ACCREDITATION
AGRÉMENT
CANADA
Qmentum

Accreditation Report

Pembroke Regional Hospital Inc.

Pembroke, ON

On-site survey dates: September 24, 2018 - September 28, 2018

Report issued: October 31, 2018

About the Accreditation Report

Pembroke Regional Hospital Inc. (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. As part of this ongoing process of quality improvement, an on-site survey was conducted in September 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 Program Manager or Client Services Coordinator is available if you have questions or need guidance.

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

We look forward to our continued partnership.

Sincerely,

Leslee Thompson
Chief Executive Officer

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Executive Summary

Pembroke Regional Hospital Inc. (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

Pembroke Regional Hospital Inc.'s accreditation decision is:

Accredited with Exemplary Standing

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

About the On-site Survey

- **On-site survey dates: September 24, 2018 to September 28, 2018**

- **Location**

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

  1. Pembroke Regional Hospital

- **Standards**

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

  System-Wide Standards

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

  Service Excellence Standards

  5. Critical Care Services - Service Excellence Standards
  6. Diagnostic Imaging Services - Service Excellence Standards
  7. Emergency Department - Service Excellence Standards
  8. Inpatient Services - Service Excellence Standards
  9. Mental Health Services - Service Excellence Standards
  10. Obstetrics Services - Service Excellence Standards
  11. Perioperative Services and Invasive Procedures - Service Excellence Standards
  12. Rehabilitation Services - Service Excellence Standards

- **Instruments**

  The organization administered:

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

Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
 Population Focus (Work with my community to anticipate and meet our needs)	40	0	0	40
 Accessibility (Give me timely and equitable services)	74	0	1	75
 Safety (Keep me safe)	460	2	14	476
 Worklife (Take care of those who take care of me)	110	2	0	112
 Client-centred Services (Partner with me and my family in our care)	308	5	1	314
 Continuity (Coordinate my care across the continuum)	62	0	0	62
 Appropriateness (Do the right thing to achieve the best results)	682	5	9	696
 Efficiency (Make the best use of resources)	48	0	0	48
Total	**1784**	**14**	**25**	**1823**

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	50 (100.0%)	0 (0.0%)	0	95 (99.0%)	1 (1.0%)	0	145 (99.3%)	1 (0.7%)	0
Infection Prevention and Control Standards	64 (98.5%)	1 (1.5%)	2	33 (94.3%)	2 (5.7%)	2	97 (97.0%)	3 (3.0%)	4
Medication Management Standards	69 (100.0%)	0 (0.0%)	9	56 (98.2%)	1 (1.8%)	7	125 (99.2%)	1 (0.8%)	16
Critical Care Services	60 (100.0%)	0 (0.0%)	0	105 (100.0%)	0 (0.0%)	0	165 (100.0%)	0 (0.0%)	0
Diagnostic Imaging Services	67 (100.0%)	0 (0.0%)	0	69 (100.0%)	0 (0.0%)	0	136 (100.0%)	0 (0.0%)	0
Emergency Department	71 (100.0%)	0 (0.0%)	0	107 (100.0%)	0 (0.0%)	0	178 (100.0%)	0 (0.0%)	0
Inpatient Services	58 (98.3%)	1 (1.7%)	1	80 (97.6%)	2 (2.4%)	3	138 (97.9%)	3 (2.1%)	4

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Mental Health Services	49 (98.0%)	1 (2.0%)	0	92 (100.0%)	0 (0.0%)	0	141 (99.3%)	1 (0.7%)	0
Obstetrics Services	72 (98.6%)	1 (1.4%)	0	86 (97.7%)	2 (2.3%)	0	158 (98.1%)	3 (1.9%)	0
Perioperative Services and Invasive Procedures	113 (98.3%)	2 (1.7%)	0	109 (100.0%)	0 (0.0%)	0	222 (99.1%)	2 (0.9%)	0
Rehabilitation Services	45 (100.0%)	0 (0.0%)	0	80 (100.0%)	0 (0.0%)	0	125 (100.0%)	0 (0.0%)	0
Total	**768 (99.2%)**	6 (0.8%)	12	948 (99.2%)	8 (0.8%)	12	1716 (99.2%)	14 (0.8%)	24

* 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 (Critical Care Services)	Met	1 of 1	0 of 0
Client Identification (Diagnostic Imaging Services)	Met	1 of 1	0 of 0
Client Identification (Emergency Department)	Met	1 of 1	0 of 0
Client Identification (Inpatient Services)	Met	1 of 1	0 of 0
Client Identification (Mental Health 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 (Obstetrics Services)	Met	1 of 1	0 of 0
Client Identification (Perioperative Services and Invasive Procedures)	Met	1 of 1	0 of 0
Client Identification (Rehabilitation Services)	Met	1 of 1	0 of 0
Information transfer at care transitions (Critical Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Emergency Department)	Met	4 of 4	1 of 1
Information transfer at care transitions (Inpatient Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Mental Health Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Obstetrics Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (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 (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	5 of 5	0 of 0
Medication reconciliation at care transitions (Rehabilitation Services)	Met	5 of 5	0 of 0
Safe Surgery Checklist (Obstetrics Services)	Met	3 of 3	2 of 2
Safe Surgery Checklist (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
The “Do Not Use” list of abbreviations (Medication Management Standards)	Met	4 of 4	3 of 3
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management Standards)	Met	4 of 4	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
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 (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 (Mental Health Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Obstetrics Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Perioperative Services and Invasive Procedures)	Met	4 of 4	2 of 2
Infusion Pumps Training (Rehabilitation Services)	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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Worklife/Workforce			
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)	Met	1 of 1	2 of 2
Hand-Hygiene Education and Training (Infection Prevention and Control Standards)	Met	1 of 1	0 of 0
Infection Rates (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Reprocessing (Infection Prevention and Control Standards)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Risk Assessment			
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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
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 (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Rehabilitation Services)	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
Pressure Ulcer Prevention (Rehabilitation Services)	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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
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 (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.

The Board is engaged and very supportive of the Hospital and the region. While the Hospital has a strong religious tradition it sees itself as a regional leader supporting more pluralistic organizations. It was evident from discussions with both the Governance and Leadership teams that the Hospital is committed to bringing services closer to home for the benefit of its catchment population.

