ACCREDITATION AGRÉMENT CANADA
Qmentum

Accreditation Report

Tillsonburg District Memorial Hospital

Tillsonburg, ON

On-site survey dates: September 24, 2017 - September 28, 2017

Report issued: January 11, 2018

About the Accreditation Report

Tillsonburg District Memorial Hospital (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. As part of this ongoing process of quality improvement, an on-site survey was conducted in September 2017. 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

Table of Contents

Executive Summary 1

Accreditation Decision 1

About the On-site Survey 2

Overview by Quality Dimensions 4

Overview by Standards 5

Overview by Required Organizational Practices 7

Summary of Surveyor Team Observations 12

Detailed On-site Survey Results 14

Priority Process Results for System-wide Standards 15

Priority Process: Governance 15

Priority Process: Planning and Service Design 17

Priority Process: Resource Management 18

Priority Process: Human Capital 19

Priority Process: Integrated Quality Management 20

Priority Process: Principle-based Care and Decision Making 21

Priority Process: Communication 22

Priority Process: Physical Environment 23

Priority Process: Emergency Preparedness 24

Priority Process: Patient Flow 25

Priority Process: Medical Devices and Equipment 26

Service Excellence Standards Results 27

Standards Set: Biomedical Laboratory Services - Direct Service Provision 28

Standards Set: Critical Care - Direct Service Provision 29

Standards Set: Diagnostic Imaging Services - Direct Service Provision 31

Standards Set: Emergency Department - Direct Service Provision 32

Standards Set: Infection Prevention and Control Standards - Direct Service Provision 34

Standards Set: Medication Management Standards - Direct Service Provision 35

Standards Set: Medicine Services - Direct Service Provision 36

Standards Set: Perioperative Services and Invasive Procedures - Direct Service Provision 39

Standards Set: Point-of-Care Testing - Direct Service Provision 42

Standards Set: Transfusion Services - Direct Service Provision 43
Instrument Results 44
Governance Functioning Tool (2016) 44
Canadian Patient Safety Culture Survey Tool 48
Worklife Pulse 50
Client Experience Tool 52
Organization's Commentary 53
Appendix A - Qmentum 54
Appendix B - Priority Processes 55

Executive Summary

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

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

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

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

Accreditation Decision

Tillsonburg District Memorial Hospital's accreditation decision is:

Accredited with Exemplary Standing

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

About the On-site Survey

- **On-site survey dates: September 24, 2017 to September 28, 2017**

- **Location**

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

  1. Tillsonburg District Memorial Hospital

- **Standards**

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

  System-Wide Standards

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

  Service Excellence Standards

  5. Biomedical Laboratory Services - Service Excellence Standards
  6. Critical Care - Service Excellence Standards
  7. Diagnostic Imaging Services - Service Excellence Standards
  8. Emergency Department - Service Excellence Standards
  9. Medicine Services - Service Excellence Standards
  10. Perioperative Services and Invasive Procedures - Service Excellence Standards
  11. Point-of-Care Testing - Service Excellence Standards
  12. Reprocessing of Reusable Medical Devices - Service Excellence Standards
  13. Transfusion Services - Service Excellence Standards

- **Instruments**

  The organization administered:

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

Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
Population Focus (Work with my community to anticipate and meet our needs)	37	4	0	41
Accessibility (Give me timely and equitable services)	56	0	0	56
Safety (Keep me safe)	502	2	17	521
Worklife (Take care of those who take care of me)	98	3	0	101
Client-centred Services (Partner with me and my family in our care)	198	18	6	222
Continuity (Coordinate my care across the continuum)	39	2	0	41
Appropriateness (Do the right thing to achieve the best results)	766	35	24	825
Efficiency (Make the best use of resources)	49	1	0	50
Total	**1745**	**65**	**47**	**1857**

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	49 (98.0%)	1 (2.0%)	0	35 (97.2%)	1 (2.8%)	0	84 (97.7%)	2 (2.3%)	0
Leadership	49 (98.0%)	1 (2.0%)	0	94 (97.9%)	2 (2.1%)	0	143 (97.9%)	3 (2.1%)	0
Infection Prevention and Control Standards	40 (100.0%)	0 (0.0%)	0	27 (93.1%)	2 (6.9%)	2	67 (97.1%)	2 (2.9%)	2
Medication Management Standards	68 (100.0%)	0 (0.0%)	10	62 (100.0%)	0 (0.0%)	2	130 (100.0%)	0 (0.0%)	12
Biomedical Laboratory Services **	71 (100.0%)	0 (0.0%)	0	104 (99.0%)	1 (1.0%)	0	175 (99.4%)	1 (0.6%)	0
Critical Care	43 (87.8%)	6 (12.2%)	1	90 (91.8%)	8 (8.2%)	17	133 (90.5%)	14 (9.5%)	18
Diagnostic Imaging Services	65 (100.0%)	0 (0.0%)	2	68 (100.0%)	0 (0.0%)	1	133 (100.0%)	0 (0.0%)	3
Emergency Department	61 (87.1%)	9 (12.9%)	1	100 (95.2%)	5 (4.8%)	2	161 (92.0%)	14 (8.0%)	3

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Medicine Services	42 (93.3%)	3 (6.7%)	0	70 (90.9%)	7 (9.1%)	0	112 (91.8%)	10 (8.2%)	0
Perioperative Services and Invasive Procedures	105 (92.9%)	8 (7.1%)	2	98 (90.7%)	10 (9.3%)	1	203 (91.9%)	18 (8.1%)	3
Point-of-Care Testing **	38 (100.0%)	0 (0.0%)	0	46 (100.0%)	0 (0.0%)	2	84 (100.0%)	0 (0.0%)	2
Reprocessing of Reusable Medical Devices	84 (100.0%)	0 (0.0%)	4	40 (100.0%)	0 (0.0%)	0	124 (100.0%)	0 (0.0%)	4
Transfusion Services **	75 (100.0%)	0 (0.0%)	0	68 (98.6%)	1 (1.4%)	0	143 (99.3%)	1 (0.7%)	0
Total	**790 (96.6%)**	28 (3.4%)	20	902 (96.1%)	37 (3.9%)	27	1692 (96.3%)	65 (3.7%)	47

