ACCREDITATION CANADA

*Driving Quality Health Services*

# Accreditation Report

## Holland Bloorview Kids Rehabilitation Hospital

Toronto, ON

*On-site survey dates: September 29, 2013 - October 2, 2013*

*Report issued: October 16, 2013*

ACCREDITATION CANADA
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*Driving Quality Health Services*
*Force motrice de la qualité des services de santé*

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## About the Accreditation Report

Holland Bloorview Kids Rehabilitation 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 2013. 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's President and CEO

On behalf of Accreditation Canada's board and staff, I extend my sincerest congratulations to your board, your leadership team, and everyone at 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 Accreditation Specialist is available if you have questions or need guidance.

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

We look forward to our continued partnership.

Sincerely,

Wendy Nicklin
President and Chief Executive Officer

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# Section 1 Executive Summary

Holland Bloorview Kids Rehabilitation 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.

## 1.1 Accreditation Decision

Holland Bloorview Kids Rehabilitation 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.

## 1.2 About the On-site Survey

- **On-site survey dates: September 29, 2013 to October 2, 2013**

- **Location**

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

  1 Holland Bloorview Kids Rehabilitation 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 Leadership
  2 Governance

  ***Service Excellence Standards***

  3 Managing Medications
  4 Infection Prevention and Control
  5 Long-Term Care Services
  6 Rehabilitation Services

- **Instruments**

  The organization administer:

  1 Governance Functioning Tool
  2 Patient Safety Culture Tool
  3 Worklife Pulse Tool

## 1.3 Overview by Quality Dimensions

Accreditation Canada defines quality in health care using eight dimensions that represent key service elements. Each criterion in the standards is associated with a quality dimension. This table 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 (Working with communities to anticipate and meet needs) | 33 | 0 | 0 | 33 |
|  Accessibility (Providing timely and equitable services) | 28 | 0 | 0 | 28 |
|  Safety (Keeping people safe) | 184 | 0 | 1 | 185 |
|  Worklife (Supporting wellness in the work environment) | 68 | 0 | 0 | 68 |
|  Client-centred Services (Putting clients and families first) | 46 | 0 | 1 | 47 |
|  Continuity of Services (Experiencing coordinated and seamless services) | 15 | 0 | 0 | 15 |
|  Effectiveness (Doing the right thing to achieve the best possible results) | 256 | 0 | 0 | 256 |
|  Efficiency (Making the best use of resources) | 31 | 0 | 0 | 31 |
| **Total** | **661** | **0** | **2** | **663** |

## 1.4 Overview by Standards

The Qmentum standards identify policies and practices that contribute to high quality, safe, and effectively managed care. Each standard has associated criteria that 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 | 44 (100.0%) | 0 (0.0%) | 0 | 34 (100.0%) | 0 (0.0%) | 0 | 78 (100.0%) | 0 (0.0%) | 0 |
| Leadership | 45 (100.0%) | 0 (0.0%) | 1 | 85 (100.0%) | 0 (0.0%) | 0 | 130 (100.0%) | 0 (0.0%) | 1 |
| Infection Prevention and Control | 53 (100.0%) | 0 (0.0%) | 0 | 44 (100.0%) | 0 (0.0%) | 0 | 97 (100.0%) | 0 (0.0%) | 0 |
| Long-Term Care Services | 23 (100.0%) | 0 (0.0%) | 1 | 72 (100.0%) | 0 (0.0%) | 0 | 95 (100.0%) | 0 (0.0%) | 1 |
| Managing Medications | 76 (100.0%) | 0 (0.0%) | 0 | 52 (100.0%) | 0 (0.0%) | 0 | 128 (100.0%) | 0 (0.0%) | 0 |
| Rehabilitation Services | 27 (100.0%) | 0 (0.0%) | 0 | 68 (100.0%) | 0 (0.0%) | 0 | 95 (100.0%) | 0 (0.0%) | 0 |
| **Total** | **268 (100.0%)** | 0 (0.0%) | 2 | 355 (100.0%) | 0 (0.0%) | 0 | 623 (100.0%) | 0 (0.0%) | 2 |

* Does not includes ROP (Required Organizational Practices)

## 1.5 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** | | | |
| Adverse Events Disclosure (Leadership) | Met | 3 of 3 | 0 of 0 |
| Adverse Events Reporting (Leadership) | Met | 1 of 1 | 1 of 1 |
| Client Safety Quarterly Reports (Leadership) | Met | 1 of 1 | 2 of 2 |
| Client Safety Related Prospective Analysis (Leadership) | Met | 1 of 1 | 1 of 1 |
| **Patient Safety Goal Area: Communication** | | | |
| Client And Family Role In Safety (Long-Term Care Services) | Met | 2 of 2 | 0 of 0 |
| Client And Family Role In Safety (Rehabilitation Services) | Met | 2 of 2 | 0 of 0 |
| Dangerous Abbreviations (Managing Medications) | Met | 4 of 4 | 3 of 3 |
| Information Transfer (Long-Term Care Services) | Met | 2 of 2 | 0 of 0 |
| Information Transfer (Rehabilitation Services) | Met | 2 of 2 | 0 of 0 |
| Medication Reconciliation As An Organizational Priority (Leadership) | Met | 4 of 4 | 0 of 0 |

| Required Organizational Practice | Overall rating | Test for Compliance Rating | |
|---|---|---|---|
| | | Major Met | Minor Met |
| **Patient Safety Goal Area: Communication** | | | |
| Medication Reconciliation At Admission (Long-Term Care Services) | Met | 4 of 4 | 1 of 1 |
| Medication Reconciliation At Admission (Rehabilitation Services) | Met | 4 of 4 | 1 of 1 |
| Medication Reconciliation at Transfer or Discharge (Long-Term Care Services) | Met | 4 of 4 | 1 of 1 |
| Medication Reconciliation at Transfer or Discharge (Rehabilitation Services) | Met | 4 of 4 | 1 of 1 |
| Two Client Identifiers (Long-Term Care Services) | Met | 1 of 1 | 0 of 0 |
| Two Client Identifiers (Managing Medications) | Met | 1 of 1 | 0 of 0 |
| Two Client Identifiers (Rehabilitation Services) | Met | 1 of 1 | 0 of 0 |
| **Patient Safety Goal Area: Medication Use** | | | |
| Concentrated Electrolytes (Managing Medications) | Met | 1 of 1 | 0 of 0 |
| Heparin Safety (Managing Medications) | Met | 4 of 4 | 0 of 0 |
| Infusion Pumps Training (Long-Term Care Services) | Met | 1 of 1 | 0 of 0 |
| Infusion Pumps Training (Managing Medications) | Met | 1 of 1 | 0 of 0 |
| Infusion Pumps Training (Rehabilitation Services) | Met | 1 of 1 | 0 of 0 |
| Medication Concentrations (Managing Medications) | Met | 1 of 1 | 0 of 0 |

| Required Organizational Practice | Overall rating | Test for Compliance Rating | |
|---|---|---|---|
| | | Major Met | Minor Met |
| **Patient Safety Goal Area: Medication Use** | | | |
| Narcotics Safety (Managing Medications) | Met | 3 of 3 | 0 of 0 |
| **Patient Safety Goal Area: Worklife/Workforce** | | | |
| Client Safety Plan (Leadership) | Met | 2 of 2 | 2 of 2 |
| Client 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** | | | |
| Antimicrobial Stewardship (Managing Medications) | Met | 4 of 4 | 1 of 1 |
| Hand Hygiene Audit (Infection Prevention and Control) | Met | 1 of 1 | 2 of 2 |
| Hand Hygiene Education And Training (Infection Prevention and Control) | Met | 2 of 2 | 0 of 0 |
| Infection Rates (Infection Prevention and Control) | Met | 1 of 1 | 3 of 3 |
| Pneumococcal Vaccine (Long-Term Care Services) | Met | 2 of 2 | 0 of 0 |
| Sterilization Processes (Infection Prevention and Control) | Met | 1 of 1 | 1 of 1 |
| **Patient Safety Goal Area: Falls Prevention** | | | |
| Falls Prevention Strategy (Long-Term Care Services) | Met | 3 of 3 | 2 of 2 |
| Falls Prevention Strategy (Rehabilitation Services) | Met | 3 of 3 | 2 of 2 |

| Required Organizational Practice | Overall rating | Test for Compliance Rating | |
|---|---|---|---|
| | | Major Met | Minor Met |
| **Patient Safety Goal Area: Risk Assessment** | | | |
| Pressure Ulcer Prevention (Long-Term Care Services) | Met | 3 of 3 | 2 of 2 |
| Pressure Ulcer Prevention (Rehabilitation Services) | Met | 3 of 3 | 2 of 2 |

## 1.6 Summary of Surveyor Team Observations

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

The organization, Holland Bloorview Kids Rehabilitation Hospital (Holland Bloorview) is commended on preparing for and participating in the Qmentum program. The organization is led by a governing body that is knowledgeable, committed and enthusiastic. The trustees have a good understanding of their roles and responsibilities and pride themselves on their accountability to their community, as is evident in: "The Big Ambition 2012/13 Annual Report." The board's selection process is well developed to ensure the appropriate skill mix to perform their duties. There are good processes in place to evaluate the functioning of the governing body (board) which is assessed using a number of evaluation tools. Board trustees attend the quality improvement committee and family advisory council meetings and have oversight for quality, safety and community engagement. The board has a robust process to evaluate the chief executive officer (CEO) which is tied to performance.