In discussions with community partners it was evident that Pembroke Regional Hospital (PRH) is respected and seen as a leader in the LHIN. The Partners were very supportive of PRH and grateful for its ongoing support. The Partners gave many examples where PRH provided leadership in the region, the group referenced: the Orthopedic Program, the Stroke Program, and monthly code sharing with the OPP. Many more examples were highlighted throughout the focus group discussion.

The Human Resource plan has good alignment with the strategic plan. PRH has had some programing changes since the last survey, an example being the spread of the Lean management program. Change management is all about communication, not only did the Human Capital Team develop a communication plan but they validated it with staff. This was further confirmed by discussions with staff during the human resources review.

The principles of Lean Management are well established throughout all clinical teams and PRH is to be commended for this achievement. The rigor of this program supports the quality and risk management program and allows staff to have a real impact on their work life. Further it has real time benefits toward patient care that were observed during a Gemba walk. For example, a staff member's idea for the reduction in Code White calls with dementia patients was being tested and early results look promising.

Throughout the clinical tracers, all departments have improved their services from the last accreditation cycle, implementing many of the recommendations. The teams have added programs and are seeing higher volumes of patients while still enhancing staff engagement. Each department's quality improvement initiatives are progressing in partnership with other departments and external partners.

There is good collegiality with teams and they all seem to work well together and support each other. There is appropriate programing offered by the hospital and when gaps are identified they are addressed e.g. the Orthopedic Program expansion. However, the Community Partners did identify an opportunity to improve services for child and adolescent mental health clients.

There is very good evidence of engagement of clients and families in various aspects of their care. The Client Engagement Focus Group (CEFG) note a change in the PRH's approach to clients and families and is more open to accept volunteers in many internal committees.

The CEFG noted the inclusion of families in care andwillingness to provide more information from the professional staff was highly valued. Clients' and families' are engaged in a range of organizational activities including:
setting the organization's Client and Family Centered Care (CFCC) objectives, providing input on service quality through client experience surveys, service planning and coordination,organizational committees, input into organizational space (both new or existing) along with quality and safety issues. However the CEFG noted that some additional education would benefit the team, in particular an opportunity to engage with other CEFG's to exchange ideas would be of benefit.

In the areas of ethics and emergency preparedness, the organization has worked very hard over the past 3 years to move these agendas forward. A full ethics framework and YODA roll-out and all 13 Emergency Preparedness codes implemented show great improvement. There are many physical plant improvements underway and planned for the future.

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)
The roles, responsibilities, and legal obligations of the governing body are defined in policy. Board policies are reviewed completely over a two year cycle. Timely access to meeting materials is available on the Board portal. The Board has a code of ethical conduct for its members and plans to have a presentation this fall as part of ongoing Board education. The Policy has been reviewed in the last six months. There is a process to develop the Hospital's by-laws and policies and they have been updated within the last 3 years. The Board uses a skills matrix when recruiting new members. The Board also considers diversity in its selection of new members.

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)

There is an organized communication strategy which included revisions to the website since the last survey.

Client and family-centred care is identified as a guiding principle for the the Hospital. The Hospital has a Patient Advisory Council and advisers are embedded on many clinical teams. Policies addressing the rights and responsibilities of clients are developed and implemented with input from clients and families. Input is sought from clients and families during the Hospital's key decision-making processes. The Patient Advisory Committee used pre-construction consultation for the orthopedic and surgical renovation.

The strategic plan and Quality Improvement Plan is reviewed on an annual basis. The LEAN program allows for goals and objectives at the team, unit, or program level to align with the strategic plan. Annual population health metrics are collected and analyzed. Annual operational plans are developed in consultation with staff and support the Quality Improvement Plan and Strategic plan. There is evidence of good consultation with the Medical Advisory Committee as the Operational Plan is developed.

There is evidence that there are formal strategies or processes used to manage change. Examples of this include: voice recognition software introduction and process of lowering the length of stay within the hospital.

Partnerships are developed with other organizations in the community to efficiently and effectively deliver and coordinate services. This included: home and community care is site based with hospital participation in discharge rounds, non-urgent Patient Transport, Health Links and Kids Health Alliance.

Priority Process: Resource Management

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

The organization has met all criteria for this priority process.
Surveyor comments on the priority process(es)
The Hospital follows Generally Accepted Accounting Principals (GAAP) and Budgets are developed in an appropriate manner. Regular reports are provided to the Board and Managers for oversight. Resource allocation decisions are made using objective criteria and are monitored with reviews as required.

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)

Pembroke Regional Hospital staff are knowledgeable, professional, and committed to providing high quality care to their community. They have embraced quality improvement and the accreditation process as part of their ongoing quality journey to ensure patient and family-centered care is delivered in alignment with their strategic goals.

Pembroke has a comprehensive human resources plan that includes actions to support strategic priorities, ensure quality of work life and work life balance, and promote a work environment based on the wellness and safety of staff and patients. The Human Resource Team is inclusive of a variety of services to support a healthy, competent workforce. This includes formal Occupational Health and Safety teams who have implemented many safety programs that includes an electronic reporting system, a review of incidents and near-misses for root cause analysis, action plans to mitigate risk, a violence prevention committee, and e-learning modules for staff education and engagement. Violence Risk Assessments have been completed on all 'high risk' areas. Staff have received training in non-violent crisis intervention as well as gentle persuasion education for staff working on the medicine inpatient units where dementia related code white incidents were identified as a lean management project. Safe client handling education has been implemented and mandatory for all employees.

Occupational health and safety (OHS) also provides social work support onsite for incident debriefing. EAP services are also available for all staff. The OHS team are also exploring the option of providing someone on site to assist with compassion fatigue during difficult clinical situations. There are supportive Return to Work programs provided for staff re-entering the workplace with a focus on an Early and Safe Return to Work project.

There are plans to roll out a new performance management and attendance support program in early 2019. Up to date Performance Appraisals were present on many employee files and were confirmed through conversations with staff but were not consistent throughout the organization.

The team has had challenges with recruitment of some positions but have been working with managers to identify potential vacancies and utilize a predictive approach to recruitment. There has also been significant focus on physician recruitment plans that includes a partnership with Family Practice to assist in the recruitment and retention of community physicians. As the organization works toward their goal to increase weighted cases, an assessment and identification of all resources required to support this, including physician resources, are being considered.