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

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	8 of 8	4 of 4
Patient safety incident disclosure (Leadership)	Met	8 of 8	4 of 4
Patient safety incident management (Leadership)	Met	12 of 12	2 of 2
Patient safety quarterly reports (Leadership)	Met	2 of 2	4 of 4
Patient Safety Goal Area: Communication			
Client Identification (Biomedical Laboratory Services)	Met	2 of 2	0 of 0
Client Identification (Critical Care)	Met	2 of 2	0 of 0
Client Identification (Diagnostic Imaging Services)	Met	2 of 2	0 of 0
Client Identification (Emergency Department)	Met	2 of 2	0 of 0
Client Identification (Medicine Services)	Met	2 of 2	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client Identification (Perioperative Services and Invasive Procedures)	Met	2 of 2	0 of 0
Client Identification (Point-of-Care Testing)	Met	2 of 2	0 of 0
Client Identification (Transfusion Services)	Met	2 of 2	0 of 0
Information transfer at care transitions (Critical Care)	Met	8 of 8	2 of 2
Information transfer at care transitions (Emergency Department)	Met	8 of 8	2 of 2
Information transfer at care transitions (Medicine Services)	Met	8 of 8	2 of 2
Information transfer at care transitions (Perioperative Services and Invasive Procedures)	Met	8 of 8	2 of 2
Medication reconciliation as a strategic priority (Leadership)	Met	8 of 8	4 of 4
Medication reconciliation at care transitions (Critical Care)	Met	10 of 10	0 of 0
Medication reconciliation at care transitions (Emergency Department)	Met	8 of 8	0 of 0
Medication reconciliation at care transitions (Medicine Services)	Met	10 of 10	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 (Perioperative Services and Invasive Procedures)	Met	16 of 16	0 of 0
Safe Surgery Checklist (Perioperative Services and Invasive Procedures)	Met	6 of 6	4 of 4
The "Do Not Use" list of abbreviations (Medication Management Standards)	Met	8 of 8	6 of 6
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management Standards)	Met	8 of 8	2 of 2
Concentrated Electrolytes (Medication Management Standards)	Met	6 of 6	0 of 0
Heparin Safety (Medication Management Standards)	Met	8 of 8	0 of 0
High-Alert Medications (Medication Management Standards)	Met	10 of 10	6 of 6
Infusion Pumps Training (Critical Care)	Met	8 of 8	4 of 4
Infusion Pumps Training (Emergency Department)	Met	8 of 8	4 of 4
Infusion Pumps Training (Medicine Services)	Met	8 of 8	4 of 4
Infusion Pumps Training (Perioperative Services and Invasive Procedures)	Met	8 of 8	4 of 4

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Narcotics Safety (Medication Management Standards)	Met	6 of 6	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Client Flow (Leadership)	Met	14 of 14	2 of 2
Patient safety plan (Leadership)	Met	4 of 4	4 of 4
Patient safety: education and training (Leadership)	Met	2 of 2	0 of 0
Preventive Maintenance Program (Leadership)	Met	6 of 6	2 of 2
Workplace Violence Prevention (Leadership)	Met	10 of 10	6 of 6
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Compliance (Infection Prevention and Control Standards)	Met	2 of 2	4 of 4
Hand-Hygiene Education and Training (Infection Prevention and Control Standards)	Met	2 of 2	0 of 0
Infection Rates (Infection Prevention and Control Standards)	Met	2 of 2	4 of 4
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Critical Care)	Met	6 of 6	4 of 4

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Diagnostic Imaging Services)	Met	6 of 6	4 of 4
Falls Prevention Strategy (Emergency Department)	Met	6 of 6	4 of 4
Falls Prevention Strategy (Medicine Services)	Met	6 of 6	4 of 4
Falls Prevention Strategy (Perioperative Services and Invasive Procedures)	Met	6 of 6	4 of 4
Pressure Ulcer Prevention (Critical Care)	Met	6 of 6	4 of 4
Pressure Ulcer Prevention (Medicine Services)	Met	6 of 6	4 of 4
Pressure Ulcer Prevention (Perioperative Services and Invasive Procedures)	Met	6 of 6	4 of 4
Suicide Prevention (Emergency Department)	Met	10 of 10	0 of 0
Venous Thromboembolism Prophylaxis (Critical Care)	Met	6 of 6	4 of 4
Venous Thromboembolism Prophylaxis (Medicine Services)	Met	6 of 6	4 of 4
Venous Thromboembolism Prophylaxis (Perioperative Services and Invasive Procedures)	Met	6 of 6	4 of 4

Summary of Surveyor Team Observations

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

Tillsonburg District Memorial Hospital (TDMH) is a community hospital that provides an assorted variety of Ambulatory Care services, 24/7 Emergency Care, Intensive Care with the option to ventilate a patient, 30 medical and surgical inpatient beds and 10 Complex Continuing beds.

Support services includes Physiotherapy, Occupational and Recreational Therapy.

TDMH has recently introduced several new members to the Leadership team, including a new President/CEO, a new Chief of Staff, two Clinical Directors and an Educator. The Senior Team is accountable for the delivery of care and services at the Alexandra Hospital in Ingersoll (AHI) and TDMH. The Board from both these hospitals have formed into a Joint Board of Directors and meet monthly. The Board members from the Tillsonburg community appear to be a dedicated and committed group. They are familiar with their responsibility of ensuring that the patients receive safe, quality care. A new RL (risk program) provides the Board with data from occurrences and familiarizes them with trends and areas for improvement. Patient stories, good and not so good ones, are heard by the Board at their regular meetings. The Board has membership on the Quality committee.

The Board is comprised of community members who bring a skill set(s) that benefit the functioning of the Board and assists with decision making. Recently a lawyer was recruited as a Board Member and it was felt her legal role was needed to support TDMH.