The board has led the organization in developing a strategic plan for 2012-2017 that will further solidify the organization as leaders in the provision of rehabilitation services for children with disabilities. The organization has a strong vibrant Foundation that increases the branding of Holland Bloorview in the community. . This organization is recognized for published articles and valuing research to inform their practice.

During this on-site survey a good number of the organization's community and community partners were interviewed. They commented Holland Bloorview has been instrumental in the discussion on transitional planning for youth. They commented on how well the organization works with community agencies to create capacity. The partners' group acknowledged the organization's focus on developing evidence-based standards of practice guidelines and how they are leaders in pediatric research. The partners recognized that Holland Bloorview has a commitment to engaging their clients/patients and families. In fact, they talked about engagement as being a part of the 'DNA' of Holland Bloorview. When the surveyor team asked for areas that Holland Bloorview could improve they talked about the community having more accessibility to the research arm of the organization.

The leadership of Holland Bloorview is strong, committed, engaged and strategic, and is well-placed for succession planning into the future. The leadership team members have a strong focus on learning and development within their own career goals. Their ability to drive the four pillars of the strategic plan is evident across the organization. The team's focus is on quality initiatives that will raise the agenda for excellence in paediatric rehabilitation. The commitment to quality improvement is commendable. Their efforts have been recognized in achieving Canada's Top Employer for Young People and maintaining the Greater Toronto's Top Employer award. The organization has developed a state-of-the-art research department that is recognized across Canada. It has completed the Bloorview Research Institute's strategic plan, engaging input from stakeholders, clients and families, academics and cross-sectional staff.

Goal statements and metrics in the quality improvement plan have been improved significantly since the organization's previous survey. There are strategies and a structure to enhance the student experience at this organization. The staff members that were interviewed are strongly committed to Holland Bloorview and are proud to be a part of the team. Their commitment and dedication to being involved in the strategic priority direction of the organization is commendable. The talent management stages for the organization have developed various awards/events to recognize staff achievements and this will be further developed next year. They have successfully recruited a Senior Director for Collaborative Practice since the last survey.

The establishment of a children's advisory committee for clients aged three years to 15 and their siblings provides input via a unique play-based model which is the first of its kind in the country. Much work has been accomplished in reviewing client programs across the organization to improve access and wait-times. The implementation of the central scheduling system is in its initial pilot phases and will be beneficial to coordinate interdisciplinary schedules and activities. The work on professional development and evidence to care has influenced practice, policy and care. The organization has received recognition and awards on their evidence-based work to date.

The organization is commended on the Family Leadership program and leadership in family-centred care which is deeply embedded in the organization. External reviewers provide evidence that this organization has embraced this practice. Client satisfaction is high at Holland Bloorview. Clients feel respected, involved and cared about by the people of the organization. The opportunity to participate in their care and review policies and procedures and to be part of the decision-making process is commendable.

The organization is committed to environmental initiatives, as noted in the Green plan.

Although the organization has positioned itself well for the future, there are a few challenges that may be barriers to achieving the goals. One is space limitations, which is now currently under review in the space utilization review process. The impact of provincial initiatives that could affect the utilization of services is a constant part of the environmental scan and can affect patient flow and wait- lists. The organization has developed mitigation plans to address its immediate fiscal challenges and will need to focus on how it will maintain sustainability for in the future.

This organization has implemented many priority initiatives during the past eighteen months, with many more identified in the strategic plan. There needs to be a constant awareness of the pace of change.

## Section 2 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 |

## 2.1 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.

### 2.1.1 Priority Process: Planning and Service Design

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

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

**Surveyor comments on the priority process(es)**

The organization, with the leadership of the board has developed a strategic plan for 2012 to 2017 that will position Holland Bloorview as leaders in the field of children's rehabilitation, both in Canada and internationally. The annual report for 2012 has been completed and it identified significant progress towards meeting their outcomes.

The organization also invites external stakeholders to evaluate performance on key indicators. This process is entirely driven and rated by the external rates.

The organization has taken client and family engagement to a whole new level. Community stakeholders talked about patient and family engagement as part of the 'DNA' of the Holland Bloorview.

The leadership team is well known in the Ontario health care community and the chief executive officer (CEO) and staff members sit on a number of provincial committees. They are able to keep abreast of provincial issues because of their active participation in these committees.

The organization has a knowledgeable and enthusiastic board of trustees, and a highly motivated leadership team led by a dynamic CEO. The senior management team is committed to quality and patient safety and champion this across the organization. The team values ongoing learning and professional development for staff members and leads by example. Middle management and staff members are committed to providing quality care to their patients and stewardship of their resources. They are well-positioned to reach their goal to be the best. The organization has won numerous awards for its work on evidence-based practice guidelines and in fact, has been instrumental in developing best practice guidelines where these did not exist before.

This organization is well known for its collaborative approach, and this was validated by the community stakeholders. The community stakeholders talked about how they work together with Holland Bloorview to build capacity in the system and the leading role that Holland Bloorview has taken in bringing stakeholders together to start the dialogue around transitional planning for youth.

Holland Bloorview is commended on the Family Leadership program. The organization provides training and support for families to be an integral part of their development, planning, implementing and evaluation of programs and services. In return, the family leaders bring the richness of client and family experience to decision-making in the organization.

Holland Bloorview is commended for the commitment to clinical education for all disciplines represented in the organization. The organization provides significant clinical placements that foster knowledge expertise in the care of children with disabilities. It has developed interdisciplinary student placement opportunities and innovative programs and services for the student population. It has introduced a process to enable medical students to spend time in the home with clients and their families and report that it has been a positive experience for both parties.

Change management expertise is available to programs and have been instrumental is assisting employees with the change process as they introduced the electronic health record (EHR) and coordinated system for referral. The operational plan is aligned with the strategic directions and progress is measured, with financial, utilization and quality reports to the board.

The organization has used two risk assessment tools to identify risk to the organization. These are the Health Insurance Reciprocal of Canada (HIROC) risk management self-appraisal modules and Enterprise Risk Management.

## 2.1.2 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)**

This organization is lead by a governing body that is knowledgeable, committed and enthusiastic. The trustees feel that the chief executive officer (CEO) and the senior management team has set high expectations for the team and therefore, it is important that trustees also hold themselves to a similar high level of standards. Trustees have a good understanding of their roles and responsibilities and state that they feel it is a privilege to be a member of this board. Although there are no requirements for board members to sign off on their roles and responsibilities; they have approved policy statements on their roles and responsibilities that require compliance. They have adopted a hybrid governance model that they feel works well for them.

The trustees are aware of their need to be accountable to their community. Board minutes are published on the organization's website and readily available to the public. The board receives reports from the Family and Client Advisory Committees and invite these committees to make presentations at board meetings.

There is a process in place to evaluate board functioning, using a board of trustees' evaluation questionnaire and a board of trustees self-evaluation form. Both forms have been completed for 2013 and the results have been analyzed and made available to board members. The trustees have also completed the Accreditation Canada Governance Tool in preparation for the survey.

There is a well-defined process for identifying the need for new board members. A skills matrix is reviewed and planning for replacement of board members begins two to three years in advance. There are discussions about potential candidates and informal interviews are held with those candidates. The short-list candidates are then formally interviewed by the board and CEO. The decision about which candidates will be offered positions on the board is made by the board as a whole. Orientation begins early on, with the interview process. The formal orientation commences in September, prior to their first meeting, and includes one-half to three-quarter day on-site meetings with every senior manager where they are provided information on that manager's portfolio. They feel that the process gives them a good understanding of the organization. Trustees also mentioned that they have an informal mentoring system by way of peer support, which helps them to obtain a better understanding of this complex organization.

Trustees of the board are required to attend at least one meeting of the Quality Committee of the Board and the Family Advisory Committee annually. The trustees model the organization's focus on client-centred care and client and family engagement. They talked about how impressed they are with the leadership role the families take on with the organization' various committees.

The trustees report that they have ample opportunities for education and that there are educational sessions at the start of every board meeting. They also have attended educational retreats on leadership at the Ontario Hospital Association (OHA) conferences.

The board of trustees and the organization have adopted the Hub and Spoke model for their bio-ethics. The organization has a well defined bio-ethics format. The CEO reports to the board regarding the activities of the bio-ethics forum.

The board regularly reviews its policies and procedures and has developed a rigorous process for this review prior to their approval.

The Business and Audit Committee chair meets with the VP Corporate Services and Finance in advance of the board meeting to review the financial report. There are quarterly financial reports submitted to the board that keeps them informed of the organization's fiscal status. The annual operating budget is presented to the Business and Audit Committee for review and then forwarded to the Quality Committee of the Board for further review prior to being presented to the board for final approval.