There are numerous activities across the organization to show support and celebrate staff accomplishments. This includes huddle celebrations, a staff newsletter that highlight all huddle celebrations, seasonal meal celebrations, long services awards, and perfect attendance awards.

A significant achievement that should be noted is the improvement across the organization with respect to staff engagement. The leadership team recognized areas with low scores from 2016 surveys and partnered with staff to develop plans and strategies to address issues. Two strategies implemented include senior leader participation in unit huddles as well as a scheduled plan to perform 'Gemba Walks" 10 times per year. The 2018 engagement survey results show significant improvement in staff engagement.

It is evident that Pembroke Regional Hospital values their employees and has invested resources in ensuring a safe, healthy, competent and engaged workforce.

Priority Process: Integrated Quality Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

An Ontario Ministry of Labor review lead to a focus on safety and the creation of a culture of safety. The LEAN program was started in 2013 and introduced LEAN as a business management tool. It is well entrenched within the Hospital. LEAN supportsl leaders and all staff throughout the organization to participate in collaborative quality improvement initiatives. LEAN processes provide for regular feedback to team members, clients, and families who participate in quality improvement initiatives.

There are clear, documented processes shared with clients and families about how to file a complaint about the organization related to their care or a violation of their rights.

It is clear that the hospitals' leaders are involved in leading quality improvement initiatives. This was evidenced by department huddles and management walk abouts. The spread and sustainability of quality improvement results is well promoted and supported.

The Hospital acquired the HIROC tool for risk management. The top 5 risks for the organization will be part of the next boards' education sessions. Each identified risk has a mitigation strategy. The risk management approach and contingency plans are disseminated throughout the by piloting in one unit and spread from there.

It is evident that a patient safety incident management system that supports reporting and learning has been implemented as confirmed by the Patient Advisory Committee .

Compliance with the medication reconciliation process is monitored and improvements are made when identified. At times, the hospitalists have found it difficult to comply with medication reconciliation.

Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The hospital has implemented a new model for ethics in the last year to move the ethics agenda forward. They have an agreement with the Centre for Bioethics to have an bioethicist available to them for development of their ethics program as well as for case discussion, education and review. The committee is comprised of leadership, staff, a chaplain and a physician and work is ongoing to add a patient family adviser. The committee has worked to develop tools that are easier to understand and more user friendly by the staff and physicians. The further development of the ethics framework along with tools and YODA poster has brought ethics to the clinical interface. Staff that were asked knew about YODA and how to escalate ethical concerns in the organization. There is a new patient pamphlet being reviewed to educate patients and families which will be soon implemented.

Along with the review of ethical dilemmas brought forward to committee, the policy is also focused on the Code of Conduct and Patient Bill of Rights, disclosure of incidents, and how ethics can play a role in the hiring and on-boarding process. Where research is being conducted the hospital uses REB at CHEO or TOH to support them in being a partner in primary research initiatives at the larger centres.

As a result of the advent of new MAID initiative, the organization has dedicated time to create a policy that meets the Catholic Health Ethics Guide that has been presented at the Board and senior team level along with education by the ethicist. There has been one request for MAID assessment since the implementation.

Overall, the hospital has made excellent progress since the last survey and should be commended.

Priority Process: Communication

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
11.4 There are policies and processes to allow clients to easily access the information in their health record in a routine and timely way.	

Surveyor comments on the priority process(es)

Pembroke Regional Hospital has developed strong networks for communication from the Board and Executive Teams to the point of care staff, partners and community. Cross appointments between the CEO, Board and Foundation has ensured unified commitment to a shared vision and strategy.

A robust communication plan has been created that is grounded in ensuring the public. staff and patients are informed, involved and engaged. The communication plan is inclusive of all forms of communication, including a traditional approach to information shared though the long standing quarterly publication called the Community Connection, to more technological forums such as Facebook, a youtube channel, and linkedin sites.

The newly adopted huddle boards throughout the organization have been well received by staff and leaders, creating a common platform to share corporate indicators and linking unit specific work to the organizational strategy. Point of care staff have articulated a feeling of being heard with respect to worklife issues and engaged in being solution focused. The involvement of Senior Leadership in team huddles has ensured a connection between point of care teams and the hospital leadership, proving a deeper understanding of the every day operational issues.

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 are 4 towers at the Pembroke site which vary in age and infrastructure needs. There has been continued work on regular HIRF submissions as well as requests for urgent needs. Tower A has been identified as a high needs area and a pre-capital submission has been written. Tower D has a new OR which meets the air exchange, filter replacement, and heat and humidity controlled needs. There is an electronic monitoring of the heat and humidity which the physical plant staff can monitor and react as needed. There are ongoing physical plant needs despite the construction projects that are underway. There is also a 10 year capital plan.

The IT departments works in conjunction with the physical plant department as they are launching a large duress system initiative to include patient wandering, child protection, Code White and RFID. There is also plans for a CITRIX and phone system upgrade along with HRIS for staff.

As the hospital has a few contractors that regular bid on contracted out work they are well familiar with the hospital and the management of construction in a building where patients are receiving care. The construction areas are well marked, clean and has regular auditing from the plant department with IPAC support.

One of their top risks remains the generator issue of emission control although the fuel system issue has been corrected and they have had no downtime issues of both main and back up power recently.

There are regular inspections by the Fire Marshall and the citing of sprinkler needs in the older areas to comply with new provincial standards. These upgrades are happening in conjunction with approved renovation with Tower A and Day Surgery at the top of the list for major needs. Tower C is slated for elevator replacement as they are often down.

An electronic work order system allows for staff to identify needs on their areas with clinical areas taking repair priority. There is regular review of staff and patient safety reports which identify areas for further review and repair.

Despite the lack of resources the team is on top of the needs of the organization and works to make the most of the funding and resources they have. Ongoing work on MoH funding and LHIN connections is required to keep the needs of this organization top of list.

Priority Process: Emergency Preparedness

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The Emergency Perparedness Committee (EPC) is commended for their work since the last survey. They have implemented all 13 codes along with EPC stations on all areas. The have a full fire safety plan along wih Code of the Month for education and training. Staff questioned through the survey knew what Code of the month was happening and what their role was in keeping knowledge current. Scenario sheets help guide the conversation at huddles on the monthly code. E-learning is available and part of on-boarding of staff and physicians as well as yearly updating with credentialing and staff annual reviews. There has been particular focus paid to locum physicians from Quebec as their Code Black is the more nationally known Orange and visa versa.