The Patient Advisory Council is in the early phases of development. With the past changes and gaps in TDMH leadership, this committee has not had regular meetings nor accomplished work. The members of this committee are willing and excited to play an active role in assisting TDMH with decision making. Many of them feel they or a loved one have used the service of the hospital, and have some ideas that could help make improvement to the service delivery model.
The Patient Advisory Council members have the opportunity to review patient comments and satisfaction forms and noted that the majority of feedback comments were positive.

TDMH has a robust Volunteer program with over 220 volunteers. The eldest volunteer is 101 years of age and provides valuable service at the Patient Registration Desk. There is an active Volunteer Program for teens between the age of 15 and 19. The program gives teenagers with an opportunity to work with patients and provide a community service. The TDMH Volunteer Team also coordinate the Dog Therapy Program, work in the Coffee and Gift Shop, sell HELPP Lottery Tickets and assist with Portering. The volunteers also assist in the Geriatric program and visit with patients, provide social events and read to the patients. TDMH Volunteer Association is commended for the work they provide to the hospital and the community at large.

Sitting at the Community partners table were LHIN representatives, Public Health and Land Ambulance, Fire Department, VP/CNE's from London Health Science Centre, St Thomas and Woodstock, Board Chair of Alexandra Hospital, Multi service and Mental health representatives, the Volunteer Service from TDMH and a staff member from the Long Term Health Facility (attached to the TDMH hospital). The working relationships between community partners and TDMH is positive and strong. Many of the care partners were involved in the development of the new strategic plan and mission, vision and value statements. There appears to be clear communication and information flow during the transition of patients and their care. There were some suggestions from community partners that would assist with the day to day work of the care providers and organizations. One suggestion was to formally structure efficient discharge rounds with interdisciplinary staff, including the physicians. It was expressed that Expected Length of Stays be posted on the patients white board so that targets are set and patient flow remains a priority. It was suggested this practice would assist with capacity and overflow issues. The lack of a Social Worker in the hospital was also viewed as a gap in service. Services such as Home Care and Home at Last are used frequently by the hospital. The community partners were pleased that CCAC and the Canadian Mental Health Association are located in the hospital.

The Long Term Care Facility attached to the TDMH hospital receives laundry and food services from the hospital. There is a sense that there is an excellent working relationship between the LTC and the hospital. The LTC facility feels supported by the hospital. During a recent flood at the LTC facility, the hospital accepted approximately 20 patients into the facility by opening rooms and beds. TDMH also prepares meal services for Meals on Wheels and between 600 and 700 meals are provide monthly.

The Foundation Department at TDMH has been officially open for 8 years. During those 8 years over 4 million dollars has be donated from the community to support the hospital capital equipment requests and other identified needs. A recent hospital golf fund raiser, raised $45,000.00. It was noted by the Executive Director of the Foundation that the community rises to the challenge when fundraising is needed for the hospital.

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.

Unmet Criteria	High Priority Criteria
Standards Set: Governance	
2.3 The governing body includes clients as members, where possible.	
3.1 The ethics framework and evidence-informed criteria are used by the governing body to guide decision making.	!

Surveyor comments on the priority process(es)

The Board from Alexandra Hospital Ingersoll and the Board from the Tillsonburg District Memorial hospitals have formed into a "Joint Board of Directors" and meet monthly. The Board members from the Tillsonburg community appear to be a dedicated and committed group. They are familiar with their responsibility of ensuring that the patients receiving care at TDMH are provided with safe, quality care. A new RL (risk program) provides the Board with data from occurrences and familiarizes them with trends and areas for improvement. Patient stories, good and not so good ones, are heard by the Board on a regular basis. The Board has membership on the Quality committee, and Quality and Risk is a standing agenda item on the Board agenda.

The Board is comprised of community members who bring a skill set(s) that contribute to the functioning of the Board and bring talent(s) that assist with decision making. Recently a lawyer was recruited as a Board Member and it was felt her legal role was needed to support the ongoing work of TDMH. Board members are recruited by word of mouth, through Facebook and the local paper, or on the Website. A orientation program for new Board members is available on a TDMH Website and new members are sent to the OHA to complete a Board course. Each new Board member is mentored by a more experience Board member. New Board members feel welcomed and supported.

The Board is in the process of determining how to include the patients and families and their voices into the meetings and into ongoing decision making. Board members feel they are connected to the community and will often hear feedback about the care provided at TDMH. The Board is encouraged to formalize the patient engagement process and patient centered care.

An education session is provided at each Board meeting and these sessions appears to be well received and appreciated by the Board. It is often an opportunity for the Board to meet front line staff and leaders. The Board agenda is done a couple of weeks ahead of the meeting. Board members can access and review the agenda and essential attachments on a website created for the Board.

The new President and CEO started her first day of work on the first day of this accreditation survey. The Board felt they did a thorough search to find the right person with the right qualities for TDMH. The President/ CEO feels her current priority is to better understand the cultures of both hospital sites and get to know the people at both hospitals.

Priority Process: Planning and Service Design

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
1.6 Input is sought from clients and families during the organization's key decision-making processes.	

Surveyor comments on the priority process(es)

The Patient and Family Centred Care Steering Committee is in the early phases of development. With the changes and gaps in TDMH leadership, this committee has not had regular meetings nor accomplished work. The members of this committee are willing and excited to play an active role in assisting TDMH with decision making. Many of them feel they or a loved one have used the service of the hospital, and have some ideas that could help make improvement to the service delivery model. When asked what type of projects they would like to assist with, the members of the council noted they would like to advocate for free WIFI for hospitalized patients and provide suggestions to assist with the patient flow to decrease wait times in the ER.

TDMH is encouraged to involve patients and family members in the early stages of change to ensure the patients and family members input is included into the project and their voices heard. These changes may include patient/family input into policy development or revision, and changes to a service or program. Some Patient and Family Centred Care Steering Committee members were included in the interviewing processes for the Integrated Senior Director, which made these members feel valued and their input important. The Senior Director was impressed with the inclusion of patients at her interview and felt it demonstrated the significance of patient presence in the organization and the pending role. The Patient and Family Centred Care Committee members have the opportunity to review the patients comments and satisfaction form and noted that the majority of feedback comments were positive.