The Committees of the Board are: Executive; Governance; Business and Audit, and Quality and Research Advisory. The board uses these committees to review and vet information to assist with making informed decisions. An example given is the credentialing process which is reviewed by the Quality Committee of the Board prior to coming to the board meeting for approval.

The board has identified patient safety as one of the key components of the value to strive for excellence and receive regular reports on patient safety from senior management.

The board led the development of the organization's strategic directions for 2012 to 2017 and has published the 'Year 1' performance report on the strategic plan. The report indicates that the organization is well on the way to achieving the goals and objectives and together, is proud of accomplishments to date.

There are rigorous processes in place to evaluate the performance of the CEO. The evaluation process sits with the executive committee of the board, which reviews the job description of the CEO and consults with human resources to evaluate the CEO's compliance to expectations, performance and goal achievement. The CEO's bonus compensation is tied to the quality improvement plan. The board identified that there is a high degree of scrutiny involved in the evaluation process.

At this time, the communication plan for the organization is in draft form and has not been approved by the board. Although the organization has had communication plans in the past, the chief, communications and strategy is new to the organization. The incumbent has developed a draft communication plan with the intent to submitting it to senior management for approval prior to asking for board approval.

### 2.1.3 Priority Process: Resource Management

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

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

**Surveyor comments on the priority process(es)**

There are well-defined processes for financial management in the organization. Managers are required to complete monthly variance reports which are rolled up to senior management and the finance department. The managers interviewed as part of the tracer process identified that they feel well supported by the finance department. It was also noted during the tracer that front-line staff members are also aware of the financial status of the organization by way of information provided at all-staff meetings.

The organization is particularly proud of the well-balanced financial sheets and has had operating surpluses 95 percent of the time. It has identified fiscal restraints as one of the challenges due to funding changes and has plans to address those issues, as the organization feels it is well-positioned given the existing fiscal status. Concerns were expressed about the organization's ability to continue to meet accumulative targets while addressing the continuing fiscal challenges of Local Health Integrated Network (LHIN) funding.

The business and audit committee of the board works closely with the finance department to understand the organization's financial status. Together, they are able to provide the board of trustees with the information they need to make sound fiscal decisions.

The finance department has recently had a review which identified an opportunity to move to a more supportive model. The organization has implemented a system whereby programs and services have been partnered with a representative from finance to train and provide ongoing support to management in managing their budget processes. This has been validated by front-line managers that were interviewed during the tracer process. They expressed their appreciation of the support from the finance department staff. This support is also provided to the research department for both the managers involved in the operation components; as well as to the researchers that are responsible for managing their own grant funding.

One of the areas identified by staff for improvement is in developing more standardized approaches to providing information to managers. The finance department is aware of this concern and has started to take measures to address these issues. Encouragement is offered to continue this effort.

There are processes in place to evaluate the effectiveness of the auditing firm used for the annual audit. Surveys are completed by both the business and audit committee of the board as well as members of the finance department and the results are analyzed. The board has used the services of the same auditing firm for a number of years and has a process in place to approve the auditor year by year, at the annual general meeting (AGM).

There is a process in place for developing an operation plan. The plan is clearly aligned with the organization's strategic directions and includes utilization data as well as the financial report for the budget year. The operating plan is reviewed by the business and audit committee and the quality committee of the board prior to being presented for approval.

There is an organized approach to the capital equipment process that has served the organization well. The capital budget is divided into two pots, one for information technology and one for all other equipment needs. Staff members commented that they have the equipment they need.

The finance department staff members are focused on fiscal accountability as they look at this as their way of protecting the resources and services to 'kids'.

### 2.1.4 Priority Process: Human Capital

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

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

**Surveyor comments on the priority process(es)**

The organization has implemented a "People Plan" which focuses on the current and future needs of Holland Bloorview insofar as human resources. The organization has identified four key areas in this plan for human resources: leadership, talent, organizational design and culture. The staff members of the organization clearly live this plan at all levels. This has also allowed human resources to have an increased presence in the day-to-day activities of the organization.

Retention of employees is key for this organization as fiscal pressures in Ontario are currently extremely challenging. Staff members feel there is a strong support for their educational needs, a push for a strong work-life balance and an excellent work environment. Holland Bloorview's success in these areas can be seen in a staff turnover rate which continues to be below industry norms. The Spotlight program for staff recognition has been universally adopted and is tracked by management. It is an example of clear recognition for employees and has been created by the organization.

Holland Bloorview participates in the National Research Council (NRC) Picker survey every two years along with a group of hospitals from the Ontario Hospitals Association (OHA). Their last participation was in 2011 and their next survey will be in the Fall of 2013. The staff response rate is strong at 81 percent. Most scores continue to be well above industry standards. None of the results was below benchmarks, which speaks to the engagement of employees across the organization. Results of the 2011 survey prompted the creation of a team, ready to manage change in the organization, borrowing ideas for change management. This team has been appreciated by employees as the organization is enrolled in multiple initiatives such as the implementation of electronic health records, which could create work stress for them.

Holland Bloorview has used evidence of best practice in the literature to adapt a process of multiple mini-interviews for its assessment of potential new employees. This ensures that the values of its new recruits are in line with the values of the entire organization. The education process of new hires is robust and is appreciated by the staff. These education sessions are also run with all types of new staff members in the hospital, which quickly allow new employees to know individuals at different levels of the organization. Holland Bloorview also has an excellent process for employee performance review, which is done well and is systematic across the organization.

In view of the new fiscal realities in Ontario, the organization's ability to adapt to new work realities will be key in allowing it to face these challenges.

### 2.1.5 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 organization has worked with the board of trustees to develop a strategic plan that focuses on four key strategies: transform care, lead the system, accelerate knowledge and inspire our people. The strategic plan titled: "Leadership in Childhood Disability" (2012 to 2017) has also identified goals related to each of the four strategic directions. A unique format has been developed to communicate the strategic report that includes individual stories of patients, families and staff, to put a face on what they want to achieve. Commendation is given for going one step further in the strategic plan by identifying expected outcomes for each of the strategic directions.

The quality management plan is aligned to the four strategic directions. There is a detailed score card with indicators that identify targets. The organization measures the results against those targets. The quality management plan addresses a number of key areas that reflect how the organization strives for excellence that includes: client and family centred care; safety; accessibility; efficiency of care; effectiveness of care; continuity of care; equity; worklife and population focus. There is a strong commitment to quality improvement across this organization that is fully supported by senior management and the board.

The organization has made a substantial investment in quality management both from a staffing resource point of view and by the commitment to educating staff. Senior management staff members have completed their Executive Quality Academy training. Staff members have taken courses to become Canadian patient safety officers, patient safety educators, and have attended course from the Ontario Hospital Association (OHA) for project management and risk, Lean methodology and Osgoode Hall Law School, York University, Clinical Risk Management courses. They have taken part in a quality retreat and quality portfolio planning in 2013. They have been recognized as Health Quality Ontario champions an are desiganted as master facilitator for Canadian Patient Safety Institute (CPSI) safety education. They are working with CPSI to develop patient safety education modules specific to the pediatric population.

The collaborative practice council has embedded quality improvement into the everyday work environment, with links to quality and risk management in developing their best practice standards.

The organization has completed a number of quality initiatives one of which was the implementation of the coordinated system for referral initiative which was the focus of the tracer activity during this survey. An issue was identified with how it was scheduling appointments and came to light via concerns voiced from patients and families. The organization completed a Lean project to address these concerns. The Lean project was three years in the planning stage, with involvement of front-line staff members, patients and families as well as management. In the process of evaluating the system, the organization identified up to ten quality initiatives that needed to be addressed to facilitate patient flow. The organization recently implemented the central scheduling system that now coordinates how patients and families book appointments in the facility, using one point of contact. This project required an education and change management process that was led by the staff. By using a model that had evolved from the electronic health record (EHR) process; the organization was able to train super users that are readily available to assist staff. They have regular huddles to identify and resolve issues and front-line staff members report that they find

these huddles helpful. As part of the Lean project, they were able to change practice models of care which facilitated an increase in the number of assessments that they were able to accommodate. This has had a significant impact on the wait-times. This is one of many examples of how the organization is committed to quality improvement and how it has used quality initiatives to create improvements in accessibility and client satisfaction.

It is clear that this organization has a culture of patient safety that is supported by a strong quality and safety department. There is an active patient safety committee that meets regularly. The organization has instituted safety walk-abouts and huddles to identify safety issues. The organization has completed failure-modes-effects-analysis (FMEA) reviews around medication issues for this fiscal year.

## 2.1.6 Priority Process: Principle-based Care and Decision Making

Identifying and decision making regarding ethical dilemmas and problems.

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

**Surveyor comments on the priority process(es)**

The organization has developed capacity to address ethical issues by recruiting a bio-ethicist and has developed a framework and a forum for staff members to bring forward their ethics issues. The organization has adopted the Hub and Spoke model with the bio-ethicist and the bio-ethical forum as the hub. The organization understood that one bio-ethicist would not be able to handle all ethics issues on site, which led to the creation of the forum with a team of bioethics facilitators as the spokes. These facilitators are staff members, clients and families that expressed an interest in bio-ethics. Membership on the bio-ethics forum is voluntary, and recruiting members to the forum is not a problem. The facilitators are trained to support staff members and are integrated across the organization for easy access. The facilitators have adopted a process of attending team meetings to listen to staff discussions to identify possible ethics issues as a way to educate and assist staff. It has also helped them to look at their practices through an ethical lense.