There has been a robust plan for mock code throughout the year internally and in exercises with community partners including fire, police,and city planners. Code reviews include scenarios for earthquakes, dirty bombs, Ebola, ionized radiation and accident disasters. A CRBN decontamination drill has been completed as well Ebola PPE exercise. The pandemic plan is updated yearly with public health. In addition, the fire department conducts a vulnerable patient occupancy drill as legislated. Each day all patients are reviewed for their transport needs if a code occurred and there is med sled training for staff.

There is a command centre model along with community centres for evacuation needs, in particular Algonquin College for the hospital's primary needs. As well there has been live Codes in Orange, Grey, Brown, Pink and Blue. The Medical Care Committee reviews Codes Blue, Pink and Orange and discuss improvements at their meetings. After every Code, exercise or real, there is a full after action report to look for areas for improvement. Fan-out lists are tested regularly to ensure staff and physician outreach and staging can occur. The committee is moving towards a desk top icon for all codes and algorithms for ease of staff access and further med sled exercises are planned. The committee is aware that sustainability of knowledge is key to ongoing staff and physician engagement and success and they are focused on ensuring the gains over the past three years are sustained.

Priority Process: People-Centred Care

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The Community Partners Focus Group stated that the relationship has changed in the last 10 years. There is a willingness to accept volunteers. The relationship with the hospital is positive. The inclusion of families in care and willingness to provide information by the professional staff was highly valued. Concerns or complaints are addressed promptly.

Communication mechanisms for sharing information among clients, families, and the organization is informed by input from clients and families. Communication includes newsletters, signage, hospital pamphlets, website redesign along withfood service and barrier identification in the physical plant.

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)
Client flow data is tracked and managed through the use of a Daily Activity Reporting Tool (DART). The DART is accessible to all levels from leadership to frontline staff. The daily bed meeting at mid morning and ad hoc supplemental discussions are regularly conducted to optimize discharge of suitable patients and collaboratively address barriers. The team has identified and managed a number of barriers to facilitate patient flow including overcoming home medical equipment and affordability. They are also engaging PSW shortages and Hospitalist workload considerations to further improvements in this area.

Priority Process: Medical Devices and Equipment

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The medical devices and equipment processes at PRH are well managed with proactive engagement from each department involved. The preventative maintenance program is led by the technician from CHEO who works onsite at PRH. The preventative maintenance program is organized and proactive.

Standards of work have been developed for the reprocessing processes in diagnostic imaging, endoscopy and central reprocessing. These are covered during orientation of new staff as well as posted in the reprocessing areas as a ready resource for staff to review as required. Reprocessing areas are physically separate in a dedicated room away from client service areas. Many records in reprocessing are still completed manually and consideration to conversion to electronic records is recommended.

Separate clean storage away from reprocessing has been in place for the last 2 years within diagnostic imaging implementing the recommendation for this from the last accreditation cycle. Within endoscopy, the current infrastructure is known not be ideal in terms of set up. That said, while awaiting a purpose built endoscopy suite in approximately two years, endoscope reprocessing is completed in three separate areas; pre-cleaning & gross decontamination, cleaning & disinfection and clean storage. This was assessed as meeting the standard, but ongoing close monitoring or similar quality assurance activities is recommended while awaiting the new endoscopy infrastructure.

Since the last accreditation cycle routine sterilization has been outsourced to Steripro. With this change came updated training and ongoing support in utilizing their electronic cataloging and tracing system for PRH staff. A strong working relationship exists with Steripro with clear roles and responsibilities established, but also collaborative work to progress quality improvement initiatives in life-cycling, functionality testing and overall process efficiencies.

Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Clinical Leadership

- Providing leadership and 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

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	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	
Priority Process: Organ and Tissue Donation	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The ICU has seven beds with the ability to surge up to nine beds if required. The unit functions in the capacity of an adult step-up/step-down unit, with varying levels of acuity including intubated patients frequently. The manager has administrative responsibility for both the emergency department and the ICU. She is a strong leader and very in tune with both her staff and the needs of the population. She is currently involved with a palliative care/end of life educational resources for the unit as a part of her own professional development.

Strong partnerships with outside agencies such as CCAC and alcohol detox services exist. They are engaged and involved in care planning in hospital while the patient is admitted to promote early, successful discharge planning.

Priority Process: Competency

Staff complete annual e-learning training and are well supported to advance their knowledge and skills in both formal and informal manners. Staff are cross-trained for both the emergency department and the ICU providing a broad skillset and flexible options for staffing.

Priority Process: Episode of Care

Multi-disciplinary rounds are completed with patient and family involvment to ensure their participation in care planning. Standardized SBAR communication is utilized during admission to and discharge from the unit.

Medication reconciliation is completed in partnership with emergency department staff and the pharmacy technician on recently admitted patients. Electronic resources which are populated by the pharmacy staff are available to MRPs at time of discharge to complete medication reconciliation of medication changes while in hospital.

Pre-printed order sets prompt evidence informed prevention of VTE, ventilator associated pneumonia, central line infections and urinary tract infections.

Priority Process: Decision Support

The team participates in the critical care information system (CCIS) to assist with planning services for the intensive care unit (ICU) population.
The ICU has hospitalist MRPs with good support from the general medicine internists or surgeons as required. For a patient requiring escalation in care Criticall is engaged with subsequent air or ground transfer.

Priority Process: Impact on Outcomes

LEAN activities continue in partnership with the Emergency Department and staff continue to be highly engaged with these processes. Preprinted order sets are used for common conditions effectively standardizing evidenced-based approaches. Improvements were made to the family room and client/family engaged multi-disciplinary rounds through ongoing QI initiatives. As further paper-based systems are converted to computer-based there will be improvement in the data available to guide future initiatives.

Priority Process: Organ and Tissue Donation

There is a policy and process for organ and tissue donation. Hospital staff have received training and education for this and are supporters of facilitating donation as applicable.

Standards Set: Diagnostic Imaging Services - Direct Service Provision

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

The organization has met all criteria for this priority process.

