GoldCare for electronic documentation, which is used to gather real-time metrics to populate the quarterly dashboard. This also enables the team to have a strong quality improvement program to evaluate and direct the services.

The team monitors client safety incidents and has a good understanding of reporting and the disclosure process. Active processes to eliminate risk and injury were observed, like putting helmets on clients who were going to ride a bike and placing soft cushions for clients to fall on.

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: November 15, 2017 to January 5, 2018**
- **Number of responses: 9**

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	92
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	0	0	100	93
3. Subcommittees need better defined roles and responsibilities.	78	0	22	65
4. As a governing body, we do not become directly involved in management issues.	11	0	89	85
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	11	89	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.	0	0	100	97
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	11	0	89	93
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	0	11	89	94
9. Our governance processes need to better ensure that everyone participates in decision making.	67	0	33	60
10. The composition of our governing body contributes to strong governance and leadership performance.	0	0	100	92
11. Individual members ask for and listen to one another's ideas and input.	0	0	100	96
12. Our ongoing education and professional development is encouraged.	0	0	100	86
13. Working relationships among individual members are positive.	0	0	100	95
14. We have a process to set bylaws and corporate policies.	0	0	100	93
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	96
16. We benchmark our performance against other similar organizations and/or national standards.	0	0	100	79
17. Contributions of individual members are reviewed regularly.	0	33	67	61
18. As a team, we regularly review how we function together and how our governance processes could be improved.	0	11	89	76
19. There is a process for improving individual effectiveness when non-performance is an issue.	14	29	57	57
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	0	22	78	81

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
21. As individual members, we need better feedback about our contribution to the governing body.	67	22	11	40
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	0	0	100	79
23. As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	90
24. As a governing body, we hear stories about clients who experienced harm during care.	0	0	100	77
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.	0	22	78	85
27. We lack explicit criteria to recruit and select new members.	78	22	0	77
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	0	13	88	86
29. The composition of our governing body allows us to meet stakeholder and community needs.	0	0	100	94
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	0	13	88	89
31. We review our own structure, including size and subcommittee structure.	0	22	78	84
32. We have a process to elect or appoint our chair.	13	0	88	87

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2016 and agreed with the instrument items.

Overall, what is your assessment of the governing body's impact over the past 12 months, in terms of driving improvements to:	% Poor / Fair	% Good	% Very Good / Excellent	%Agree * Canadian Average
	Organization	Organization	Organization	
33. Patient safety	0	0	100	79

Overall, what is your assessment of the governing body's impact over the past 12 months, in terms of driving improvements to:	% Poor / Fair	% Good	% Very Good / Excellent	%Agree * Canadian Average
	Organization	Organization	Organization	
34. Quality of care	0	0	100	81

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2016 and agreed with the instrument items.

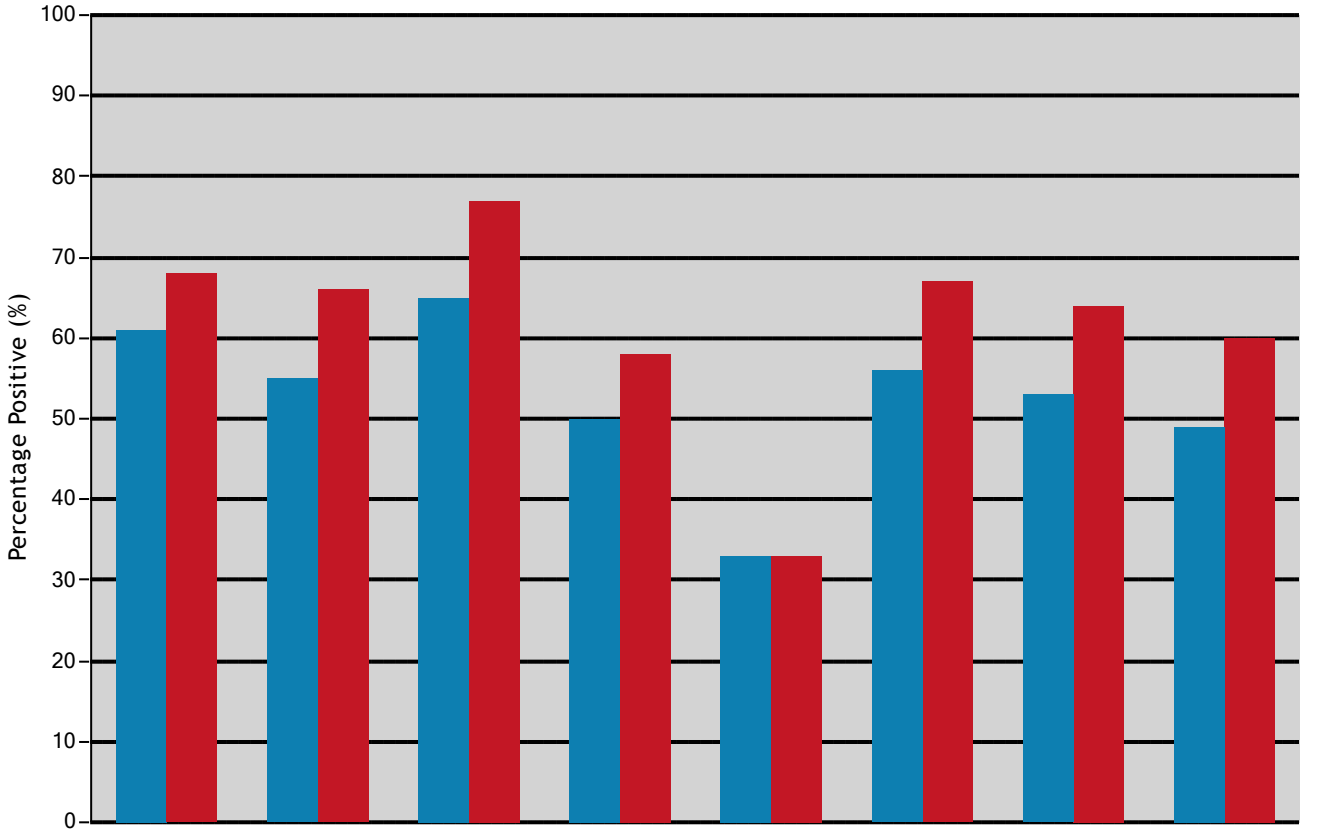
Canadian Patient Safety Culture Survey Tool

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 24, 2016 to November 16, 2016**
- **Minimum responses rate (based on the number of eligible employees): 320**
- **Number of responses: 669**

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
	61%	55%	65%	50%	33%	56%	53%	49%
	68%	66%	77%	58%	33%	67%	64%	60%

Legend

Kingston Health Sciences Centre

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2017 and agreed with the instrument items.

Worklife Pulse

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

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

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

Client Experience Tool

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

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

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

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

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

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

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

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

Appendix A - Qmentum

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

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

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

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

Action Planning

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

Appendix B - Priority Processes

Priority processes associated with system-wide standards

Priority Process	Description
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.