There is an ethics worksheet, which is built on the IDEA principles of: identify the facts, determine relevant ethic principles, explore options and act-recommend and implement. There are green flags that are attached to every computer as a reminder to staff.

Consensus capacity was identified as one of the key ethics issues. Facilitators gave an example where a consensus capacity issue was creating a road block to a patient discharge, which is one of the key initiatives for transition of care. They talked about how the team was able to use the ethics framework to work through the issue and facilitate the wishes of the patient for transition.

The forum members were able to provide examples of how they use their values to facilitate good decision making. The example given had to do with distribution of their Family Support Fund. They used their value statements to develop five criteria to assist in making decisions for financial dispersals. This process has brought a measure of comfort to staff members involved in this process and have to make tough decisions about who gets funding. They have posted the application form on the website and have experienced a rise in applications. There is a process to revisit the criteria and principles on a regular basis.

Another project the bio-ethics forum members worked on was to develop a framework that they can use to assist them in making ethical decisions with regard to the drug shortage. Although they have not had to use the format to date, it is good to see that they have taken a proactive approach to this issue.

The Holland Bloorview research department has its own research ethics committee which is responsible for reviewing and approving research projects. This research ethics committee is part of a network of hospital research ethics committees that meet together on a regular basis. They are involved in joint research projects and are now working on a way to harmonize the research ethics approval process to facilitate these joint research projects.

The forum members collect data on their consults and recognize that they can do better in this area. They see approximately 75 referrals per year however, they may be missing data on referrals that the facilitators are working on their work areas, as these do not always come to the forum level to be counted. Encouragement is offered to develop a process to collect this workload to assist in identifying the true extent of their work in the organization.

Both the bio-ethics forum and the research ethics committee are commended for the active and full engagement of patients and families as facilitators and leaders on their committees.

The forum members are particularly proud of the support they have received from senior management and with the communication each of the members brings to the table. They comment on how open communication is between patients, families, staff and senior management.

### 2.1.7 Priority Process: Communication

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

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

**Surveyor comments on the priority process(es)**

The philosophy of this organization is that engagement is the best way to communicate to staff members and the preferred method is done via face-to-face meetings. The chief executive officer (CEO) and other members of the senior management team attend regular all-staff meetings where two-way dialogue is invited and encouraged. Staff members report that they find these sessions useful. Staff members also commented that management will drop in on their program and team meetings to bring staff members up to date and for information exchange purposes.

Staff members also have access to information on the intranet via the View Finder application and report that they use this tool often to obtain updates. They also commented that the notices that are posted in the hospital in strategic areas are most helpful. The organization makes good use of posters for a number of initiatives, and quality improvement, strategic directions and research are well displayed.

The organization has always had a communication plan but at the time of this survey, the communication plan was in draft form. The Chief of Communication and Strategy is a relatively new hire to the organization (June 2013). The incumbent has worked with her team to develop this draft communication plan and now needs to submit the draft plan to senior management prior to seeking board of trustee approval. The draft plan identifies the lines of communication strategies and tactics specific to internal and external communication strategies.

Similar to the finance department, the communication and strategy staff members are assigned to programs and services to assist managers and staff members with their communication needs. This has created clear lines of communication for the managers.

The organization has used focus group discussions to evaluate the communication and used an example of how it was able to improve communication with referring physicians to inform them which in turn, has resulted in significant progress on their wait-times.

Holland Bloorview has implemented an electronic health record (EHR) that has been rolled out across the organization. The last phase to come on board is in the ambulatory care areas. The organization continues to use some paper charting in ambulatory care for reports and referrals that come from outside the hospital but are now developing a scanning process to add these electronically to the chart. The organization has also created a paper chart for physicians that consult at their clinics. This process will also be phased out once they have all of these physicians on board. The organization encouraged feedback and engagement from all areas of the hospital including patients and family in the process of developing the EHR. The organization worked with experts in change management to assist staff members with the change process. It developed a comprehensive training program with super users that provide ongoing training to staff. There is good use of huddles to identify issues in a timely manner to facilitate resolutions. This is the same process that was used in developing the coordinated system for referrals which is now up and running. The organization is already receiving positive feedback from patients and families about the system.

The information services department feels that it is getting closer to meeting the information technology (IT) needs of the organization. The department is evaluating the adoption of the EHR and has scored the highest rate of use compared to other hospitals in Ontario that have implemented EHR. The organization has built a high level of security into their IT system to protect patient confidentiality. The information services department is coming to the end of the existing five-year strategic plan and is currently working on the new five-year strategic plan.

The organization has a robust process for developing practice standards that reflect best practice. This is facilitated by the Professional Advisory Committee with representation from families and patients, communication and strategy, change management leads, and representatives from each professional practice council. The progress being made on evidence-based standards is well recognized by their community stakeholders.

## 2.1.8 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)**

Bloorview Holland, built in 2006, is a modern facility serving individuals with disabilities. Facility management staff members are commended for their efforts and being knowledgeable in providing a clean, modern, well-maintained and welcoming environment. The space in the front lobby is particularly inviting, with comfortable furniture and various pieces of art work. The facility has many private and comfortable seating areas for clients and families. The outside grounds are nicely cared for with accessible pathways, and include beautiful spiral gardens which are also accessible. Outdoor balconies are accessible for clients/families in many areas.

The organization demonstrates commitment to Green leadership, with recycling, water conservation, solar energy and energy efficient systems. This organization was chosen as one of five finalists for the Ontario Hospital 2013 Green Hospital Scorecard Water Conservation and Protection award. The organization has been recognized for its corporate commitment to environmental excellence in reducing its daily hydro needs. The lighting retrofit was a major project for 2013.

There is a robust electronic preventive maintenance program, with great attention to equipment and system safety. There is a rigorous protocol for pool maintenance and safety. Policies exist for fleet management. The team is aware of the legislative requirements and adheres to the regulations and codes such as sprinkler checks. The team is involved in quality initiatives such as resolving the false code blues by installing a custom cover to prevent accidental activation by clients. Dust collectors are in place to ensure a safe environment for the orthotics team.

Space is becoming limited across the organization. The modular offices for clinicians on the second level are crowded and lack privacy. The organization is encouraged to continue with its space review initiative.

## 2.1.9 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)**

Emergency preparedness (EP) is a noted strength of the organization. Holland Bloorview has a well-defined contingency plan for all types of emergencies and follows standardized colour codes and nomenclature for all codes. There are standing committees that support EP and these are: contingency planning; pandemic planning and health and safety.

The team practices codes during the year, with regularly scheduled drills of code red, along with other codes that are practiced annually. The organization has completed two table-top code green exercises in the past year and practices code green in the area where the fire station is pulled during the code red drill  When code reds are practiced, they are done on a site-wide basis rather than isolated areas. When there are code drills, they are consistently debriefed and any lessons learned are acted on. Observer sheets are used for code red drills so that observers in the facility can document any opportunities for improvement.

There are two emergency generators that can support most of the facility in the event of a power disruption. The generators are tested weekly with a full cut-over taking place once per month. The organization has an adequate supply of fuel on site to support the generators. The organization has an agreement with a provider to ensure that the facility is a priority for receiving fuel supplies in the event of a prolonged emergency. There are some emergency supplies on site such as water and dry food to support the organization in the event of a disaster or pandemic.

The team is open to learning from issues that may arise during practice drills for example, ensuring that fire doors close properly during drills, ensuring that codes are announced overhead at the proper volume and adjusting the volume of the overhead paging systems so that it is not disruptive to patients and families. Holland Bloorview is unique in that it has an on-site school as well as day programs. The school participates in the EP program and drills are carried out in the school setting. There are tests of the overhead paging system at 0800 and 1800 hours every day and the code blue system is tested every day also.

The organization has partnerships with the Police and Fire departments as well as Emergency Health Services to support its contingency plan. Contracts are in place for an external review of fire systems on an annual basis. Reciprocal agreements are in place with other providers should there be a need to decant the facility. For patients, an arrangement is in place with the Lyndhurst Centre to receive patients. For the school, an arrangement is in place with another special needs school and for the day care an agreement is in place with another nearby day care. The organization also supports Toronto Sick Children's Hospital as a decanting site for that hospital given the unique services provided by Holland Bloorview to support children with specific health care needs.

The organization has systems and processes in place to engage families to ensure that they are aware of their role in EP and the organization has excellent systems in place to communicate with families and to keep them aware. It has maintained good relationships with its neighbours and there are no significant hazards in the community that represent a potential threat to the organization from an EP perspective.

Commendation is given for its education and refresher training related to codes. The code white training is excellent and there is a process in place to identify members of the code white team and to ensure that team members are aware of their roles. There is an on-site code blue team and a response process is defined for day-time hours. After hours, the site relies on 911 response for code blue. There are emergency response stations located outside the building and the surveillance cameras are programmed such that they will focus on an emergency response station should it be activated.