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

The Diagnostic Imaging Department is a purpose design-built area which houses CR, MRI, CT, US , mammography (OBSP site), interventional, pain injections and echo. As well, the department houses nuclear medicine which has been struggling with staffing. The volume in the department has increased in the last 2 years with about 6000 images per month being completed. The service is available 24/7 all year round with most day shift from morning to early evening and on-call post regular hours. The department services Renfrew County and is a highly regarded top 10 performer in the LHIN indicators for care delivery. Presently they are involved in a LHIN initiative lead by KPMG to look at a central intake model.

There are 6 radiologists in the department that speak about their cohesive team and their approach to all modalities of interpretation. They indicate the variety is what keeps them in the department along with learning opportunities among themselves and with the larger centres. They have also worked with the local family physicians to educate about modality choice when ordering outpatient diagnostics. The staff have regular training and take students on a regular basis. Orientation is comprehensive and they also speak to a great spirit in their department. The are all proud of their ability to provide care closer to home and feel supported by leadership in their capital equipment needs given the cost and competing hospital needs.With the installation of the new MRI, the team was proactive in fire department and maintenance training to safely work with this new modality.

They have a strong collaboration with the ED and have streamlined the missed exam process for call-backs for repeat tests or further treatment. They have also implemented a 3 hour response time to ED needs. Their largest struggle is in the echo area where they are struggling to find enough internal medicine to cover the service needs to have the service move to a new location inside the hospital.

They are recruiting a patient family advisor to their leadership team and have used advisors for their wayfinding and other patient friendly initiatives. Overall, the team has worked hard since the last survey to ensure they have closed any standards gaps and have used lean management and initiatives for better service delivery.

Standards Set: Emergency Department - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The emergency department (ED) is a positive, engaged work environment with approximately 36,000 visits per year. The department team has 23 stretcher bays including one negative pressure room available to isolate suspected infectious diseases.

The emergency department staff were very positive and are highly engaged in providing quality patient care and participating in continuous quality improvement. Processes, policies and current initiatives were well known to all staff interviewed.

Priority Process: Competency

Annual e-learning training is completed by all staff. Staff are cross-trained for both emergency and ICU work fostering a collaborative approach between both units.

A lack of local pediatrician outpatient availability was noted at the last accreditation cycle review and continues to be unavailable. Exploration of options for Senior Pediatric Resident led outreach clinics may be a potential solution.

Priority Process: Episode of Care

Medication reconciliation is completed on all admitted patients and target to over age 65 at risk populations.

Falls prevention program updates have recently been implemented with staff buy-in.

A new initiative with specifically designated patient representatives is soon to be implemented. Grounded in patient feedback received from comment cards, this is intended to further foster communication with patients in the waiting room especially during busy periods.

Observed, described and documentation for care transitions covers the requisite information for handovers in care.

Priority Process: Decision Support

Increased use of computer based charting and data entry has identified opportunities to ensure consistency, metric data collection and communication. Strategies to to continue to advance in this area have been initiated.

Priority Process: Impact on Outcomes

Quality improvement initiatives have been undertaken to improve discharge planning consistency, pneumonia treatment pathways and physiotherapy mobility reviews in the emergency department with good results. In particular, the discharge planning consistency improvements demonstrate the team is obtaining patient and family feedback and utilizing PDSA in order to make improvements in a timely manner to better serve their population.

Daily huddles continue to engage the staff in continuous quality improvement and frequently includes outside partnership engagement/participation.

Priority Process: Organ and Tissue Donation

There is a policy and process for organ and tissue donation. Hospital staff have received training and education for this and are supporters of facilitating donation as applicable.

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

Unmet Criteria		High Priority Criteria
Priority Process: Infection Prevention and Control		
2.4	There is an interdisciplinary committee to provide guidance about the IPC program.	
2.5	The interdisciplinary committee regularly evaluates the program's structure and functions and makes improvements as needed.	
14.1	There is a quality improvement plan for the IPC program.	!
Surveyor comments on the priority process(es)		
Priority Process: Infection Prevention and Control		

Infection Prevention and Control has 2.0 FTEs (1 full time, 2 part time and some casual nurses), dedicated Infection Control Practitioners.Although there is not a dedicated infectious disease physician onsite, the team has successfully built partnerships with an ID physician in Ottawa and are working on developing a medical and surgical physician lead for ICP within Pembroke Regional Hospital.

Infection Prevention and Control measure numerous performance indicators, including surgical site infection rates, hospital acquired infections, MRSA, VRE, Central Line infections rate, and Clostridium Difficile infections (C-Diff). C-Diff rates were identified as an area for improvement. The Board of Directors as well as the leadership team identified reduction in hospital acquired C-Diff as a strategic priority and have successfully seen a significant reduction.

Antimicrobial stewardship has been a high priority for ICP and in partnership with strong physician champions, have worked with physicians and pharmacy to successfully begin implementing best practices in antibiotic prescribing practices. ICP nurses have developed a partnership with the facility maintenance department that includes attendance at weekly meetings and 'walk abouts' to ensure connectivity to ongoing maintenance projects, ensuring that an infection control lens is part of all projects.

ICP should establish a formalized interdisciplinary committee with Terms of Reference and a formalized quality improvement plan. Peer auditors for hand hygiene should be implemented to ensure accuracy of auditing. An audit process for dress code should be formalized to ensure compliance to best practices. Physician and leadership champions for flu vaccine should be established to assist in improving vaccine rates.

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	
5.4 Standardized communication tools are used to share information about a client's care within and between teams.	!
Priority Process: Episode of Care	
8.7 Translation and interpretation services are available for clients and families as needed.	
Priority Process: Decision Support	
12.4 Clients are able to access information in their records, including electronic medical/health records, in a routine, client-centred, and timely way.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

See summary in episode of care

Priority Process: Competency

See summary in episode of care

Priority Process: Episode of Care

The 2nd floor and 3rd floor Medicine units have a combined 53 inpatient beds that serve a wide range of medical conditions. The obvious pride and commitment by the team to quality person-centered care was evident from the hospitalist physicians, Director, Manager, Educator, discharge planners, and front-line staff.