Patients, admitted to the hospital, receive a hand out booklet which highlights the patients' rights and responsibilities, TDMH's Code of Conduct, Discharge and Infection Control information, as well as Patient safety information.

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 Resource Committee has Board representation form both the Tillsonburg and the Ingersoll Hospitals. The budget for TDMH is balanced. There are clear processes in place for the development and distribution of the capital and operational budgets. The Board receives financial updates as part of the Board meeting agenda. Clinical Directors own their operational budgets and there is financial mentorship to support these leaders.

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)

There are several ways in which TDMH recognizes its' staff. A Service Award event occurs every fall to recognize those staff who have been with the organization 5 years and more. The Rosie Award recognizes a staff member that represents the values of the organization. Staff members can nominate individuals and a selection committee chooses the successful candidate. There is significant pride associated with being a Rosie award winner.

The hospital encourages staff to continue with ongoing learning and will pay 50% of the cost of a course up to an annual donation of $2500.00. TDMH is commended for supporting their staff's professional development. Performance appraisals are completed every two years. Lunch and Learns occur ad hoc.

The hospital uses various sources when recruiting staff. Postings are placed on their Website, Healthline, Healthforce etcetera. For all new staff, back checks and reference checks are completed by external companies. The hospital provides a one day orientation for corporate topics such as privacy, Code of Conduct, WHMIS, Patient Safety, Violence in the Workplace etcetera. Role and unit specific orientation occurs following corporate orientation.

TDMH owns and provides housing or rents to locums, visiting physicians or physicians who are locating to the area. In TDMH owning houses close to the hospital, this has become a recruiting strategy and one that seems to be supporting the organization in a positive way.

There is an Employee Assistance Program for staff and physicians.

Priority Process: Integrated Quality Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The Integrated Quality Committee includes Board and staff members from the Ingersoll and Tillsonburg hospital sites. Quality and incident reports are discussed and shared at the Board, Management and front line staff levels. The organization has a well developed Quality Improvement Plan and a Patient Safety Plan.

A new computer risk pro program was installed in February 2017. Key leaders have access to the incident and data reports, and leaders do the follow up as required. Staff have been educated on how to use the risk pro system and are becoming familiar and more comfortable with incident entry. Trending of incidences occurs. The organization will move toward entering staff incidents in the RL system so that Occupational Health and Safety will receive direct staff incident files. Reported incidents are also reviewed by the Quality and Patient Safety Committee and shared with team members on a regular basis.

For their prospective analysis, TDMH worked on project entitle "Close Loop Medication Administration" Closed Loop Medication Administration already occurred in the inpatient units and the technology and associated processes were extended to the ER Department. The decision to move forward with this project was based on the number of medication incidents occurring in the ER. The project improved patient safety by allowing Computerized Physician Order Entry, the use of automated dispensing cabinets and barcode assisted medication charting in the ER Department. It also ensured that the healthcare professionals had access to the same patient clinical information at the point of care. Over the course of the past six months, it has been confirmed through auditing that there were 275 incidents whereby the wrong drug was scanned and the healthcare provider was alerted prior to administering the medication. The TDMH team is commended for this successful safety initiative.

Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems.

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
1.7 An ethics framework to support ethical practice is developed or adopted, and implemented with input from clients and families.	!

Surveyor comments on the priority process(es)

TDMH has an Ethics Framework that has recently been refreshed and revised. The framework has been used in the organization for years and it meets the needs of the hospital. Alexandra Hospital Ingersoll also uses the same framework. The committee meets quarterly and ad hoc meetings are called when a case or situation has occurred. The Ethicist is available to the organization as needed, attends Ethics committee meetings and provides Lunch and Learns to the staff.

The CNE chairs the Ethics committee and is accountable to the overall processes. The hospital is in discussion in regards to how and when to utilize patients and families into the ethics committee membership and into the work of the committee. They are encouraged to move forward with the inclusion of patients and families and will find that they will reap the benefits of patient and family input.

The hospital has policies and protocols in place for a Medical Assisted In Dying case that may appear on their door step. The hospital is commended for this work.

In speaking with the Board and staff, it is evident that the ethical framework is not well known or used. It is a recommendation the hospital provides and practices ethical table top education sessions with staff, the Board and Leadership. There is an identified need for these groups to learn how to identify an ethical issue and work through the step by step worksheet. It is better to have staff familiar with the processes and paper work and be prepared if or when an ethical situation arises.

Priority Process: Communication

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
7.5 There is an organization communication plan that addresses disseminating information to and receiving information from internal and external stakeholders.	

Surveyor comments on the priority process(es)

TDMH has policies and protocols in place to protect the privacy of patient information. Departments that house charts are secured and these areas are locked when staff are not in the departments. There are no medical health records stored off site. The hospital is considering scanning charts. Currently, patients who are readmitted will have an old chart in Medical Records and this chart must be physically located and transported to the clinical area.

All staff, including volunteers and physicians must sign a confidentiality form. Client and staff may access their medical record providing they fill out the required paperwork. Charts are audited to ensure the circle of care remains intact.

TDMH appears to be well connected to its external partners. Leaders from the hospital sit at various community tables.

To enhance communication within the hospital, TDMH has a "Weekly Newsbrief for TDMH Members". Topics in this newsbrief include Patient Safety Information, Employee Incident Report information, Diabetes Education, Ethics, Upcoming education and training sessions etcetera. On a monthly basis, TDMH also published the "TDMH Topical" which includes topics such as the introduction of new staff to the organization, retiring staff, upcoming and past hospital social events.

Twice a year, Spring and Fall, TDMH releases a community newsletter entitled "Report to the Community". This paper has a message from the CEO and from the Board, Foundation information, AHI/TDMH Strategic Plan and clinical information from departments such as Diagnostic Imaging, Dialysis etcetera.

Intrahospital emails and websites are used to provide information for staff. Patients can access information on TDMH's website.

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)

The physical plant of the facility is very well maintained. Conscious efforts have been made to reduce clutter in patient care areas and in other parts of the facility. The maintenance areas are remarkably tidy and well maintained. Maintenance schedules are carefully followed and all equipment kept in good working order.