The boardroom is designated as the emergency operations centre (EOC) in the event of an emergency. Given its location at the top of the building, the organization is urged to assess whether this is the best location for an EOC in the event of a prolonged emergency. The organization has not tested its fan-out system but has used it in the past. It is kept up to date with quarterly updates distributed. The organization may wish to consider doing an annual test of its fan-out list.

Excellent outbreak management processes are in place. The organization works effectively with the City of Toronto Department of Public Health for surveillance and outbreak declaration. Given the population served, the threshold for declaring an outbreak is lower than other populations. Given that the building is relatively new, it was designed to support good infection prevention and control practices and outbreak management. The building design allows for the effective cohorting of patients and to isolate specific areas to contain outbreaks. There are good communication processes with families and the community during an outbreak and the team works to resolve outbreaks as quickly as possible. In the event of an outbreak, the outbreak management team meets each day of the outbreak to assess the outbreak and communicate actions to the organization. Given that there is a school on site, outbreak management extends to the school and some school programs are curtailed during outbreaks. Recreation activities may be curtailed or restricted to specific areas during outbreaks.

The organization has a pandemic plan that is a living document and open to regular revision. The plan was developed in collaboration with the ethics network to ensure that it incorporated ethical decision-making in the event of a pandemic.

Overall, EP is a noted strength of the organization with excellent policies, procedures and systems in place to support effective emergency preparedness, outbreak management and pandemic planning.

### 2.1.10 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 identified transition from children's services to adult services as an issue related to patient flow. Holland Bloorview has partnered with the Anne Johnston Health Station to implement an improved transition model for youths with spina bifida. This improved transition model will make it easier for clients and families to prepare for the transition. The model includes improved information transfer processes along with more educational material.

The organization is also working with its partners in the community on the development, implementation and evaluation of a planned transition of young adults in the complex continuing care unit to appropriate homes in the community and has already managed to transition three of their six patients in this program.

The organization introduced a new intake and length of stay pathway and has measured the impact on length of stay. The organization reports it has achieved improved patient flow and reduced their average length of stay.

The organization has completed a review of their key clinics and services to help address the access and wait-time issues. It has moved resources where needs are greater to meet patient demands and capacity.

The organization has made great strides in addressing the wait-time issues and is now challenged to sustain this progress.

### 2.1.11 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)**

Holland Bloorview has an excellent supply of medical devices and equipment. It has a clear process in place for the purchase of new equipment. Excellent education occurs for staff members on the safe use of medical equipment.

The organization has a strong preventive maintenance (PM) plan. This is well-documented, evaluated for effectiveness and incidents are tracked. The organization also tracks near misses related to medical devices and creates change to ensure the quality of the care is at the highest possible level. The organization also tracks turnaround time on its equipment maintenance issues.

Holland Bloorview shares its biomedical engineer with the Hospital for Sick Children as a 0.5 full-time equivalent (FTE). This partnership works well. The organization has a database of its entire inventory of medical devices and equipment. It is currently working on a five-year plan to categorize asset types for its entire inventory with average life cycles for these items. This will allow the organization to plan in advance its needs in replacement costs.

The organization is encouraged to standardize its process for the loaning of equipment to families.

## 2.2 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 overall goals and direction to the team of people providing services.

**Competency**

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

**Episode of Care**

- Providing clients with coordinated services from their first encounter with a health care provider through their last contact related to their health issue

**Decision Support**

- Using information, research, data, and technology to support management and clinical decision making

**Impact on Outcomes**

- Identifying and monitoring process and outcome measures to evaluate and improve service quality and client outcomes

**Medication Management**

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

**Infection Prevention and Control**

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

### 2.2.1 Standards Set: Infection Prevention and Control

| Unmet Criteria | High Priority Criteria |
|---|---|
| **Priority Process: Infection Prevention and Control** | |

The organization has met all criteria for this priority process.

**Surveyor comments on the priority process(es)**

**Priority Process: Infection Prevention and Control**

Holland Bloorview has a strong program of infection prevention and control. The organization carefully tracks its rate of infections. It declares quickly of possible outbreak situations and acts accordingly. The organization has developed key indicators which are part of its strategic plan surrounding the number of hospital infections and outbreaks. The team has also created links to effective partners to ensure that a broad representation is present in its initiatives. An example of this is the participation of Toronto Public Health in its infection control committee meetings.

The organization has created an effective education program in infection prevention and control (IPAC). It is embedded in the orientation of new staff members and volunteers. Hand-hygiene education is also stressed. Audits in hand-hygiene are consistently done across the organization. The results of these are posted in all clinical areas which allow staff members to clearly see their own success in these initiatives. The global results of hand-hygiene audits are also included in the indicators for adherence to the strategic plan of the institution. An education process exists as well for the families of clients. They are invited to take an active role in ensuring handwashing occurs and in ensuring they also perform these activities. A re-orientation occurs after every 60 days of an inpatient stay to ensure this education portion is fresh in the minds of the parents.

The physical environment was found to be clean throughout the rehabilitation hospital facilities. The organization has a clear process for the disinfection of patient areas and contaminated rooms. These are also monitored and checks are made.

In early September 2013, the organization entered into partnership with Steripro for the sterilization and reprocessing of all its surgical equipment (surgical and bronchoscopes). All key parameters for this are followed. The staff members have a clear understanding of all processes related to this.

The infection prevention and control (IPAC) team has also taken steps in creating best practises for infection prevention in cleaning non-critical equipment such as blood pressure cuffs between patient use. This work was recently published in the Canadian Journal of Infection Control.

### 2.2.2 Standards Set: Long-Term Care Services

| Unmet Criteria | High Priority Criteria |
|---|---|
| **Priority Process: Clinical Leadership** | |
| The organization has met all criteria for this priority process. | |
| **Priority Process: Competency** | |
| The organization has met all criteria for this priority process. | |
| **Priority Process: Episode of Care** | |
| 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 complex continuing care (CCC) team has good awareness of the population it serves and has embarked on a process to transition its alternate level of care (ALC) clients to other settings. To date, three of six ALC clients have moved to other care locations outside of Holland Bloorview. There are defined admission criteria for the population served and there is a defined intake and admission process. Admission criteria are posted on the organization's web-site and information is provided to referral sites to ensure that they are aware of the CCC admission criteria. At this time, the majority of referrals come from the Toronto Hospital for Sick Children but CCC is attempting to diversify its referral patterns.

The CCC offers a unique service to support children whose needs cannot be met in other settings. The unit is working to ensure that it is achieving some patient flow by working closely with families to support the transition of clients to other settings closer to the family's home. The CCC has developed goals and objectives that are aligned with the organization's strategic plan and the team regularly measures performance against those goals and objectives. In addition, the teams have access to the necessary equipment, supplies and resources to support the work of the teams. Students and volunteers are an important part of the care team and both groups are effectively orientated to the unit to ensure that they are aware of their roles and their individual responsibilities. For those clients where it is appropriate, there is a standard in place for the administration and documentation of the provision of the pneumococcal vaccine.

A significant number of CCC clients are ventilator-dependent and the lay-out of the unit is designed in such a way as to support the team providing efficient care to clients requiring the use of ventilators. The unit is

about to embark on a re-visioning exercise to ensure that it is meeting the needs of the population that could benefit from its services and care model.

**Priority Process: Competency**

Continuing complex care (CCC) follows a primary nursing team model and has well-established teams with little staff turnover, to support the care needs of patients/clients. The is a multidisciplinary team structure that includes nursing, physiotherapy, occupational therapy, child life therapeutic clowns, speech language pathology, social work, medicine, respiratory therapy, nutrition and other disciplines to support the care of clients. The names of team members are posted in the client room so that families are aware of the membership of the care team.

For new team members, initial orientation and education is carried out effectively on CCC. There is a defined orientation program for new team members as well as annual mandatory education, delivered through e-learning modules and face-to-face instruction. Team members have received education on infusion pumps. The recent replacement of pumps to the specific-measurable-attainable-realistic-time-sensitive (SMART) pumps was supported by education to ensure that team members were competent in using these new pumps. Every team member has a regular performance appraisal every spring and the review of their performance translates into the development of a personal performance plan with development goals.

There are no unregulated personnel that deliver direct care to clients of CCC. This is a team of many disciplines whose members work together to deliver effective care to clients in a coordinated manner. Every staff member receives training on workplace violence and challenging behaviours. There is documentation in the electronic health record (EHR) that provides information to team members on behavioural issues relative to specific clients.

There are excellent 'rounding' processes in place and the team is inclusive of families and clients to ensure that they participate in rounds as much as possible. Family team goal planning is a hallmark of the CCC team, with the focus being on the strengths of the client rather than the deficits. The team uses a modified situation-background-assess-recommend (SBAR) format to articulate the goals of the client.

**Priority Process: Episode of Care**

For continuing complex care (CCC), the team engages family members to ensure that they are aware of the team members providing care to their loved one. At the time of admissions, families are orientated to their care team and are made aware of the core team that will be providing care. The initial assessment of a new CCC client requires input from all interdisciplinary team members to create an integrated assessment of the client and their care needs. The assessment covers all areas of the client’s needs including psychosocial and physical needs.