The units were clean, organized and each patient room was equipped with white boards where patients, family, and staff document and contribute to the plan of care, goals, and discharge planning. There is

construction work on the 2nd floor unit which has resulted in some clutter in the narrow halls. The unit should be routinely inspected for sterile supply storage as some items were noted on the floor in supply rooms and some were being stored on the counter next to a sink.

Huddle boards are present on both units . Information is posted with respect to Key Performance Indicators such as hand hygiene audits, medication reconciliation, falls rates, pressure ulcer incidence as well as other unit specific goals and quality improvement projects. The staff are engaged in lean management quality improvement activities and articulated the value in being able to identify improvement opportunities and be part of the change required to impact better patient care.

The team is well versed in the ethics framework and were able to provide a recent example of when that framework was utilized by the team. The medicine inpatient unit does not provide MAiD care, however they do provide palliative care and end of life care. They have invested in education for the team on end of life care.

The team has identified a significant increase in patients with dementia and the correlation with code white incidents on the medicine units. They have made improving the care of patients with dementia one of their unit priorities, providing education to staff on 'gentle persuasion' techniques.

The team has also developed an assessment process to identify patients who are high risk for readmission and have developed strategies to link patients with follow up on discharge with their family physician as well as telephone follow up to assess the needs for additional home supports. They have also developed a partnership with their paramedic program so all patients who have experienced a fall within the past year and is over 65 years of age will get a home assessment through the paramedic program.

The team also identified 'falls' as an area for improvement with their patient population. They have implemented falls huddles that allow for a root cause assessment within 15 minutes of a fall incident. They have successfully reduced their falls rate by about 50%.

Bedside rounds has been implemented, is interdisciplinary, and includes the patient and family.

Priority Process: Decision Support

See summary in episode of care

Priority Process: Impact on Outcomes

See summary in episode of care

Standards Set: Medication Management Standards - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Medication Management	
3.3 The interdisciplinary committee regularly reviews and updates the formulary.	
Surveyor comments on the priority process(es)	
Priority Process: Medication Management	

The pharmacy, IPAC and MD team have worked hard since the last survey to move forward on antibiotic stewardship. Without an electronic pharmacy system there is no capacity to generate physician scorecards for this initiative. The team indicates a greater partnership with physicians on this work and an ASP computer module has been helpful in moving this initiative forward.

The pharmacy team is a lean team who struggle to maintain their work and to move pharmacy management forward. They clearly know what needs to be done next but human resources are at a minimum to make that happen. The pharmacy formulary requires a full review but there is limited resources to make that happen.

The hospital has spent time on the med reconciliation initiative given a fully paper process and have a process to collect BPMH and reconcile medications at transfer and discharge. A more automated process would help with the implementation of order sets and allow for better tracking and auditing of care protocols.

As a P&T Committee was not getting traction, pharmacy issues have been taken to the Medical Care Committee. There is now a realization that this committee needs a pharmacy sub-committee to address pharmacy/medication initiatives and issues.

The department has a pharmacy plan which includes full implementation of temperature controlled fridges with monitoring across the hospital. Smart pumps would also be helpful for programmed dosages and tracking. As well the department has their sights set on CPOE, unit dose and other initiatives that have been captured from a consultant review and road mapping for the department.

Since the last survey there is a pharmacist available 24/7 when required and an after hours locked med cupboard. There has also been work completed on pre-filled syringes, and an IV push initiative in response to a minibag shortage.

Despite staffing issues the department is proud of their many successes which includes oral/liquid narcotic unit dose, a closed loop system for chemo, the ASP module, mock chemo spill drills and the beginning of a shadowing program for nursing and pharm techs to understand each others role better. There is present work on a medical marijuana P&P and an IV to oral initiatives to prepare patients for discharge or decrease LOS.

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	
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	
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

The hospital provides inpatient services for voluntary patients in a 15 bed unit that can flex up if needed. The department has a close association with the Emergency Department and mental health staff attend patients in the ED to assess the need for inpatient or community services using an Evaluation of Needs triage tool.

There are about 110 staff dedicated to mental health services in the hospital and community setting and as this network is integrated, a single health record supports the patient journey and wraps services around each patient providing a seamless system of care. There is an annual meeting of all of these services to connect as a network system. The crisis team provides a pivotal role in connecting services and working with the police in the community if required. A system navigator role on the unit is a new position and plays the role of community crisis worker in the hospital to provide intermediate support and liaison to the community. A peer support worker role is seen as the voice of wisdom for patients/clients.

There is an identified physician human resource issue and often a patient presents to the hospital as the only way to have access to a psychiatrist. Although there is training of physicians at the site, shortages in Ottawa and Cornwall draw new psychiatrists to the larger centers.

If patients present to the ED that are under 18 the crisis service sees them and plays a navigator role to services at CHEO or Phoenix services.

Priority Process: Competency

The staff speak of a good orientation to the service as well as ongoing on-line and in-service training.The staff mix is RN, RPN, SW, discharge planning and ward clerk support with a recreation therapist as a new addition 2 years ago. The team speaks of working well together and feeling supported by the leadership team and especially since the LEAN initiative. All staff speak of the constant communication and information exchange to make their team function for best patient care.

Huddles happen twice weekly and support idea exchange for improvements and sharing of kudos cards to staff which makes for a positive work environment.

Priority Process: Episode of Care

Although the inpatient service is a voluntary admission unit they at times it support involuntary patients until they can be transferred to Ottawa. There is a seclusion room on the unit which is readily available. As the hospital oversees the community services there is a good integration of services for the patients and seamlessly transition in and out of services. Housing remains a challenge for the team in finding appropriate accommodation for clients.

A positive patient experience is supported by various strategies including a patient adviser on the leadership team, in-hospital surveys of patients, a patient lounge suggestion box and the Ontario Perception of Care tool for the evaluation of mental health services by clients. Clients have access to a lounge they designed and have access to the Recovery Library on-line.

There is a Code White response team and reviews occur for post team outcomes along with staff training for deescalation and other techniques.

Priority Process: Decision Support

The patient record in mental health is paper based along with community and ED reports available. A new patient tracking board is being trialed in the area with positive feedback from staff. Their ability to flag patient issues, discharge planning and safety tracking provides line of sight to all staff.

The staff have worked hard to support patients with the use of their cell phones to decrease anxiety in a balance for rules around it's use during daytime hours. The phones are surrendered at night to a charging station. This is good example of working with clients to find a workable solution to support patient recovery.