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 organization has a detailed and robust disaster planning manual. After a recent review it was decided that many of the code plans were outdated and overly complicated, so a detailed review was done with the assistance of an outside consultant. As a result, all of the plans have been rewritten in a consistent format. These will be replacing the existing plans in a detailed sequence, with specific training of all staff in each new plan, followed by a mock survey carried out according to a detailed schedule.

In the past four years, they have carried out well over one hundred Emergency Planning Activities, including most recently the Fire Safety Plan and the Evacuation Plan.

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)
The organization has effective processes for managing patient flow issues. Partnerships with outside agencies allow prompt management of overcrowding. Waiting times for most services are not prolonged.

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 device reprocessing department is very well organized and staffed by enthusiastic professionals. The procedures followed are fully compliant with standards, with effective flow through processes and up-to-date, well maintained equipment. All operating room, endoscopy unit and diagnostic imaging equipment are processed according to applicable standards.

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

Diagnostic Services: Laboratory

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

Point-of-care Testing Services

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

Transfusion Services

- Transfusion Services

Standards Set: Biomedical Laboratory Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Diagnostic Services: Laboratory	
6.3 Education and training are provided to team members on how to work respectfully and effectively with clients and families with diverse cultural backgrounds, religious beliefs, and care needs.	
Surveyor comments on the priority process(es)	
Priority Process: Diagnostic Services: Laboratory	
The lab provides a broad range of services with appropriate policies and procedures. Defined QI goals and objectives are in place.	

Standards Set: Critical Care - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.1	Services are co-designed with clients and families, partners, and the community.	!
1.2	Information is collected from clients and families, partners, and the community to inform service design.	
1.3	Service-specific goals and objectives are developed, with input from clients and families.	
4.4	An intensivist or critical care specialist is available daily to consult with admitting physicians in open ICUs.	
Priority Process: Competency		
3.4	Education and training are provided to team members on how to work respectfully and effectively with clients and families with diverse cultural backgrounds, religious beliefs, and care needs.	
Priority Process: Episode of Care		
8.15	A comprehensive and individualized care plan is developed and documented in partnership with the client and family.	!
9.1	The client's individualized care plan is followed when services are provided.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
15.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
15.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
17.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!

17.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
17.5	Quality improvement activities are designed and tested to meet objectives.	!
17.6	New or existing indicator data are used to establish a baseline for each indicator.	
17.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!

Priority Process: Organ and Tissue Donation

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

There has not been any process for getting input from clients into service planning or design. Intensivists are not available to come to the facility.

Priority Process: Competency

The staff are well trained and competent. However, there is no specific cultural sensitivity training.

Priority Process: Episode of Care

The care provided meets all requirements except that there are no comprehensive, individual care plans for each patient.

Priority Process: Decision Support

Patient records are complete and up to date. Patient histories had been dictated but were not yet transcribed 48 hours after admission. Decision support overall was acceptable.

Priority Process: Impact on Outcomes

The Critical Care Unit does not have specific, defined quality improvement objectives with defined baselines and targets.

Priority Process: Organ and Tissue Donation

Most organ donation services are provided through Trillium Gift of Life, with whom the facility has regular communication. All deaths in the facility are reported to Trillium.

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 well laid out, with very good wayfinding materials. The facilities meet all requirements, with very good procedure rooms and changing areas. Washrooms are readily available. The equipment is fairly new, and all of it is well-maintained. The staff are well-trained and enthusiastic.

Standards Set: Emergency Department - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.1	Services are co-designed with clients and families, partners, and the community.	!
Priority Process: Competency		
4.5	Education and training are provided to team members on how to work respectfully and effectively with clients and families with diverse cultural backgrounds, religious beliefs, and care needs.	
4.13	Education and training are provided on how to identify palliative and end-of-life care needs.	!
4.15	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
4.16	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
6.4	Team members are recognized for their contributions.	
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		
16.1	There is a standardized procedure to select evidence-informed guidelines that are appropriate for the services offered.	!
16.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
16.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
16.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!

16.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
18.7	Quality improvement activities are designed and tested to meet objectives.	!
18.11	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
18.12	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	

Priority Process: Organ and Tissue Donation

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

There is no process to engage clients and families in the design of ED services

Priority Process: Competency

Staff are not provided with specific training on cultural and religious sensitivity issues or palliative and end of life issues. There is not specific avenues for engagement of clients and families in the area of opportunities for growth.

Priority Process: Episode of Care

The processes and procedures of care appear to meet all required standards.

Priority Process: Decision Support

Decision support and document management meets all standards.

Priority Process: Impact on Outcomes

Most of the care provided in the ED does not appear to follow any guidelines. While there are defined Key Performance Indicators, there does not appear to be a formal QI agenda specific to the ED.

Priority Process: Organ and Tissue Donation

The organization is closely allied with Trillium Gift of Life, which organizes and provides organ donation services.

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

Unmet Criteria		High Priority Criteria
Priority Process: Infection Prevention and Control		
5.2	Team members, clients and families, and volunteers are engaged when developing the multi-faceted approach for IPC.	
8.4	Team members, and volunteers have access to dedicated hand-washing sinks.	
Surveyor comments on the priority process(es)		
Priority Process: Infection Prevention and Control		

Infection Control policies and practices are very good and meet all required standards. Hand hygiene rates for the first moment are consistently 90+%. Careful auditing is done of environmental cleaning. Antibiotic use is carefully monitored and addressed when necessary. More formal input from clients and families would be optimal.

Standards Set: Medication Management Standards - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Medication Management	

The organization has met all criteria for this priority process.

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

The Pharmacy Department is located in a secure area of the basement. The 2 doors are locked at all times with keypad access. There are no pharmacy signs outside of the doors indicating where the Pharmacy Department is located. There is a camera outside of the pharmacy department which allows for staff to monitor the doors from inside Pharmacy. The pharmacy is well lit with good ventilation and adequate space.

When the Pharmacy Department is closed or when a Pharmacist is not available, a company called Northwest can be contacted. This company will verify orders. The P&T committee membership includes staff from the Tillsonburg and Ingersoll Hospital. The Pharmacist joins in the Medical Advisor Council meetings in Tillsonburg.