Medication reconciliation is a noted strength of CCC and it is consistently carried out along using a best possible medication history (BPMH). Medication reconciliation is carried out at admission, upon transfer and discharge. Family members are key members of the team and are empowered to support the care process, where appropriate. Following the initial assessment, the team shares the assessment with families and clients and they work together to develop goals of care with the family and client. Families are involved in setting the goals of care and goals of care are updated during the clients' stay to ensure that they are reflecting client progress as they move toward transitioning to another setting.

Pressure ulcer risk is assessed at admission and is part of the electronic health record (EHR) with a risk score being available to team members via the electronic health record. There are also safe medication

management practices in place that include the handling, securing and destruction of medications, as appropriate. The team consistently uses two client identifiers prior to providing any care or treatment to the client. Pain assessment is completed on every client and an individualized numeric rating scale is used to assess the client's pain based on the unique attributes of every client and their ability to express pain.

The team practices good medication management practices and utilizes an electronic medication administration record (eMAR) to support medication administration. The code status of every client is documented and is visible in the electronic health record (EHR). There is a code blue team on-site and a response process in place should a code blue be called. Though rare, the team is able to support end-of-life care for clients and there are palliative care skills among the care team. As appropriate, end-of-life issues are reviewed with families and code status is updated to reflect any changes that are required. To support these kind of decisions, the team has access to ethics resources and can draw upon the in-house ethics team to support decision making.

The CCC team is commended for its focus on quality of life. The team supports clients attending school on site, as well as to other schools that can meet client needs. There are regular outings and recreation opportunities that may occur at bedside or in group settings. Recognition is given for the support for the therapeutic clowns as well as the ongoing financial commitment by the Foundation to support the Therapeutic Clown Program. There are also quality of life programs that extend to families. These include the availability of massage, on-site accommodations, pot-luck dinners and the family leaders program. The organization also supports the Youth Advisory Committee and has a Child Advisory Council.

Having a school on-site is a great asset as it supports the transition of the client from institution to a community setting and supports their transition to the school setting. Following transition to another setting, there is follow-up by the team to ensure that the transition is going well. The respite program provides opportunities to reconnect with the client to assess their transition. As part of the discharge process, information is transferred to the new care setting, be it in the community or institutional, to ensure that the new care team is aware of client needs.

**Priority Process: Decision Support**

Holland Bloorview has made the development of an electronic health record (EHR) a priority, using the Meditech system. All inpatient documentation is captured in the EHR and team members access it to understand client care needs and for care planning. Team members are aware of the information contained in the EHR and document their care delivery using the EHR. As continuing complex care (CCC) clients may transfer to other care settings during their stay such as to Toronto Sick Children's or Sunnybrook Medical Centre, information is shared between CCC and those care settings to support client care.

Laboratory services are provided by Sunnybrook Medical Centre and results are available via the EHR. Any critical values are flagged in the EHR so that care team members are aware.

Evidence-based best practices are in place and the team works together to develop and modify practice based on evidence and continuous quality improvement. Given its academic nature, Holland Bloorview is developing a stronger research focus and is broadening the opportunities for students to be placed here as part of the educational programs.

**Priority Process: Impact on Outcomes**

The continuing complex care (CCC) team has good resources to support the care needs of their clients. Team members are able to effectively identify risks and share risk issues amongst the team. Equally, the team is able to have discussions about clients that choose to live at risk and how to support their care needs and choices. A fall risk assessment is consistently carried out on every client, a score is assigned and where necessary, a coloured armband is placed on the client to identify that they are a fall risk. The outcome of the fall risk assessment is contained in the EHR along with the associated care plan.

The CCC team has access to the equipment and supplies they require and there are processes in place to acquire equipment and other resources to support client care if they are not immediately available. The team consistently uses two identifiers prior to providing care and service to its clients.

There is an incident reporting system in place that supports online reporting of incidents and communication of the incident via Meditech. There is a clear process for the disclosure of adverse events to families and clients and family members could articulate how they are kept informed of any adverse events related to their child. There are excellent processes in place to engage families in care and to ensure that the family voice is heard when providing care to CCC clients.

There is a strong focus on quality improvement, client safety and risk management. Families are actively engaged in quality, risk and safety and are aware of their roles. The organization is recognized for its excellent focus on engaging families as part of the care team and for keeping families informed about the care needs of the client and determining the goals of care.

The team is recognized for its focus on the psychosocial needs of the client and supporting the spiritual needs of the client and family. The reflection room is a tremendous asset that is available for use by any faiths or simply as a place for quiet meditation. The family resource centre is also an excellent service on the site to support the transition of clients and their families to other care settings.

The CCC program is a service that uniquely positions Holland Bloorview to support the care needs of clients transitioning from acute care to community. The team is aware of the need to look at the service model to ensure that it is meeting the needs of the community and to focus on the successful transition of clients to other settings. It is undertaking this work from a sound foundation of providing high-quality care that meets the needs of the clients its supports, while actively engaging families in care delivery and transition planning.

### 2.2.3 Standards Set: Managing Medications

| 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** |

Holland Bloorview has three full-time equivalent (FTE) pharmacists and three FTE pharmacy technicians within the portfolio of pharmacy services. The unit is well run and offers excellent guidance to staff members and clinicians working in the facility. A 0.2 FTE pharmacist is now protected to work in the pharmacy research unit which is providing guidance and support for any investigational drug studies occurring on site. This is furthering the organization's commitment to supporting research endeavours.

The pharmacy and therapeutics committee is effective at reviewing its formulary, assessing medication-related risk and reporting important findings to the medical advisory committee (MAC). Adverse events and near misses are also carefully reviewed, documented and information is fed back to the clinical teams. Changes to clinical activities are often made based on the review of these events.

Over the past three years a significant amount of work has been performed around medication reconciliation in the ambulatory care setting. Holland Bloorview has a long standing process for inpatient medication reconciliation and has now pushed the envelope by creating an effective and systematic system for its ambulatory care services. This is truly a new strength for this organization. Holland Bloorview was thorough in its approach to implementing this change and in fact sought the help of the Institute for Safe Medication Practises (ISMP) to ensure it had assessed all angles of the problem. The program is well designed and is truly innovative. The organization also has a consistent medication management process in place.

The pharmacy policies are clear and available online for access by all. Policies are also in place for the use of a patient's own medications. Medication samples are banned from the facility.

The challenges for Holland Bloorview in upcoming years includes the creation of an electronic medication reconciliation program and giving consideration of bar coding of pharmaceutical products for enhanced safety.

### 2.2.4 Standards Set: Rehabilitation Services

| Unmet Criteria | High Priority Criteria |
|---|---|
| **Priority Process: Clinical Leadership** | |
| The organization has met all criteria for this priority process. | |
| **Priority Process: Competency** | |
| The organization has met all criteria for this priority process. | |
| **Priority Process: Episode of Care** | |
| 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 child development program (CDP) provides a range of speciality ambulatory clinics including eleven ambulatory medical clinics for Hypertonia, feeding and neuromuscular, three internal clinics and two community satellite clinics. The team has established goals and objectives which are aligned with the organization's strategic plan.

The program has implemented strategies to reduce the waiting times for the Branson clinic by redirecting clients to other clinics. The spina bifida program is commended for auctioning the recommendations from the Toronto Central Local Health Integration Network (TCLHIN) Youth Advisory Committee by collaborating with the Anne Johnson Health Station in transitioning clients from paediatric to adult care. The joint hiring of a nurse practitioner (NP) position is commendable. The team is encouraged to continue its work in service integration across the rehabilitation continuum.

The participation and inclusion team is working towards its goals which align with the organizational's strategic plan. A utilization review was conducted to define the demands and capacity of the program and improve the wait-times. An expansion of program hours, and directing case loads has allowed the workload to reach the acceptable targets.

For inpatient rehabilitation at Holland Bloorview, the team is clear on the populations it serves from the brain injury rehabilitation team (BIRT) and specialized orthopedic and developmental rehabilitation (SODR) team. They have established the appropriate team model with the right skill mix on the team to meet the

needs of their clients. The team includes students that have a significant presence on the units and are integral to the team. The BIRT and SODR teams have established goals and objectives that are aligned with the strategic plan and they regularly measure their performance against those goals and objectives. The teams have access to the necessary equipment, supplies and resources to support the work of the teams.

There is strong clinical leadership on all teams whose members' problem solve daily to reduce the barriers facing persons with a disability.

**Priority Process: Competency**

The initial orientation and education of new team members is a noted strength of the rehabilitation teams. New team members follow a detailed orientation and education plan that ensures that they are competent to provide care to clients/patients. For existing team members, there is an annual core competencies education program that is delivered with a combination of e-learning and in-person education sessions.

Team members have received education on infusion pumps and the recent replacement of specific-measurable-attainable-realistic-time sensitive (SMART) pumps was supported by education to ensure that team members were competent in using these new pumps. Every team member has a regular performance appraisal each spring and the review of their performance translates into the development of a personal performance plan with development goals.