Priority Process: Impact on Outcomes

The service is very open to client and family input and improvements to make their services more accessible and comprehensive. The service uses feedback to make changes and involves the patients and families. There is a post discharge call service to follow-up with patients post discharge.

The service collects data about their patient and services both at the hospital and in the community. They monitor indicators both at the local and network level.

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	
4.4 Standardized communication tools are used to share information about a client's care within and between teams.	!
Priority Process: Episode of Care	
7.7 Translation and interpretation services are available for clients and families as needed.	
Priority Process: Decision Support	
14.4 Clients are able to access information in their records, including electronic medical/health records, in a routine, client-centred, and timely way.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

See summary in episode of care

Priority Process: Competency

See summary in episode of care

Priority Process: Episode of Care

The Obstetrical department demonstrates excellence in care delivery for approximately 750 births a year.The dedication and commitment to quality family-centered maternal and newborn care was evident throughout the team, including strong engagement by the unit manager, lactation consultant and point of care staff. Although the hospital does not have a 'baby friendly' designation, the department follows many of the baby friendly processes which has resulted in significant improvements in their patient-centered approach to maternal and newborn care.

Prior to delivery, patients are often seen in the early assessment clinic which is located within the Obstetric unit. There is a consistent nursing team that provide this care as well as labor and delivery/postpartum care which allows for a consistent approach across the continuum of care. There has been a significant focus on infant loss and the support of end of life care for infants with staff education and support through the Pregnancy and Infant Loss program.

The team has a huddle board and actively participates in lean management quality improvement activities. The huddle board provides a forum to evaluate unit priorities such as 'skin to skin' within 2 hours of delivery and 'skin to skin', breast or sucralose for painful procedures. The staff have embraced these quality improvement goals and this is evident in their audits for compliance. Interviews with patients validated the significant improvements this team have made around patient and family-centered care and patient experience.

Priority Process: Decision Support

See summary in episode of care

Priority Process: Impact on Outcomes

See summary episode of care

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.	!
6.13	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
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 surgical program runs four rooms daily. The services provided are otolaryngology (ENT), general surgery, orthopedics, dental, urology, ophthalmology, endoscopy and gynecology. The orthopedics service has been added since the last accreditation cycle and the entire organization has adapted well to the addition of this valued service for the population.

The team has re-engaged LEAN methodology and staff are active participants in the morning huddle and ongoing quality improvement initiatives.

Priority Process: Competency

Utilizing the Choosing Wisely resources, preoperative assessment requirements were updated to increase efficiency in targeted low-risk populations. A quality improvement initiative also streamlined the OR booking process through process mapping and collaboration.

A post-op specific SBAR communication tool is in place. OR to recovery staff communication at this transition covers standardized content.

Performance evaluation of the peri-operative staff is currently not being completed. It is reported they are awaiting HR development and direction on the methods to be utilized consistently across the organization.

Priority Process: Episode of Care

A post-op specific SBAR communication tool is in place. OR to recovery staff communication at this transition covers standardized content, but not in a structured manner compared to other communication. It is recommended this communication be reviewed to determine if standardization would be beneficial.

Medication Reconciliation is completed on admitted patients. It can easily be located on the patient charts. Medication reconciliation for day surgery patients is not done.

Fall risk assessments are completed at admission.

Priority Process: Decision Support

An electronic whiteboard/patient tracking mechanism throughout peri-operative services has been identified as an opportunity for improvement in communication, collaboration and data metric generation to progress beyond the current manual system.

Priority Process: Impact on Outcomes

A number of quality improvement activities have been undertaken. A couple of notable recent successes include improving OR turnover times, streamlining pre-op assessments and monitoring case cancellations for trends. Review of opportunities to automate some of the data gathering to inform initiatives like these is recommended.

Priority Process: Medication Management

Medication management for the perioperative services meets all standards from storage to medication preparation to administration of high-risk medications.

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Hospital is responsible for stroke care in the region and responds to code stroke for the region. The Team follows Canadian best practice guidelines for stroke care.

The Hospital uses lean methodology to set goals and align there goals with the Hospital strategic plan. Staff engagement on the team is very high. The LHIN set a rehab intensity 90 min per patient per day over a 7 day week which was achieved using the LEAN management system.

Unit huddles are used to plan care on a daily basis. The Provincial Stroke Program sets goals for stroke care.

Information on services is available to clients and families, partner organizations and the community via the Hospital website and written materials. A universally-accessible environment is created with input from clients and families. The space is well designed and appropriate to the point of including a fully functional accessible apartment.

Priority Process: Competency

Required training and education are defined for all team members with input from clients and families. In addition, a rehab mentorship program is provided to new staff for up to a 150 hours. Credentials, qualifications, and competencies are verified, documented,up-to-date and subject to an annual review.

The LEAN management system is a collaborative approach is used to deliver services. The LEAN Management Systems allows team members to be recognized for their contributions.

Following a Ministry of Labor visit, education and training are provided to team members addressing how to prevent and manage workplace violence, including abuse, aggression, threats, and assaults.

Priority Process: Episode of Care

Current and potential clients and their families can access essential services 24 hours a day, seven days a week. Information about the client is gathered as part of the intake process and as required. The client's capacity to provide informed consent is determined on admission. Clients and families are provided with information about how to file a complaint or report violations of their rights.

Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions and is well done.

To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated and is well done. Each client's risk for developing a pressure ulcer is assessed and interventions to prevent pressure ulcers are implemented. 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.

Priority Process: Decision Support

Technology and information systems requirements and gaps are identified and communicated to the organization's leaders. An accurate, up-to-date, and complete record is maintained for each client, in partnership with the client and family.

Policies and procedures for securely storing, retaining, and destroying client records are followed. Training and education about legislation to protect client privacy and appropriately use client information are provided.

Priority Process: Impact on Outcomes

There is a standardized procedure to select evidence-informed guidelines that are appropriate for the services offered. Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families. A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families. Patient safety incidents are reported according to the organization's policy and documented in the client and the organization record as applicable. Patient safety incidents are disclosed to the affected clients and families according to the organization's policy, and support is facilitated if necessary.

Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities. Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.

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: February 5, 2018 to February 16, 2018**
- **Number of responses: 13**

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	N/A
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	0	0	100	N/A
3. Subcommittees need better defined roles and responsibilities.	85	15	0	N/A
4. As a governing body, we do not become directly involved in management issues.	0	0	100	N/A
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	N/A

	% 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	N/A
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	0	100	N/A
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	0	0	100	N/A
9. Our governance processes need to better ensure that everyone participates in decision making.	77	8	15	N/A
10. The composition of our governing body contributes to strong governance and leadership performance.	0	0	100	N/A
11. Individual members ask for and listen to one another's ideas and input.	0	0	100	N/A
12. Our ongoing education and professional development is encouraged.	0	0	100	N/A
13. Working relationships among individual members are positive.	0	0	100	N/A
14. We have a process to set bylaws and corporate policies.	0	8	92	N/A
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	8	92	N/A
16. We benchmark our performance against other similar organizations and/or national standards.	0	15	85	N/A
17. Contributions of individual members are reviewed regularly.	0	0	100	N/A
18. As a team, we regularly review how we function together and how our governance processes could be improved.	0	15	85	N/A
19. There is a process for improving individual effectiveness when non-performance is an issue.	0	15	85	N/A
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	0	0	100	N/A

	% 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.	62	15	23	N/A
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	0	0	100	N/A
23. As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	N/A
24. As a governing body, we hear stories about clients who experienced harm during care.	0	15	85	N/A
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	0	0	100	N/A
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	0	0	100	N/A
27. We lack explicit criteria to recruit and select new members.	77	15	8	N/A
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	0	0	100	N/A
29. The composition of our governing body allows us to meet stakeholder and community needs.	0	0	100	N/A
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	N/A
31. We review our own structure, including size and subcommittee structure.	0	0	100	N/A
32. We have a process to elect or appoint our chair.	0	8	92	N/A

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	15	85	N/A
34. Quality of care	0	15	85	N/A

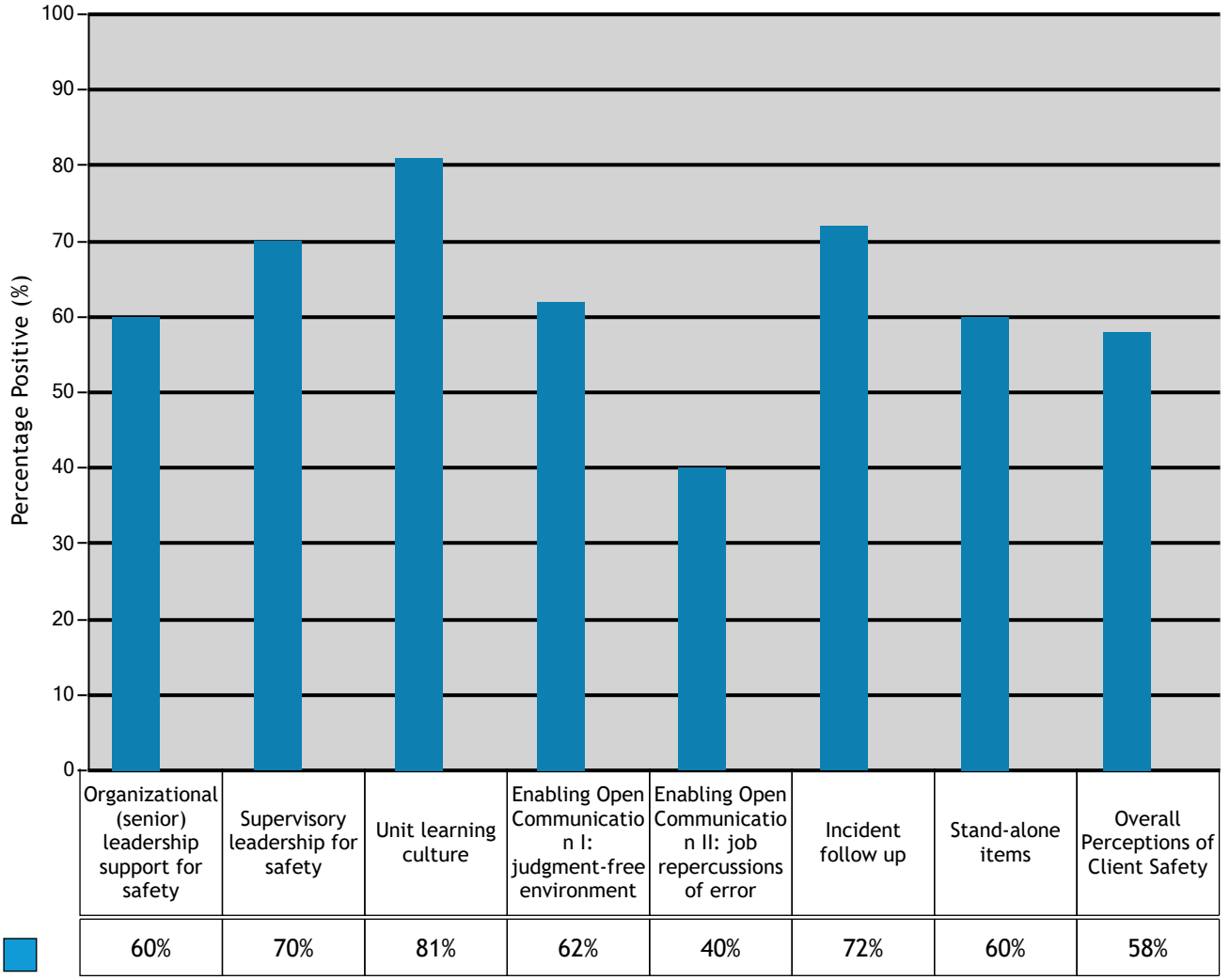
Canadian Patient Safety Culture Survey Tool

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: June 5, 2017 to June 20, 2017**
- **Minimum responses rate (based on the number of eligible employees): 201**
- **Number of responses: 223**

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



Organizational (senior) leadership support for safety	Supervisory leadership for safety	Unit learning culture	Enabling Open Communication I: judgment-free environment	Enabling Open Communication II: job repercussions of error	Incident follow up	Stand-alone items	Overall Perceptions of Client Safety
60%	70%	81%	62%	40%	72%	60%	58%

Legend

Pembroke Regional Hospital Inc.

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.