Computerized Physician Order Entry is used at TDMH. There are some patient safety issues and staff concerns with the Medical Health record being part paper and part on the computer. The hospital is working toward having the complete Medical Health Record on line.

The Pharmacy Department was instrumental in helping with the completion of the project "Closed Loop Medication Administration in the Emergency Department". The objectives met from this project were:
a) improved patient safety
b) improved quality of patient care provided
c) leverage technology to improve team member workflow and satisfaction.

Standards Set: Medicine Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.3	Service-specific goals and objectives are developed, with input from clients and families.	
5.2	Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from clients and families where appropriate.	
Priority Process: Competency		
3.1	Required training and education are defined for all team members with input from clients and families.	!
3.4	Education and training are provided to team members on how to work respectfully and effectively with clients and families with diverse cultural backgrounds, religious beliefs, and care needs.	
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
11.5	Information is documented in the client's record in partnership with the client and family.	
12.2	Policies on the use of electronic communications and technologies are developed and followed, with input from clients and families.	
Priority Process: Impact on Outcomes		
15.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
15.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
15.5	Quality improvement activities are designed and tested to meet objectives.	!
15.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Clinical Director has been in the organization for approximately 3 weeks. She is in the learning phase of getting to know current practices and staff. The Clinical Director is collecting ideas on what indicators and data she would like to collect and use to advance practices and patient care on the Medical Unit.

The clinical areas have a Unit Base Council and the council is encouraged to consider patient and families as committee members.

Priority Process: Competency

Performance appraisals are performed once every two years. Staff find the feedback from the PA's valuable and beneficial toward professional development. Staff complete mandatory learnings in an e learning computer program. These modules can be completed at work, during down time or at home. There is a computerized Mosby learning program that provides staff with the opportunity to learn skills and review pertinent information.

Staff meetings are held on a regular basis and if staff are unable to attend a meeting, the minutes are posted on line.

Security is an issue for staff and they feel a security guard on the evening and night shift would provide a sense of safety for staff and patients. Staff feel they have a only a small number of staff on each unit during the night shift and an extra pair of hands would help give support and security to those working. Some Staff reported that their cars have been vandalized in the parking lot.

Priority Process: Episode of Care

Bedside white boards are located at each patient's bedside. The staff are encourage to fill these out in their entirety and include Expected Discharge dates. This provides the family and patient with the opportunity to work toward and prepare for the discharge date.

The hospital is encouraged to look at the SW Regional Wound Care Committee and consider learning opportunities for skin care and pressure wounds. The Hill Rom Prevalence Study, offered annually and for free, would provide TDMH with a baseline data set on pressure wounds. This date an be used to lay a foundation for future years and allow the hospital the opportunity to measure outcomes from wound care initiatives

Physiotherapy, Occupational Therapy and Respiratory Therapy is provided at TDMH. The resources are limited and there appears to be an identified gap in Social Work.

Priority Process: Decision Support

Currently the patients' health record is 'part paper and part computer'. The organization is working toward a computerized health record. One discharged the health record is collected and sent to Medical Records for storage. The old charts can be pulled and taken to the clinical area, should the patient be readmitted to TDMH.

There should be consideration given to providing huddles so staff can visibly see indicator data and take ownership for results and outcomes.

The hospital is working toward the inclusion of patient and family input into decision making.

Priority Process: Impact on Outcomes

The leadership team for the Medical program is forming, now that leadership is in place. Goals and Objectives will be developed for the program. Quality indicators will be determined and measured for the Medical program and other clinical areas.

The organization is encouraged to include patients into the work of this program. Perhaps consider a Unit Based Council with patient and family membership.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.1	Services are co-designed with clients and families, partners, and the community.	!
1.2	Information is collected from clients and families, partners, and the community to inform service design.	
1.3	Service-specific goals and objectives are developed, with input from clients and families.	
1.4	Services are reviewed and monitored for appropriateness, with input from clients and families.	
2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
Priority Process: Competency		
6.4	Education and training are provided to team members on how to work respectfully and effectively with clients and families with diverse cultural backgrounds, religious beliefs, and care needs.	
6.12	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
Priority Process: Episode of Care		
14.4	Procedure-specific care maps or guidelines are used to guide the client through preparation for and recovery from the procedure.	
20.16	There is a process to follow up with discharged day surgery clients.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
23.1	There is a standardized procedure to select evidence-informed guidelines that are appropriate for the services offered.	!

23.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
23.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
23.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
23.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
25.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
25.5	Quality improvement activities are designed and tested to meet objectives.	!
25.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
25.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

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 Perioperative Services Department has no process to involve clients and families into service planning and design. The services to be provided are determined solely by the practitioners who choose to work here, and not by the needs of the community.

Priority Process: Competency

There needs to be more training provided on respectful treatment of cultural differences. Also, there needs to be much stronger involvement of patients and families in their care and the design of services.

Priority Process: Episode of Care

The organization does not use procedure-specific care maps. No post-procedure follow up is done on day surgery cases.

Priority Process: Decision Support

There are good processes for document management and decision support

Priority Process: Impact on Outcomes

The organization does not use evidence-informed guidelines to direct patient care. The use of guidelines seems to be determined solely by the service provider. There is a lack of formal quality improvement objectives with measurable time frames.

Priority Process: Medication Management

The medication management processes in the operating room, PACU and endoscopy areas meet all requirements.

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

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

The organization has met all criteria for this priority process.

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

The only tests done by POCT are blood glucose and urinalysis. Both of these have very tight criteria and rigorous controls .

Standards Set: Transfusion Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Transfusion Services	
4.4 Education and training are provided to team members on how to work respectfully and effectively with clients and families with diverse cultural backgrounds, religious beliefs, and care needs.	
Surveyor comments on the priority process(es)	
Priority Process: Transfusion Services	
Transfusion services are very well designed and managed with appropriate policies and procedures in place.	

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: September 13, 2016 to November 24, 2016**
- **Number of responses: 7**

Governance Functioning Tool Results

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1. We regularly review and ensure compliance with applicable laws, legislation, and regulations.	0	0	100	92
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	0	0	100	93
3. Subcommittees need better defined roles and responsibilities.	100	0	0	65
4. As a governing body, we do not become directly involved in management issues.	0	0	100	85
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	94

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
6. Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	97
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	0	100	93
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	0	0	100	94
9. Our governance processes need to better ensure that everyone participates in decision making.	86	14	0	60
10. The composition of our governing body contributes to strong governance and leadership performance.	0	0	100	92
11. Individual members ask for and listen to one another's ideas and input.	0	0	100	96
12. Our ongoing education and professional development is encouraged.	0	0	100	86
13. Working relationships among individual members are positive.	0	0	100	95
14. We have a process to set bylaws and corporate policies.	0	0	100	93
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	96
16. We benchmark our performance against other similar organizations and/or national standards.	0	0	100	79
17. Contributions of individual members are reviewed regularly.	0	29	71	61
18. As a team, we regularly review how we function together and how our governance processes could be improved.	0	14	86	76
19. There is a process for improving individual effectiveness when non-performance is an issue.	0	17	83	57
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	0	0	100	81

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
21. As individual members, we need better feedback about our contribution to the governing body.	29	57	14	40
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	0	0	100	79
23. As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	90
24. As a governing body, we hear stories about clients who experienced harm during care.	0	17	83	77
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	0	0	100	89
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	0	0	100	85
27. We lack explicit criteria to recruit and select new members.	86	14	0	77
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	0	0	100	86
29. The composition of our governing body allows us to meet stakeholder and community needs.	0	0	100	94
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	89
31. We review our own structure, including size and subcommittee structure.	0	0	100	84
32. We have a process to elect or appoint our chair.	0	0	100	87

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

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

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

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

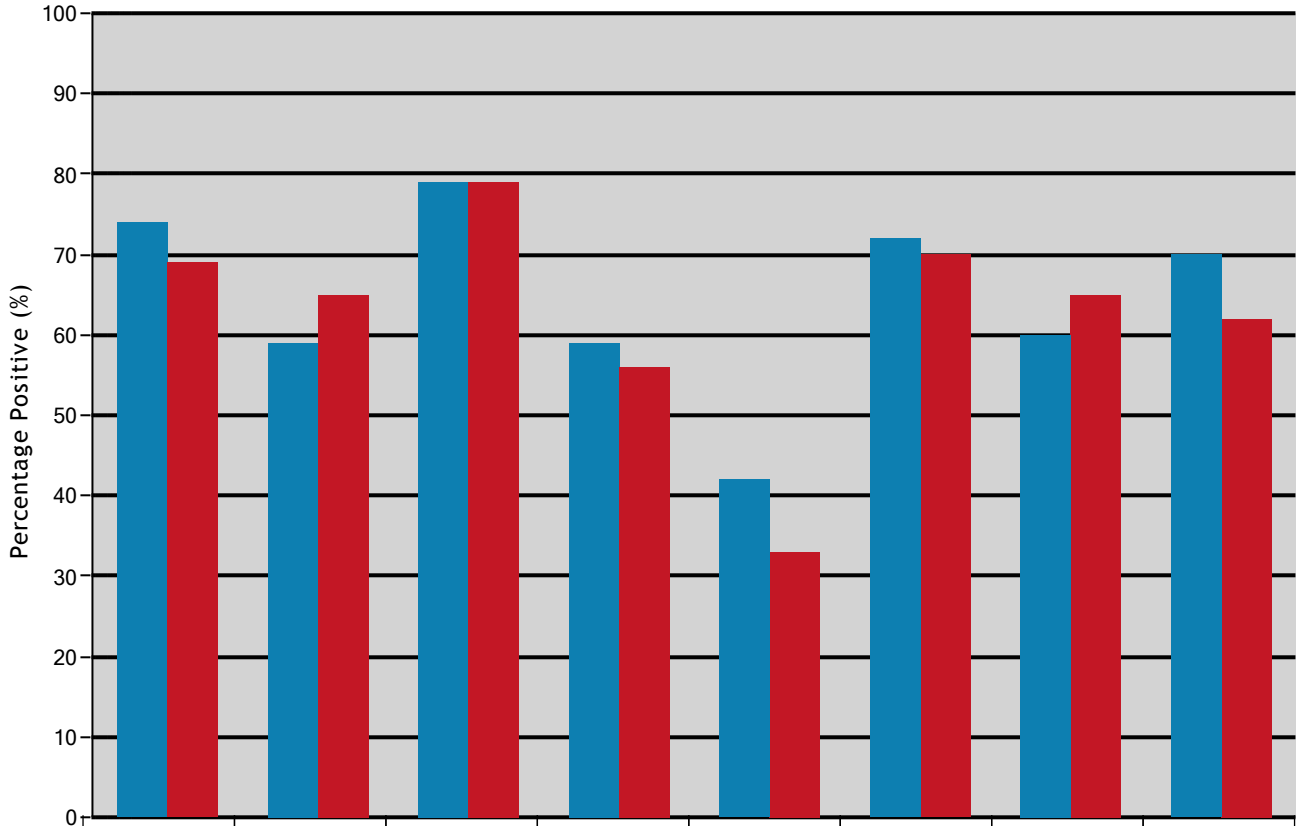
Canadian Patient Safety Culture Survey Tool

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

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

- **Data collection period: September 13, 2016 to October 19, 2016**
- **Minimum responses rate (based on the number of eligible employees): 49**
- **Number of responses: 80**

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
	74%	59%	79%	59%	42%	72%	60%	70%
	69%	65%	79%	56%	33%	70%	65%	62%