Staff members feel very supported by the organization in attending educational sessions and enhancing their personal learning. Many clinicians have joint appointments with educational institutions and have participated in publishing journal articles. There is a strong commitment to being the 'best we can be' via research and learning and seeking out the opportunities that will enhance the advancement of pediatric rehabilitation.

**Priority Process: Episode of Care**

The child development program and the participation and inclusion program are dedicated to serve the needs of their clients and families. An interdisciplinary team approach to care is evident and supports their vision to create a world of possibility for kids with disabilities. The staff members implement effective interventions based on evidence. Clients and families that were interviewed were highly complimentary of the services they received. They feel supported, respected and involved in their care.

The child development and participation and inclusion programs have had many successes. The implementation of the ambulatory care electronic health record is a major accomplishment. Both programs have implemented strategies to decrease wait-times for clients and improve access to services. The team will continue to monitor the sustainability of these initiatives.

The brain injury rehabilitation team (BIRT) and specialized orthopedic and developmental rehabilitation team (SODR) do a great job in ensuring that families and clients know who their care team will be at admission and in some cases, prior to admission. Inpatient rehabilitation follows a primary nursing team model to ensure consistency in the care team. The rehabilitation team has the ability to expedite an admission should it be necessary to accommodate a client sooner than planned. The team follows a collaborative admission assessment clinical pathway that requires input from all interdisciplinary team members to create an integrated assessment of the client and their care needs. This is completed within five days of admission. This assessment covers all areas of the client’s needs including psychosocial and physical needs.

Medication reconciliation is a noted strength of inpatient rehabilitation and it is consistently carried out with a best possible medication history (BPMH). Following the initial assessment, the team shares the assessment with families and clients and members work together to develop goals of care with the family and client. The team works with the client and family to ensure that they are able to support the client's needs post-discharge and there is post-discharge follow-up. Pressure ulcer risk is assessed at admission and is part of the electronic health record (EHR) with a risk score being available to team members via the EHR. There are safe medication management practices in place that include the handling, securing and destruction of medications, as appropriate.

The goal of BIRT and SODR is to support the safe discharge of clients to other settings. The team works collaboratively with the client and family to develop a safe discharge plan and to ensure that resources are available to support the ongoing care needs of the client.

Since the previous survey the implementation of medication reconciliation in an ambulatory care setting has been achieved. In a response to client /family needs, a coordinated system for referrals for ambulatory care is being piloted. This initiative will promote a single standardized point of contact for intake, consistent triaging of client needs and reduce administrative time on coordinating appointments. The Therapeutic Lifeskills Program is commended for leading the way in medication management in a non-medical environment. The parent handbook 2013-2014, welcoming children to Holland Bloorview Nursery school is an excellent resource for parents. This booklet was also reviewed by the client and family review team.

The respite program for both inpatients and outpatients has improved access for client families needing this support. The commitment and level of client/family engagement at Holland Bloorview is remarkable. The work of the Family Leaders and the Family Advisory Committee is beneficial in changing practices. Their role is valued in reviewing research proposals or being the keynote during the organization's research day.

The teams are aware of their opportunities for improvement such as the need for the child development program (CDP) to provide more general information to families. Encouragement is offered to continue to work on service designs to improve access to care for Cleft Lip and Palate, Psychopharmacology and Life Span. The P&I program is encouraged to improve compliance with documentation standards in the area of client education, and continue to collaborate with other programs to enhance client access to all resources at Holland Bloorview.

**Priority Process: Decision Support**

Holland Bloorview has made the development of an electronic health record (EHR) a priority using its Meditech system. All inpatient documentation is captured in the EHR and team members access it to understand client care needs and for care planning. It is clear that the rehabilitation programs pride themselves on adopting best practice standards and in changing their practices based on evidence. As an academic organization, Holland Bloorview is engaged in research and continues to develop its research expertise with closer collaboration between researchers and the care team. The numerous published papers as well as Canadian and international clinical paper presentations by staff members of the rehabilitation programs is commendable.

**Priority Process: Impact on Outcomes**

Holland Bloorview has a culture of safety. The organization informs and educates clients and families, in writing and verbally about their role in promoting safety. A brochure titled: "Understanding your role in safety: Clients and families" is noted. The brochure includes tips on handwashing, preventing falls, bone health, medication safety and client identification. It is noted that this pamphlet has the client and family reviewed stamp of approval logo. Families are encouraged to be a family leader by being trained for a family advisor. They can sit on committees, be a document reviewer, or participate in focus groups, be a family mentor or a teacher. Sharing family experiences at education forums, staff orientations or conferences is encouraged and welcomed. In surveying family leaders, over 80 percent rated their experience as being a authentically valued by the organization.

In the annual report, the organization has many measures to track performance. It involves outside community partners such as the Greater Toronto Area (GTA) Rehabilitation Network, and Grandview Children's Centre to seek their view and ratings, and this is impressive. The hand-hygiene program is being closely monitored and showing good results with compliance.

The rehabilitation teams have access to a tremendous amount of resources to support their work. The teams have good resources and they are able to draw upon the corporate resources of the organization to support quality improvement and change management. The teams have access to the equipment and supplies they require and there are processes in place to acquire equipment and other resources to support client care if they are not immediately available

The team consistently uses two identifiers prior to providing care and service to its clients. The inpatient rehabilitation team may wish to consider adding the client’s photo to the eMAR to provide an additional identifier when administering medications.

There is a falls assessment in place for all inpatient admissions and a care plan is developed based on the falls risk of the client. The child development team has a modified falls assessment program that stresses a collaborative approach for environmental safety during ambulatory visits. Blue bands to identify clients at risk for falls has been implemented in the P&I program

There are regular rounds in place to support client care and rounds often involve the client and family. Families and clients are aware of their roles in ensuring client safety. There is an incident reporting system in place that supports online reporting of incidents and communication of the incident via Meditech. The team may wish to consider allowing the person reporting the incident to assign the severity level rather than the recipient of the incident report assigning the severity.

There is a clear process for the disclosure of adverse events to families and clients and family members could articulate how they are kept informed of any adverse events related to their child. There are excellent processes in place to engage families in care and to ensure that the family voice is heard when providing care to the rehabilitation clients. In addition, there is a strong focus on continuous quality improvement and putting processes in place to improve care and monitor the impact of improvement efforts.

The teams are encouraged to work on the processes and approaches of transitioning youth to adult programs.

# Section 3 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.

## 3.1 Governance Functioning Tool

The Governance Functioning Tool enables members of the governing body to assess board structures and processes, provide their perceptions and opinions, and identify priorities for action. 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: December 12, 2012 to January 7, 2013**
- **Number of responses: 9**

**Governance Functioning Tool Results**

| | | % Disagree | % Neutral | % Agree | %Agree * Canadian Average |
|---|---|---|---|---|---|
| | | Organization | Organization | Organization | |
| 1 | We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations. | 0 | 0 | 100 | 92 |
| 2 | Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed. | 0 | 0 | 100 | 94 |
| 3 | We have sub-committees that have clearly-defined roles and responsibilities. | 0 | 0 | 100 | 96 |
| 4 | Our roles and responsibilities are clearly identified and distinguished from those delegated to the CEO and/or senior management. We do not become overly involved in management issues. | 0 | 0 | 100 | 95 |
| 5 | We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decision-making. | 0 | 0 | 100 | 92 |

| | % Disagree | % Neutral | % Agree | %Agree * Canadian Average |
|---|---|---|---|---|
| | Organization | Organization | Organization | |
| 6 Disagreements are viewed as a search for solutions rather than a “win/lose”. | 0 | 0 | 100 | 92 |
| 7 Our meetings are held frequently enough to make sure we are able to make timely decisions. | 0 | 0 | 100 | 96 |
| 8 Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable). | 0 | 0 | 100 | 95 |
| 9 Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making. | 0 | 0 | 100 | 94 |
| 10 Our governance processes make sure that everyone participates in decision-making. | 0 | 0 | 100 | 92 |
| 11 Individual members are actively involved in policy-making and strategic planning. | 0 | 0 | 100 | 87 |
| 12 The composition of our governing body contributes to high governance and leadership performance. | 0 | 0 | 100 | 91 |
| 13 Our governing body’s dynamics enable group dialogue and discussion. Individual members ask for and listen to one another’s ideas and input. | 0 | 0 | 100 | 93 |
| 14 Our ongoing education and professional development is encouraged. | 0 | 0 | 100 | 86 |
| 15 Working relationships among individual members and committees are positive. | 0 | 0 | 100 | 96 |
| 16 We have a process to set bylaws and corporate policies. | 0 | 0 | 100 | 95 |
| 17 Our bylaws and corporate policies cover confidentiality and conflict of interest. | 0 | 0 | 100 | 96 |
| 18 We formally evaluate our own performance on a regular basis. | 0 | 11 | 89 | 72 |
| 19 We benchmark our performance against other similar organizations and/or national standards. | 0 | 0 | 100 | 64 |
| 20 Contributions of individual members are reviewed regularly. | 0 | 0 | 100 | 58 |