Legend

Tillsonburg District Memorial Hospital

* Canadian Average

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

Worklife Pulse

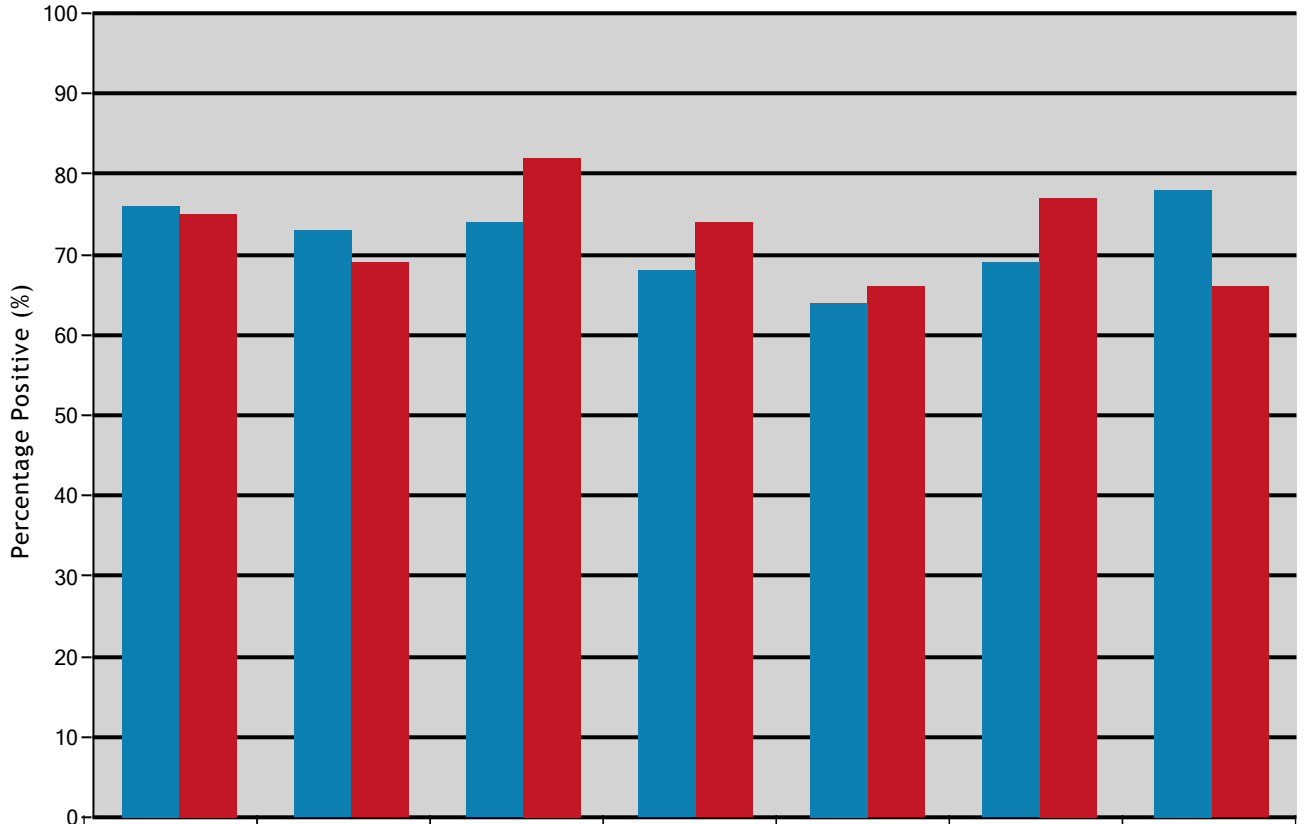
Accreditation Canada helps organizations create high quality workplaces that support workforce wellbeing and performance. This is why Accreditation Canada provides organizations with the Worklife Pulse Tool, an evidence-informed questionnaire that takes a snapshot of the quality of worklife.

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

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

- **Data collection period: September 13, 2016 to October 19, 2016**
- **Minimum responses rate (based on the number of eligible employees): 117**
- **Number of responses: 148**

Worklife Pulse: Results of Work Environment



	Job	Training and Development	Coworkers	Immediate Supervisor	Senior Management	Safety and Health	Overall Experience
	76%	73%	74%	68%	64%	69%	78%
	75%	69%	82%	74%	66%	77%	66%

Legend

Tillsonburg District Memorial Hospital

* Canadian Average

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

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

Organization's Commentary

After the on-site survey, the organization was invited provide comments to be included in this report about its experience with Qmentum and the accreditation process.

Tillsonburg District Memorial Hospital (TDMH) was pleased to welcome Donnalene Tuer-Hodes and Dr. Mark Taylor to our hospital community. During the on-site Accreditation Survey, the surveyors visited virtually every area of the hospital, meeting with many team members, physicians, and volunteers as well as many patients and their families and our Board of Directors.

Our Surveyors highlighted many successes since our last survey including the introduction of our online incident reporting system, our new physician model of care in the Emergency Department (ED), the integration project in the operating rooms and the expansion of closed loop medication administration to the ED. They also recognized the tremendous challenges faced by the organization including leadership turnover, the recent retirement of many skilled nurses and the fragmented (electronic and paper) health record.

The surveyors took notice of many areas where the TDMH community takes great pride including our dedicated and committed Board of Directors and team and our 220 incredible volunteers! They also noted the strength of our relationships with our community and key partners. Our facilities, while aging, were observed to be well kept and exceptionally clean.

The TDMH leadership team has reviewed the on-site survey report and appreciates its findings. They accurately capture the successes and challenges of our small community hospital. In the coming weeks we will be focusing our attention on the opportunities for improvement highlighted in the report to guide our work to improve quality and safety at TDMH. We will be working towards addressing the unmet criteria noted in the survey report including ensuring our ethics framework “lives” in the organization, strengthening our Patient and Family Advisory Council and introducing key performance indicators reflecting goals and objectives identified by our quality and safety team.

On behalf of the TDMH community, we would like to sincerely thank our surveyors for their complete and comprehensive review of our organization. We look forward to embracing the recommendations as we continue to drive excellence in patient care close to home for the community we serve.

Sandy Jansen
President & Chief Executive Officer

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

Priority processes associated with population-specific standards

Priority Process	Description
Chronic Disease Management	Integrating and coordinating services across the continuum of care for populations with chronic conditions

Priority Process	Description
Population Health and Wellness	Promoting and protecting the health of the populations and communities served through leadership, partnership, and innovation.

Priority processes associated with service excellence standards

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

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