| | % Disagree | % Neutral | % Agree | %Agree * Canadian Average |
|---|---|---|---|---|
| | Organization | Organization | Organization | |
| 21 As a team, we regularly review how we function together and how our governance processes could be improved. | 0 | 0 | 100 | 76 |
| 22 There is a process for improving individual effectiveness when nonperformance is an issue. | 0 | 0 | 100 | 52 |
| 23 We regularly identify areas for improvement and engage in our own quality improvement activities. | 0 | 0 | 100 | 77 |
| 24 As a governing body, we annually release a formal statement of our achievements that is shared with the organization's staff as well as external partners and the community. | 0 | 0 | 100 | 82 |
| 25 As individual members, we receive adequate feedback about our contribution to the governing body. | 0 | 0 | 100 | 65 |
| 26 Our chair has clear roles and responsibilities and runs the governing body effectively. | 0 | 0 | 100 | 95 |
| 27 We receive ongoing education on how to interpret information on quality and patient safety performance. | 0 | 0 | 100 | 80 |
| 28 As a governing body, we oversee the development of the organization's strategic plan. | 0 | 0 | 100 | 94 |
| 29 As a governing body, we hear stories about clients that experienced harm during care. | 0 | 0 | 100 | 83 |
| 30 The performance measures we track as a governing body give us a good understanding of organizational performance. | 0 | 0 | 100 | 90 |
| 31 We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience. | 0 | 0 | 100 | 84 |
| 32 We have explicit criteria to recruit and select new members. | 0 | 0 | 100 | 79 |
| 33 Our renewal cycle is appropriately managed to ensure continuity on the governing body. | 0 | 0 | 100 | 87 |

| | | % Disagree | % Neutral | % Agree | %Agree * Canadian Average |
|---|---|---|---|---|---|
| | | Organization | Organization | Organization | |
| 34 | The composition of our governing body allows us to meet stakeholder and community needs. | 0 | 0 | 100 | 91 |
| 35 | Clear written policies define term lengths and limits for individual members, as well as compensation. | 0 | 0 | 100 | 94 |
| 36 | We review our own structure, including size and sub-committee structure. | 0 | 0 | 100 | 87 |
| 37 | We have a process to elect or appoint our chair. | 0 | 0 | 100 | 92 |

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2013 and agreed with the instrument items.

## 3.2 Patient Safety Culture Tool

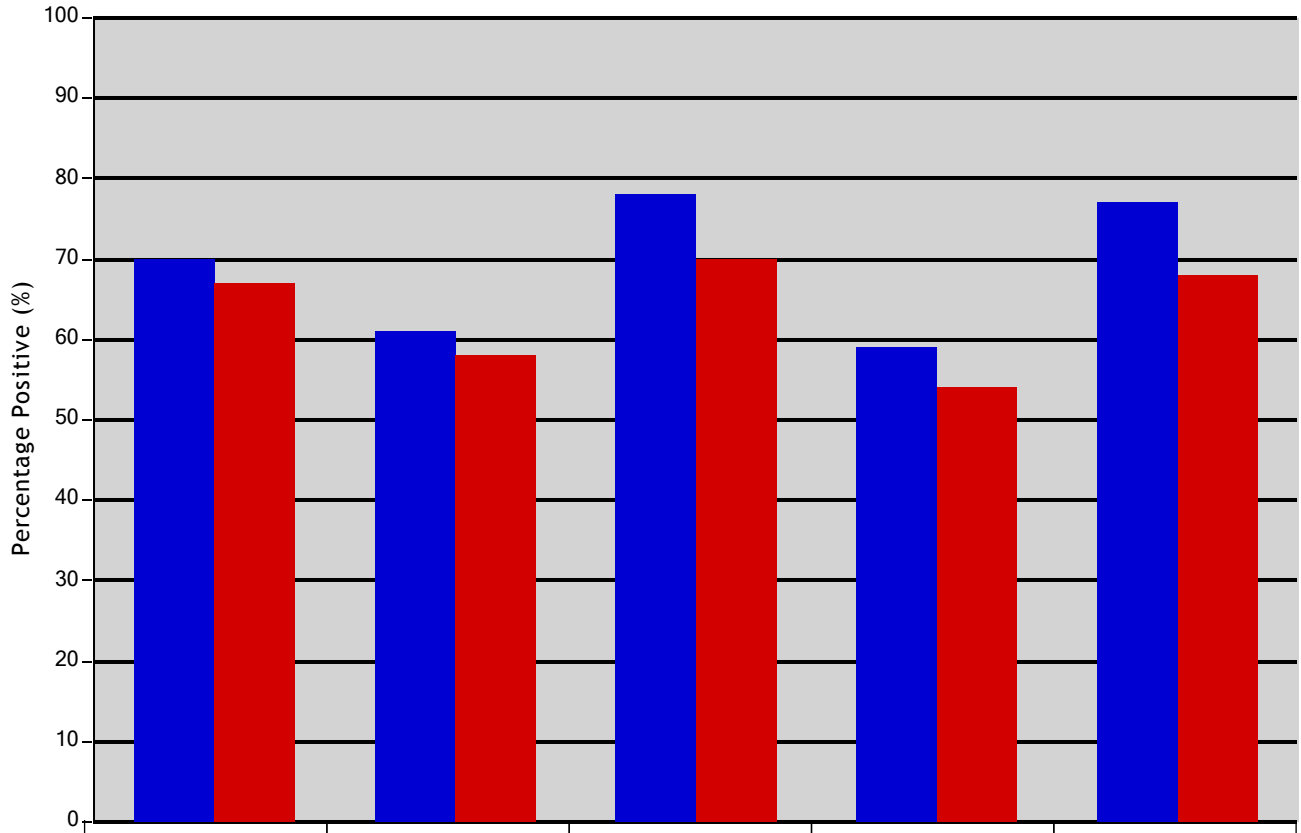
Organizational culture is widely recognized as a significant driver in changing behavior and expectations in order to increase safety within organizations. A key step in this process is the ability to measure the presence and degree of safety culture. This is why Accreditation Canada provides organizations 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: February 27, 2013 to March 22, 2013**
- **Minimum responses rate (based on the number of eligible employees): 197**
- **Number of responses: 333**

**Patient Safety Culture: Results by Patient Safety Culture Dimension**




| | Senior leadership support for safety (valuing safety) | Supervisory leadership support for safety | Patient safety learning culture | Communication barriers/talking about errors | Overall perception of patient safety |
|---|---|---|---|---|---|
| | 70% | 61% | 78% | 59% | 77% |
| | 67% | 58% | 70% | 54% | 68% |

**Legend**

Holland Bloorview Kids Rehabilitation Hospital

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2013 and agreed with the instrument items.

## 3.3 Worklife Pulse Tool

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

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

The organization used an approved substitute tool for measuring the quality of worklife but did not provide Accreditation Canada with results.

# 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. The organization provides Accreditation Canada with evidence of the actions it has taken to address these required follow ups.

## Evidence Review and Ongoing Improvement

Five months after the on-site survey, Accreditation Canada evaluates the evidence submitted by the organization. If the evidence shows that a sufficient percentage of previously unmet criteria are now met, a new accreditation decision that reflects the organization's progress may be issued.

# Appendix B Priority Processes

## Priority processes associated with system-wide standards

| Priority Process | Description |
|---|---|
| Communication | Communicating effectively at all levels of the organization and with external stakeholders |
| Emergency Preparedness | Planning for and managing emergencies, disasters, or other aspects of public safety |
| 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 decision making regarding ethical dilemmas and problems. |
| Resource Management | Monitoring, administration, and integration of activities involved with the appropriate allocation and use of resources. |

## Priority processes associated with population-specific standards

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

## 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 overall goals and direction to the team of people providing services. |
| Competency | Developing a skilled, knowledgeable, interdisciplinary team that can manage and deliver effective programs and services |
| Decision Support | Using information, research, data, and technology to support management and clinical decision making |
| Diagnostic Services: Imaging | Ensuring the availability of diagnostic imaging services to assist medical professionals in diagnosing and monitoring health conditions |
| Diagnostic Services: Laboratory | Ensuring the availability of laboratory services to assist medical professionals in diagnosing and monitoring health conditions |
| Episode of Care | Providing clients with coordinated services from their first encounter with a health care provider through their last contact related to their health issue |
| Impact on Outcomes | Identifying and monitoring process and outcome measures to evaluate and improve service quality and client outcomes |
| Infection Prevention and Control | Implementing measures to prevent and reduce the acquisition and transmission of infection among staff, service providers, clients, and families |
| Medication Management | Using interdisciplinary teams to manage the provision of medication to clients |
| Organ and Tissue Donation | Providing organ donation services for deceased donors and their families, including identifying potential donors, approaching families, and recovering organs |
| Organ and Tissue Transplant | Providing organ transplant services, from initial assessment of transplant candidates to providing follow-up care to recipients |
| Organ Donation (Living) | Providing organ donation services for living donors, including supporting potential donors to make informed decisions, conducting donor suitability testing, and carrying out donation procedures |
| Point-of-care Testing Services | Using non-laboratory tests delivered at the point of care to determine the presence of health problems |

| Priority Process | Description |
|---|---|
| Primary Care Clinical Encounter | Providing primary care in the clinical setting, including making primary care services accessible, completing the encounter, and coordinating services |
| Surgical Procedures | Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge |