ACCREDITATION CANADA



Driving Quality Health Services

Accreditation Report

Quinte Health Care Corporation

Belleville, ON

On-site survey dates: May 3, 2015 - May 8, 2015

Report issued: May 25, 2015

ACCREDITATION CANADA
AGRÉMENT CANADA

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

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About the Accreditation Report

Quinte Health Care Corporation (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 May 2015. 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

Quinte Health Care Corporation (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

Quinte Health Care Corporation'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: May 3, 2015 to May 8, 2015**

- **Locations**

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

  1 Quinte Health Care Corporation, Belleville General Hospital
  2 Quinte Health Care Corporation, North Hastings Hospital
  3 Quinte Health Care Corporation, Prince Edward County Memorial Hospital
  4 Quinte Health Care Corporation, Trenton Memorial Hospital

- **Standards**

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

  System-Wide Standards

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

  Service Excellence Standards

  5 Cancer Care and Oncology Services
  6 Reprocessing and Sterilization of Reusable Medical Devices
  7 Critical Care
  8 Point-of-Care Testing
  9 Diagnostic Imaging Services
  10 Medicine Services
  11 Rehabilitation Services
  12 Community-Based Mental Health Services and Supports Standards
  13 Obstetrics Services
  14 Mental Health Services
  15 Transfusion Services
  16 Biomedical Laboratory Services
  17 Perioperative Services and Invasive Procedures Standards
  18 Long-Term Care Services
  19 Emergency Department

- **Instruments**

  The organization administered:

  1 Governance Functioning Tool
  2 Canadian Patient Safety Culture Survey Tool
  3 Worklife Pulse
  4 Client Experience 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 (Work with my community to anticipate and meet our needs)	80	0	0	80
 Accessibility (Give me timely and equitable services)	105	0	0	105
 Safety (Keep me safe)	645	2	22	669
 Worklife (Take care of those who take care of me)	162	0	1	163
 Client-centred Services (Partner with me and my family in our care)	240	0	3	243
 Continuity of Services (Coordinate my care across the continuum)	76	0	3	79
 Appropriateness (Do the right thing to achieve the best results)	1040	1	9	1050
 Efficiency (Make the best use of resources)	72	0	0	72
Total	**2420**	**3**	**38**	**2461**

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	42 (100.0%)	0 (0.0%)	0	32 (100.0%)	0 (0.0%)	0	74 (100.0%)	0 (0.0%)	0
Leadership	46 (100.0%)	0 (0.0%)	0	85 (100.0%)	0 (0.0%)	0	131 (100.0%)	0 (0.0%)	0
Infection Prevention and Control Standards	40 (100.0%)	0 (0.0%)	1	29 (100.0%)	0 (0.0%)	2	69 (100.0%)	0 (0.0%)	3
Medication Management Standards	74 (100.0%)	0 (0.0%)	4	61 (100.0%)	0 (0.0%)	3	135 (100.0%)	0 (0.0%)	7
Biomedical Laboratory Services **	71 (100.0%)	0 (0.0%)	0	103 (100.0%)	0 (0.0%)	0	174 (100.0%)	0 (0.0%)	0
Cancer Care and Oncology Services	33 (100.0%)	0 (0.0%)	0	73 (98.6%)	1 (1.4%)	2	106 (99.1%)	1 (0.9%)	2
Community-Based Mental Health Services and Supports Standards	21 (100.0%)	0 (0.0%)	1	113 (100.0%)	0 (0.0%)	0	134 (100.0%)	0 (0.0%)	1
Critical Care	34 (100.0%)	0 (0.0%)	0	94 (100.0%)	0 (0.0%)	1	128 (100.0%)	0 (0.0%)	1
Diagnostic Imaging Services	65 (100.0%)	0 (0.0%)	2	67 (100.0%)	0 (0.0%)	1	132 (100.0%)	0 (0.0%)	3

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Emergency Department	47 (100.0%)	0 (0.0%)	0	80 (100.0%)	0 (0.0%)	0	127 (100.0%)	0 (0.0%)	0
Long-Term Care Services	39 (97.5%)	1 (2.5%)	0	92 (98.9%)	1 (1.1%)	1	131 (98.5%)	2 (1.5%)	1
Medicine Services	30 (100.0%)	0 (0.0%)	1	71 (100.0%)	0 (0.0%)	0	101 (100.0%)	0 (0.0%)	1
Mental Health Services	36 (100.0%)	0 (0.0%)	0	88 (100.0%)	0 (0.0%)	0	124 (100.0%)	0 (0.0%)	0
Obstetrics Services	62 (100.0%)	0 (0.0%)	2	80 (100.0%)	0 (0.0%)	0	142 (100.0%)	0 (0.0%)	2
Perioperative Services and Invasive Procedures Standards	97 (100.0%)	0 (0.0%)	3	88 (100.0%)	0 (0.0%)	0	185 (100.0%)	0 (0.0%)	3
Point-of-Care Testing **	38 (100.0%)	0 (0.0%)	0	48 (100.0%)	0 (0.0%)	0	86 (100.0%)	0 (0.0%)	0
Rehabilitation Services	31 (100.0%)	0 (0.0%)	0	69 (100.0%)	0 (0.0%)	1	100 (100.0%)	0 (0.0%)	1
Reprocessing and Sterilization of Reusable Medical Devices	49 (100.0%)	0 (0.0%)	4	61 (100.0%)	0 (0.0%)	2	110 (100.0%)	0 (0.0%)	6
Transfusion Services **	70 (100.0%)	0 (0.0%)	5	66 (100.0%)	0 (0.0%)	1	136 (100.0%)	0 (0.0%)	6
Total	**925 (99.9%)**	1 (0.1%)	23	1400 (99.9%)	2 (0.1%)	14	2325 (99.9%)	3 (0.1%)	37

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

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			
Accountability for Quality (Governance)	Met	4 of 4	2 of 2
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 (Cancer Care and Oncology Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Community-Based Mental Health Services and Supports Standards)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Critical Care)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Diagnostic Imaging Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Long-Term Care Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Medicine Services)	Met	2 of 2	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client And Family Role In Safety (Mental Health Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Obstetrics Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Perioperative Services and Invasive Procedures Standards)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Rehabilitation Services)	Met	2 of 2	0 of 0
Dangerous Abbreviations (Medication Management Standards)	Met	4 of 4	3 of 3
Information Transfer (Cancer Care and Oncology Services)	Met	2 of 2	0 of 0
Information Transfer (Community-Based Mental Health Services and Supports Standards)	Met	2 of 2	0 of 0
Information Transfer (Critical Care)	Met	2 of 2	0 of 0
Information Transfer (Emergency Department)	Met	2 of 2	0 of 0
Information Transfer (Long-Term Care Services)	Met	2 of 2	0 of 0
Information Transfer (Medicine Services)	Met	2 of 2	0 of 0
Information Transfer (Mental Health Services)	Met	2 of 2	0 of 0
Information Transfer (Obstetrics Services)	Met	2 of 2	0 of 0
Information Transfer (Rehabilitation Services)	Met	2 of 2	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation as a strategic priority (Leadership)	Met	4 of 4	2 of 2
Medication reconciliation at care transitions (Cancer Care and Oncology Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Community-Based Mental Health Services and Supports Standards)	Met	4 of 4	1 of 1
Medication reconciliation at care transitions (Critical Care)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Emergency Department)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Long-Term Care Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Medicine Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Mental Health Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures Standards)	Met	7 of 7	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Rehabilitation Services)	Met	5 of 5	0 of 0
Safe Surgery Checklist (Obstetrics Services)	Met	3 of 3	2 of 2
Safe Surgery Checklist (Perioperative Services and Invasive Procedures Standards)	Met	3 of 3	2 of 2
Two Client Identifiers (Biomedical Laboratory Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Cancer Care and Oncology Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Critical Care)	Met	1 of 1	0 of 0
Two Client Identifiers (Diagnostic Imaging Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Emergency Department)	Met	1 of 1	0 of 0
Two Client Identifiers (Long-Term Care Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Medicine Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Mental Health Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Obstetrics Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Perioperative Services and Invasive Procedures Standards)	Met	1 of 1	0 of 0
Two Client Identifiers (Point-of-Care Testing)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Two Client Identifiers (Rehabilitation Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Transfusion Services)	Met	1 of 1	0 of 0
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management Standards)	Met	4 of 4	1 of 1
Concentrated Electrolytes (Medication Management Standards)	Met	3 of 3	0 of 0
Heparin Safety (Medication Management Standards)	Met	4 of 4	0 of 0
High-Alert Medications (Medication Management Standards)	Met	5 of 5	3 of 3
Infusion Pumps Training (Cancer Care and Oncology Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Critical Care)	Met	1 of 1	0 of 0
Infusion Pumps Training (Emergency Department)	Met	1 of 1	0 of 0
Infusion Pumps Training (Long-Term Care Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Medicine Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Mental Health Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Obstetrics Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Perioperative Services and Invasive Procedures Standards)	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			
Infusion Pumps Training (Rehabilitation Services)	Met	1 of 1	0 of 0
Narcotics Safety (Medication Management Standards)	Met	3 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Client Flow (Leadership)	Met	7 of 7	1 of 1
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			
Hand-Hygiene Compliance (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Hand-Hygiene Education and Training (Infection Prevention and Control Standards)	Met	1 of 1	0 of 0
Infection Rates (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Pneumococcal Vaccine (Long-Term Care Services)	Met	2 of 2	0 of 0
Patient Safety Goal Area: Falls Prevention			
Falls Prevention Strategy (Cancer Care and Oncology 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: Falls Prevention			
Falls Prevention Strategy (Diagnostic Imaging Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Emergency Department)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Long-Term Care Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Medicine Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Mental Health Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Obstetrics Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Perioperative Services and Invasive Procedures Standards)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Rehabilitation Services)	Met	3 of 3	2 of 2
Patient Safety Goal Area: Risk Assessment			
Pressure Ulcer Prevention (Critical Care)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Long-Term Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Medicine Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Perioperative Services and Invasive Procedures Standards)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (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			
Suicide Prevention (Community-Based Mental Health Services and Supports Standards)	Met	5 of 5	0 of 0
Suicide Prevention (Mental Health Services)	Met	5 of 5	0 of 0
Venous Thromboembolism Prophylaxis (Cancer Care and Oncology Services)	Met	2 of 2	2 of 2
Venous Thromboembolism Prophylaxis (Critical Care)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Medicine Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Perioperative Services and Invasive Procedures Standards)	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, Quinte Health Care Corporation is commended on preparing for and participating in the Qmentum survey program. The surveyor team visited and were hosted at all hospitals that comprise Quinte Health Corporation (QHC). It was clear to surveyors that the organization takes accreditation seriously and significant preparations and promotion took place leading up to the on-site survey. The enthusiasm for the survey and the hospitality of QHC was refreshing to experience and appreciated by the surveyor team.

Community partners are viewed the strength of the organization to be its staff members that were described as committed, flexible and collaborative. Leadership is described as engaging, innovative, willing to partner and open to pursuing opportunities of mutual benefit to patients/clients and respective organizations. The QHC's information technology (IT) department is identified as particularly responsive and supportive.

Participants in the community partners' focus group feel the QHC could enhance its communication both across and between the organization's sites and the communities it serves. The organization is encouraged to tell its story with clarity and be forthright and not dependent on others to determine the messages. Strong partnerships were identified and are appreciated. Partners expressed concern over the loss of the: "P.A.R.T.Y Program", which appears to have stalled. Health Links is regarded as positive for all partners although participants described overlap in memberships. The substantive relationship with Loyalist College has matured and is deemed to be a win-win situation, particularly for the access to electronic documentation. Also shared at the meeting was that a strong partnership exists with local Fire Departments and it was felt QHCC had fire and safety at the forefront. The Fire Department is appreciative of the work done together. Flu immunization amongst staff members is regarded as on par with other like organizations and it was recognized and appreciated that QHC is trying hard and utilizing a variety of strategies to increase uptake among staff.

The leadership team of QHC was found to be welcoming and most helpful. All members of the leadership team are engaged, insightful and realistic in their assessment of progress made since the previous survey. Much has been accomplished via this leadership and it is clear a culture of continuous improvement is maturing and taking the organization in the direction it needs to go. There is a clear investment in professional development that needs to be shared across all levels as planned. The pace of work and myriad of demands within a changing internal and external environment has resulted in considerable anxiousness and angst yet it has not deterred the leadership from moving forward with progressive and creative initiatives. The strategic directions are clear and considerable thought and effort has gone into helping the front lines understand the organization's future directions and how individuals and teams can help with achievement.

There is evidence of strong medical staff engagement in the organization with several champions emerging that are anxious to support change and improvements. Current budgetary challenges have afforded an opportunity to further engage physicians in understanding the organization's financially precarious circumstances going forward and challenge them, along with others to recognize the overall situation and provide organization-wide ideas for sustainability in coming years. This level of physician engagement and understanding, while still not optimal, would be the envy of many organizations.

Staff members have a clear understanding and appreciation of the needs of their patients and the local communities. They consistently strive to be helpful and accessible. Multi-tasking and collaboration was much in evidence during the survey. Considerable investments in information technology (IT) and decision support have begun paying dividends across the organization. Staff members, physicians and governors feel strongly supported with data and information to guide reporting and quality improvement. Standard work is becoming to be

accepted and practiced by leaders and the organization is strongly encouraged to continue its efforts at continuous quality improvement using the tools of Lean.

Patient safety is a priority however, there are challenges and further work in this area is encouraged. The organization is also encouraged to continue its implementation of enterprise risk management. A framework exists and there are aspects of operations that have risk consideration identified and built in, nevertheless, this important initiative needs further nurturing.

The board of directors is engaged and understands the role in governance. A solid recruitment and orientation process exists for new members. Board members participate in regular learning events and development opportunities and have come to develop a trusting relationship with the leadership at QHC. The board has active committees and it tracks progress toward achieving operational goals and the strategic plan. The board and leadership are also guided by a large community advisory committee (CAC) of stakeholders that serve as conduits for two-way communication and as a source of potential board members. The board is aware of risks facing the organization and members are realistic in their assessments and supportive of plans to minimize risks.

Clients of the organization are complimentary of and pleased with the levels of care provided and with the providers. Issues of food were highlighted by several in-patients. Opportunities for choice were deemed to be limited, examples of wastage were shared and it was also suggested that a move to using local produce and organic products should be pursued.

Many clients shared concerns and disapproval of any plan to reduce services or close existing facilities. The move to develop expertise and "centres of excellence" at specific sites is recognized and applauded. This approach appears to be working well and several patients indicated that while they want access to their local hospital, they also want to ensure they are receiving the best care possible and are willing to travel to obtain it. The organization is commended for its sensitivities to these issues while operating and managing in a resource constrained environment requiring strategic investments, innovations and quality improvement initiatives to maintain safe and efficient care at all sites.

In general, facilities are spacious and well maintained, reflecting a pride amongst the staff members and those they serve.

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: Governance

Meeting the demands for excellence in governance practice.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The board of directors is comprised of interested volunteers that have substantial and varied experiences in leadership roles in the public and private sectors. Recruitment follows a substantial process that works well and is with a nominating committee primarily made up by the community advisory group.

The board possesses a strong sense of community expectations, and identified solid examples of how it developed policy to address concerns and angst amongst stakeholders in the communities that make up the catchment area for the organization. Board meetings are held in different communities to facilitate accessibility to the governors. The strategic plan was developed based on wide engagement of stakeholders and utilizing "scenario planning". Board members also have a solid understanding of their roles and responsibilities and are aware of the challenges all organizations face in the implementation of strategic plans. Indicators are monitored and track success of the plan. A balanced scorecard is utilized and colour-coding helps board members be efficient in tracking organizational performance. Probing questions are asked of leadership in a manner that respects the separations of governance and operations. Performance is shared internally and externally.

The board participates in annual education sessions and there are learning opportunities and tours provided prior to many board meetings that help keep members in touch with, and visible to staff. Committees of the board are active and do the "heavy lifting" with results coming to the board in an efficient manner.

Although a relatively large body, the community advisory committee is deemed to be an effective vehicle, a conduit of two-way information and a valued source of talent for future governance roles.

The board identified learning that has occurred through the several iterations of the annual quality improvement plans (QIPs) that are submitted to government. Members also identified significant changes and success as a result of the QIP processes.

The board has a solid orientation and selection process and members were pleased with the professional development opportunities that are afforded them. They also seek and receive feedback on their performances, and past evaluations have resulted in significant enhancements such as a consent agenda, and consolidation of committee meetings.

The board also evaluates the chief executive officer (CEO) and chief of staff against an annual work plan. There appears to be good working relationships with the foundations. There still appears to be some opportunities for more sharing of equipment and resources across all hospitals.

The board has identified several risks to the organization namely: physician recruitment and retention, demographics pertaining to the increased and aging population and success of a new model of care.

2.1.2 Priority Process: Planning and Service Design

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

There is a substantive strategic planning process that engages all key stakeholders. A unique approach to establishing and sharing the values of the organization has been developed and it resonates with those associated with the organization.

The organization works with a variety of partners to collect and share information and data about the populations and areas served by Quinte Health Care Corporation. Environmental scanning and benchmarking occur and the organization is encouraged to continue working with its regional partners. More formal arrangements need consideration. Further development of understanding the needs of mental health and addictions population is an area for increased attention.

There is some evidence that mechanisms for monitoring the execution and effectiveness of strategic and operational plans are maturing and need to be accelerated. The organization recognizes the need for longer term planning, particularly in the current resource-constrained environment in the province.

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)

The organization maintains a regular planning cycle of which matters of resource allocation are an integral part. An appropriate time frame is followed as strategic directions cascade to directors and then to teams so they can develop their internal processes and plans leading into the new fiscal year. A broad range of partners are engaged and the organization has made considerable efforts to share their fiscal realities and solicit input.

In recent years there has been an increased emphasis on education about the organization's budget in order that those considering the organization's challenges may have a broader lens upon which to build sustainability. The organization faces significant financial challenges in the coming years. This is not dissimilar to other health organizations and hospitals being challenged to understand and then maximize their funding under the Health System Funding Reform regime introduced by the ministry. The organization is encouraged to continue its focus on understanding and sharing its challenges while seeking to maximize its opportunities.

The organization is commended for recognizing the need for longer term viability and decentralizing the budget building process. Several committees feed into the capital planning process. A successful redevelopment is winding down at one hospital site and plans to proceed with a major new project that calls for closer alignment with a family health team (FHT) and a hospital has been envisioned for several years and is being pursued with the ministry.

An annual replacement plan exists for key pieces of equipment.

The organization is supported by and appreciative of the efforts of multiple Foundations. The benefits of Foundations working within their respective communities are understood. These vital partners are encouraged to recognize the need to also view their role in a broader perspective, as their respective contributors benefit from enhanced equipment and services across the Quinte Health Care Corporation catchment area.

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)

Staff wellness is clearly a priority for the organization and internal and external experts are utilized. Also, spiritual care coordinators are available to work with staff. Recognition of staff takes place in several ways and outstanding attendance is regularly rewarded and appreciated.

The organization is proactive in offering a diverse array of training opportunities. Success is recognized with a Quality of Worklife Award from the Ontario Health Association (OHA) and the organization is commended for this result and for investing the time to pursue the award again.

There is a substantive orientation process that has been reviewed and updated within the last two years. A multi-media program is utilized. Formal feedback on the program is solicited.

The Exceptional Workplace team initiative of the chief executive officer (CEO) is commended and is recognized as an innovative and creative way to solicit input on staff frustrations and develop solutions to issues in the workplace.

A medical human resources plan is updated quarterly. Evidence of medical leadership development exists and a well-developed approach to create a culture of learning amongst physicians exists and is deserving of recognition. These investments have potential for significant benefits to physicians and to the organization. Also noteworthy is the development of a physician portal and annual online physician privilege renewal process, which includes performance appraisals of physicians. There is evidence of significant investment in Medical Affairs and this appears to have resulted in higher physician engagement scores. The organization surveys staff members and physicians regularly and all feedback is reviewed.

Those responsible for human capital development are approachable and seek to be collaborative. They are striving to align with the organization's strategic plan and are encouraged to make this an operational reality. New personnel and roles in this area bode well for success and the team is encouraged to ensure that as a service and support function, team members are cohesive and proactive in: "going to" staff and partners.

Linking staff members to patient safety and utilizing audits is recommended. The recent establishment of the Quinte Health Care Corporation's utilization advisory committee is applauded. The committee is encouraged to pursue proper utilization and consider the "Choosing Wisely Campaigns" to encourage physician involvement and activity.

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)

There have been significant positive improvements related to quality and risk at Quinte Health Care Corporation (QHCC) since the previous survey. Electronic incident reporting has been implemented and there has been a significant increase in reporting by staff. Considerable improvements were also identified in the Patient Safety Culture Tool results. The expectation and implementation of huddles is regarded as having a significant impact on shifting the culture towards enhancing quality improvement and sharing at the front lines.

The quality improvement plan (QIP) process is maturing and results are monitored by the leadership and the board. A corporate dashboard facilitates monitoring and reporting. Decision support capacities are strong and accessible and well-subscribed by many providers on a daily basis. Unit-based quality improvement teams have been created and have their own goals and objectives that are expected to align with organizational priorities. Resource challenges require prioritization of more substantial initiatives.

There is recognition that the director level in the organization has to become champions of quality improvement and this is being supported and realized with positive results.

A disclosure policy exists and is followed. The organization prides itself in being open and transparent.

Patient feedback has moved online from being paper-based previously, and the result is richer reporting and ease of measurement and monitoring of trends.

Quinte Health Care Corporation (QHCC) has changed insurers and is pursuing an enterprise risk management approach. Risks are identified and influence organizational priorities and are utilized in fiscal planning. There is evidence that contracts are managed and results are monitored for quality and patient safety. During the survey an example of having a contract re-negotiated when indicators of quality were deemed unsatisfactory was shared.

The organization is commended for its program entitled: "Multi Event Analysis", which examined a series of significant events to determine potential common causes. Processes were reviewed and although no apparent links were found, lessons learned were realized and action plans developed by teams that resulted in improvements. This was a solid effort of which the organization can be proud as it ensures key foci are realized and sustained.

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 ethics committee meets every two months to review cases or to engage in case studies of ethical situations in the literature, current events, or in forward planning for future concerns management. The committee was active in the drug shortage issues of 2013, and is keeping abreast of such issues as assisted suicide legislation that will be available in the future.

The committee leads are concerned about keeping the committee alive given that the organization is not faced with ethical dilemmas every day that require committee support. Ethics as a topic is reviewed at orientation to the hospital site and additional education occurs at the committee level. The committee members have engaged in workshops, ethics network meetings, ethics courses and other activities to maintain and grow their expertise. They have created consultation service brochures and pocket tools to aid staff members in their work. Their service contact is available via the intranet where the ethical framework and consult request forms are posted. The committee has just completed a needs assessment survey with staff members to better understand their needs to tailor future teaching.

There is the belief that in the future there is the need to align quality and ethics more closely together, as the organization tackles the health care decisions facing all hospitals in future health care specifically, resource decisions. The committee also believes it should be more closely aligned with policy development to provide the ethical lens. The committee leadership is considering the VA-hospital models of the USA which are worth exploring.

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 Quinte Healthcare Corporation (QHCC) is recognized for its efforts at transparency in its communication with stakeholders. The communication plan is aligned with the strategic plan and is used to evaluate information sharing venues and techniques across the organization, and with the community at large. Continuous quality improvement activities are developed based on these evaluations.

Some examples of the venues being used to ensure information flow across the organization include, but are not limited to: the website; internet access for all staff; intranet (pod cast and videos); newsletters; weekly update bulletins via email; and regular 'huddles' and team meetings. It is noted that 'virtual huddles' are now being piloted at Trenton Memorial Hospital site. This suggestion was put forward by the night staff members that are unable to participate in these day time activities.

There are forums to share information with external stakeholders. Some examples include: printed materials; planned news releases; open board meetings with the exception of limited in-camera sessions; and, visibility of board members, chief executive officer and senior leaders across the QHCC catchment area.

It is noted that efforts to enhance communication with all stakeholders will be important as the organization continues with the implementation of its strategic directions. Engagement surveys are done to collect feedback from both internal and external stakeholders. The next survey is scheduled for later on in 2015.

The organization is committed to capacity building via the availability of education and training for staff members that are not currently technologically literate.

Attention to privacy and confidentiality of information is positively noted, as is the safeguarding of information via a back-up process.

The draft privacy framework is acknowledged. The establishment of the Compass System has enabled better trending of data and is indicating an improvement in the validity and accuracy of information being delivered across the organization. This is positively noted.

Encouragement is given to continue the work begun on the development of an expanded social media policy.

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)

Since the organization's previous survey Quinte Health Care Corporation (QHCC) has undergone significant infrastructure upgrades particularly at the Belleville General Hospital site. These upgrades have resulted in improved patient care delivery environments and better work space for staff. Plans continue for a new Prince Edward Memorial Hospital.

There is an automated preventive maintenance program. Refinements to this program continue as a risk management and quality improvement initiative.

The facility services department has been successful in providing ready access to all routine and contracted inspections via the website. Staff members of this department can be proud of this achievement.

Back-up generators are in place across the organization in the event of utilities failure. These generators are tested weekly as part of the preventive maintenance program.

Upgrading of the building automation system (BAS) has been ongoing during the past year. These upgrades are expected to be completed by the end of May 2015.

Security officers are part of a contracted service for the corporation. They are stationed in the emergency department(s) and provide added protection for patients and staff. These officers are trained to respond to code white and are considered an asset by staff.

Environmentally friendly programs such as recycling, energy management initiatives, and the design and implementation of the 'smart sharps' reusable containers are positively recognized.

Housekeeping staff members work diligently to ensure a clean and pleasant environment. The focus on innovative infection prevention and control practices is commendable.

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 operation centres and secondary back-ups exist at all hospital sites. Actual and mock events have served as significant learning experiences for the organization. Debriefing after actual and training events are consistently held and there is evidence that action is taken to address deficiencies or areas of concern raised.

There is a well-developed staff training program and new employees are prepared by their orientation sessions.

An emergency preparedness committee exists and an Ebola information management system (IMS) working group was established following a high profile suspected case of Ebola. As a result of the Ebola work, the committee was in a position to share their experiences with others and presented their findings to others to aid in provincial preparedness.

The organization has comprehensive policies and procedures, takes an all-hazards approach, complies with pertinent legislation and regulations and works with external partners in planning.

Training has been enhanced by an in-house video. Also, a new evacuation device (MedSled) was acquired to replace an outdated and cumbersome tool.

There is evidence that considerable effort has been expended by the organization to improve its emergency preparedness since its previous survey. However, a gap in monthly fire drills recorded and evaluated was noted. This was due to personnel issues (leave and sudden resignation) and was not detected by the leadership. This has been identified and appears to have been addressed. The leadership of the organization is reminded to be ever vigilant in setting expectations for regular drills, as outlined in the policies and then ensuring these occur and are recorded.

Staff members identified the burden that is often imposed on the organization from external expectations, particularly related to the cost of maintaining equipment (pandemic and CBRNE) and keeping it up-to-date with minimal or no support. Yet, they persevere, actively lobby for resources and are engaged in planning at the Local Health Integrated Network (LHIN) level.

The organization is encouraged to correct issues of overhead paging and door closures identified in the evaluations and debriefs. The organization is also supported in its efforts to acquire a less cumbersome method of updating its fan-out lists.

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)

Not unlike other hospitals in Ontario the Quinte Health Care Corporation (QHCC) continues to pursue solutions to patient flow bottlenecks. The flow team works form end-to-end, from admission diversion to discharge planning to keep the beds open and accessible to the community. There are bed scrums at least three times per day across the sites to maximize bed usage. Unit bullet rounds and patient white boards are active tools for day-to-day patient goal management and discharge planning initiatives. The teams continue to work towards good expected day of discharge (EDD) planning so the patient and family are in step with the planned trajectory for the patient, be it to home, another site, or a transition bed in the community.

The Community Care Access Committee (CCAC) conducts telephone discharges or in-person planning depending on the complexity of the patient needs. The team members are active health links partners in community care planning for the region. The team has good community connections which helps in complex management to the next or final transition for care.

There is a robust surge protocol which is used daily during the peak patient season. Infection prevention and control (IPAC), managers and team leaders are all involved at each of the sites and cross-sites to support patient flow. Although the philosophy of right bed is supported, there are at times, off-service patients to the next best possible unit for care. Given the flow pressures the organization has worked to minimize the impact on the need for cancellation of surgeries. The team indicates that Quinte 5 has one of the best pull-time for patients to their units, and works hard to make this happen every day.

A new position, "Rapid Admission Nurse" assignment has just been incorporated into the team and is receiving positive reviews. This role helps with admissions across the hospital sites and is nimble enough to support whatever is needed for example, discharge support to keep flow happening. The use of the Meditech situation-background-assessment-recommendation (SBAR) transfer form allows for the electronic hand-off for patient received from the ED and other areas.

Although patient flow is a day-to-day stressor, the team is working hard every day in support of their patients and families. An upcoming Discovery Day will be an opportunity for providers to talk about new ideas for flow management. This could include increasing clinic access rather than admissions (Senior Link is on example), and increased focus on acute care for elders (ACE) mobilization, and early activation. The QHCC is focused on making patient access and flow a priority.

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)

The medical devices and reprocessing department (MDRD) team members are knowledgeable and committed to their role in support of safe patient care. They are the centre for reprocessing for the Belleville site and extended sites as required and are looking forward to their upcoming redevelopment of the current space. The staff members are provided a good orientation and ongoing training and have a new software system that supports cleaning and sorting of instruments via an online manual and inventory of instruments.

The MDRD staff members in the endoscopy area of the hospital site where reprocessing of scopes is delivered are confident in the process for broken, or missing instruments and in the quality checks and indicator strip application to ensure safe sterilization processes. In the last few years staff members have been certified for their roles using both on-site and off-site programs. Their attention to detail with every instrument is what makes the work challenging and more so on the extremely busy case days.

The team tracks incidents as identified by the department and works closely with the operating room (OR) team. Encouragement is offered to have OR registered nursing (RN) staff members have partner days in the reprocessing area where they can better understand the 'lived' experience of the area staff members to better support their patient care activities.

The MDRD staff members are consulted in purchases of equipment requiring reprocessing. In the cases where equipment is loaned from vendors for use there is a standard operating procedure (SOP) for the reprocessing and return of equipment.

At all sites the staff members are engaged in their work flow and work as a team to deliver safe service to patients. The cross-training to all department areas allows for coverage and variety in this focused work.

The organization has out-sourced its medical device repair and support services and has a roving team available to all sites. This team is at-the-ready to support damaged or broken bio-medical equipment same day, or next day and as required to support the clinical need. There is a formal preventive maintenance (PM) process for each of the areas and sites to ensure that all equipment is reviewed and refreshed as required. The team members are active in the purchase of new capital equipment and are involved in multi-hospital purchases.

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:

Point-of-care Testing Services

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

Clinical Leadership

- Providing leadership and 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

Organ and Tissue Donation

- Providing organ donation services for deceased donors and their families, including identifying potential donors, approaching families, and recovering organs

Infection Prevention and Control

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

Surgical Procedures

- Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge

Diagnostic Services: Imaging

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

Diagnostic Services: Laboratory

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

Transfusion Services

- Transfusion Services

2.2.1 Standards Set: Biomedical Laboratory Services

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

Surveyor comments on the priority process(es)
Priority Process: Diagnostic Services: Laboratory
The main laboratory for this organization is located at the Belleville General Hospital site. Laboratory testing is available at the other hospital sites using Point-of-Care Testing (POCT). The laboratory is in a newly renovated space, which is quite extensive and has good resources and equipment. The team leadership is experienced and knowledgeable. Staff members are fully trained and receive the proper orientation when they begin work with this team. The POCT function works well at the smaller hospitals and while it is operated by the nursing staff, the quality control functions are managed by laboratory staff. The laboratory measures turnaround times and does this well. In particular, service to the emergency department is prompt and meets targets.

2.2.2 Standards Set: Cancer Care and Oncology 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	
11.5 Following transition or end of service, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning.	
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 interdisciplinary team is knowledgeable about its patients and the community it serves. There is a strong focus on patient oriented care and services.

Whenever possible, patients and their families are included in the care planning. Support is provided for both the patient and the family in achieving patient goals.

Goals and objectives for Cancer Care and Oncology Services are aligned with the strategic direction and monitored regularly for progress.

Priority Process: Competency

The interdisciplinary team is committed to providing safe, quality care and services to its patients. The team uses evidence-based information and best practice guidelines in reviewing and improving the cancer care program.

Many partnerships exist with peer organizations, both at the regional and provincial levels.

Priority Process: Episode of Care

There is a comprehensive, holistic admission and assessment process in place. The interdisciplinary team uses the information gained from these processes to ensure individualized patient care.

Based on the on-site interviews the cancer care team members are respected by the patients.

Priority Process: Decision Support

The team is provided with education and training on a regular basis specifically as it relates to cancer care. It is further noted that the clinic staff members work closely with Cancer Care Ontario (CCO).

Orientation to the unit is quite detailed especially as it relates to the preparation and administration of chemotherapy.

Priority Process: Impact on Outcomes

Indicators have been established for care and service delivery. These indicators are reviewed and analyzed for quality improvement opportunities.

Information regarding safety is provided to both patients and their families via several venues. The recent introduction of the patient/family educational presentation on what to expect during chemotherapy treatment is acknowledged with approval. It is further noted that printed material from this presentation is given to the patient for quick reference.

Sharing of information across the team is done in a variety of ways, including the "5 for 5" morning sessions, monthly Tumour Board meetings, and unit huddles.

2.2.3 Standards Set: Community-Based Mental Health Services and Supports Standards

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 interdisciplinary teams are knowledgeable about the communities they serve and collaborate with a variety of stakeholders to coordinate and deliver services. Well-developed working relationships have been established in the community, and this has a positive impact on patient outcomes.

Staff members of the crisis team, the transition outpatient centre (TOC), the children and youth program and the assertive community treatment team (ACTT) are committed to the delivery of recovery oriented patient care. They are seen as leaders in their field within the community served.

Representatives from community-based mental health programs actively participate in local committees, and the Mental Health Coalition with the South East Local Health Integrated Network (SE LHIN) is just one example.

Priority Process: Competency

The interdisciplinary team has skilled and competent service providers, several of whom have been with the organization for many years and consequently, have tremendous knowledge about the populations served.

Staff members report they have access to both internal and external educational opportunities. This provides for evidence-based practices and guidelines which are used for the delivery of services. This commitment to ongoing educational programs is noteworthy.

Priority Process: Episode of Care

Staff members are committed and passionate about their work. There is evidence of a positive work culture. There is great pride in the work being done and the impact the various services have on the lives of patients and their families.

Goals and objectives are developed for the program areas in accordance with the strategic plan. Progress is monitored and shared regularly. The recovery model philosophy is embraced across all programs. There are frequent opportunities and venues for the team to share information and problem solve. Standardized assessments tools are being used by team members to help guide service planning.

Medication management is only applicable to the assertive community treatment team (ACTT), with limited applicability to the Transitional Out-patient Centre (TOC).

All staff members receive anti-stigma training and act as educators across the other departments in the Quinte Health Care Corporation (QCHH). Staff members also speak at public events in relation to this topic. The introduction of an anti-stigma education program to emergency department staff members has been planned by the South East Local Health Integrated Network (SE LHIN). However, this is currently on hold due to funding constraints. It is noted that the Mental Health Services Community Advisory Committee members will bring forward and discuss any concerns about the Mental Health programming.

Attention to staff safety is noted with approval. The team is recognized for its efforts in educating local school board employees in ASSIST techniques. Staff members are well trained to identify and mitigate risks to clients and themselves. The incident reporting is viewed positively as an opportunity to help them identify trends and take remedial action.

Priority Process: Decision Support

Best practice guidelines and evidence-based practice guidelines are accessible for all teams. There is adherence to legislative requirements, as mandated by the province.

Privacy and confidentiality of information is noted with approval.

Priority Process: Impact on Outcomes

Managers and staff members are strong advocates for their programs and for the resources required to achieve program objectives. Fiscal constraints along with scarce resources limits what can be done however, there has been a lot of good work undertaken to build a strong case for identified needs.

The recent redesign of mental health services by the South East Local Health Integrated Network (SE LHIN) has created some anxiety for the team and within the sector in general, as to the pending impact on services as a result of this redesign. The team is wished well in its efforts to promote its programs as these changes unfold.

2.2.4 Standards Set: Critical Care

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The intensive care unit is located at the Belleville General Hospital. This is a relatively newly renovated space and patients are cared for in individual rooms. This promotes a degree of privacy and aids with infection prevention and control. There is a long desk facing the majority of the rooms where nurses can enter patient documentation and do other similar tasks while still observing their patients. In addition, documentation can be done at the bedside using terminals installed in each of the rooms for this purpose.

The team leadership has determined that approximately 50% of admissions are related to pneumonia or chronic obstructive pulmonary disease.

Priority Process: Competency

There is a full orientation program for new hires, tailored to the individual needs of staff.

There is one main type of infusion pump in use in this organization. However, there are several other types also used from time to time. Team members are trained in the use of all types of pumps that they encounter.

Also, online and printed information is available for additional support.

The timing of the interdisciplinary rounds is quite variable as the physician has other responsibilities. If the physician was able to attend the rounds every morning without the distraction of needing to see patients in other locations this would result in a satisfactory outcome for all attending these rounds.

Priority Process: Episode of Care

The critical care team is in the process of developing a Critical Care rapid response team (CCRT). This will be led by a nurse with intensive care training, and the nurse will be backed up by the RT and MRP for that patient.

There are standardized admission criteria for the intensive care unit. These are somewhat broad in nature to allow for flexibility. This is necessary given the nature of the organization, with four different hospitals.

The team is comfortable with patients that present with advance directives. There is liaison with the Trillium Gift of Life Network to facilitate tissue and organ donation in accordance with the wishes of the patient and family.

Priority Process: Decision Support

This is a closed intensive care unit (ICU), and all patients are managed by an intensivist. Overnight coverage is provided by the internal medicine specialist on call.

Priority Process: Impact on Outcomes

The Safer Healthcare Now bundles for ventilator associated pneumonia (VAP) and central line infections (CLI) are implemented.

Priority Process: Organ and Tissue Donation

The organization uses the resources and services provided by the Trillium Gift of Life Network.

2.2.5 Standards Set: Diagnostic Imaging Services

Unmet Criteria	High Priority Criteria
Priority Process: Diagnostic Services: Imaging	
The organization has met all criteria for this priority process.	

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

The diagnostic imaging services receive referrals from a variety of sources. The staff members have noticed an increase in the number of seniors accessing services.

Several episodes of care were witnessed during the on-site survey and staff members appeared to be knowledgeable, skilled and friendly. Two client identifiers were consistently used and providers were friendly, considerate and introduced themselves to each of the patients. Staff members commented they had access to educational opportunities and did their best to avail these. There is also yearly training provided for compliance in areas such as: "WHMIS and "Transportation of Dangerous Goods". Patients interviewed were pleased with the services provided and most felt that wait times were reasonable and they were kept informed, safe and well-treated by their providers. Privacy was stated as reasonable. It is suggested that the service explore opportunities for improving how personal belongings are handled as currently patients must carry their clothes and belonging with them without a basket or carrying device.

There is an appropriate range of modalities and the equipment is fully maintained and modern. It appears to be well-supported by the communities and the organization in terms of equipment and capital acquisitions. Space is deemed as adequate and accessible, and effective use is being made of existing areas. There was the feeling expressed that the time to explore a major capital renovation to modernize the area may be at hand. Crowding in some areas was observed and family members felt the waiting space was cold.

The organization screens clients for health and safety risks using a variety of tools. Though in its early stages of implementation, a kiosk registration process has been undertaken and is applauded.

The service has a newly established quality committee that includes the chief radiologist. Standard metrics exist and are monitored and posted on a performance board in the area. The importance of including all sites in a daily huddle where key metrics, opportunities for improvement and special recognitions ("kudos") are shared should be recognized and innovative ways pursued.

Training of leaders in continuous improvement based on the tenants of Lean is underway and further training for managers and staff is planned. Efforts are encouraged to share the results of quality improvement activities widely with patients and all partners.

The organization has attracted an ample supply of radiologists which it hopes to sustain. Radiologists support proper referrals and utilization. This group is encouraged to continue its consideration of implementing a peer review process for quality, although it is recognized that an efficient peer review process may require upgrades to the picture archiving communications system (PACS). Also a more 'regionalized' approach within the LHIN and neighbouring areas may also facilitate such a peer review opportunity. It was felt that the chief

of radiology and the various leads were active and engaged in sustaining and improving the service. Some concern was raised that radiologists do not always leave their offices to participate in fire drills.

2.2.6 Standards Set: Emergency Department

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

The emergency department with the highest volumes in the organization is located at the Belleville General Hospital (BGH) site. The other hospital sites also have active emergency departments. At the BGH site, the space has been recently renovated and is quite extensive. Many desirable features have been included in the redesign.

Team leaders are aware of the commonly presenting problems, and have adjusted services to suit the need.

Priority Process: Competency

A thorough orientation program is provided to all new hires for the emergency departments (EDs). Education for RD staff members is supported by the team leader and by the organization.

Staff members working at the smaller hospital sites are particularly adept at multi-tasking to ensure that all jobs get done. All staff members are trained in prevention of workplace violence and de-escalation of crisis situations. Staff members receive regular performance appraisals. Staff members are recognized on a regular basis and serve as a nice bonus of the daily huddles conducted by the team.

Priority Process: Episode of Care

The organization has designated a nurse to assist the Emergency Medical Services (EMS) with patient offload at the Belleville General Hospital site. The organization has the lowest off-load time in the South East Local Health Integrated Network in Ontario.

The triage nurses can see the waiting room from their desks, or via a screen at every hospital site in the organization.

The newly constructed space in Belleville affords good patient privacy. Some of the smaller hospital sites have cubicles that are separated by curtains. Staff members are aware of the privacy and confidentiality issues.

Priority Process: Decision Support

Evidence-based protocols are in use across the four hospitals of the Quinte Health Care Corporation. In addition, information management systems and screens showing patient location and so on are standardized across the hospital sites. These support patient care and patient flow.

Priority Process: Impact on Outcomes

Clients/patients are assessed and reassessed prior to their physician initial assessment. Subsequent assessments are fitted to the clinical situation.

Priority Process: Organ and Tissue Donation

The team collaborates with the Trillium Gift of Life Network to facilitate tissue and organ donation.

2.2.7 Standards Set: Infection Prevention and Control Standards

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

The infection prevention and control (IPAC) team plans year by year with both provider partners and at a one-day IPAC retreat. The team members work closely with public health (PH), the local health integrated network (LHIN) and a regional infection control committee. In the future, the team might consider planning the retreat before fiscal year-end to better align the year's activities, and work to launch in the month of April.

The team scans the environment regularly for the latest infection concerns across the province, country and world. The team has been proactive in planning for future infection control issues which is commendable. The organization is well-entrenched in surveillance and with legislated requirements such as Ebola management. In fact, Quinte Health Care Corporation was among the first organizations with a suspected Ebola patient. Personal protective equipment (PPE) training for Ebola has been comprehensive, with ongoing re-education to keep staff members current and patient-ready. Screening happens at entry points of the organization to minimize risk and exposure.

While the team speaks of the challenges of cross-site coverage it has a plan in place to service the four hospital sites. There is a robust IPAC committee which meets regularly for planning and indicator review. The committee continues to react to data and re-calibrate the plans as required to have maximum reach. The organization uses a multi-media approach to educate physicians and staff. The organization has a process for immunization management and monitoring and reports good uptake of the flu vaccine this winter. Flu vaccines were readily accessible to physicians and staff.

The IPAC professionals are trained and certified for their roles. There is excellent physician support of the team and they are entrenched in the day-to-day work of the team, and with the program professionals providing consult services are required.

The pharmacists are active in their partnership of antibiotic stewardship which has resulted in increasing the on-the-ground traction of accepted antibiotic recommendations. The IPAC team is involved in equipment purchase and ongoing cleaning protocols as well as for furniture, from waiting room furniture to commode chairs. The team also consults with medical devices and reprocessing (MDRD) for any reprocessing concerns such as pack failures.

The organization has worked hard on the issue of Clostridium difficile to ensure it is ahead of an outbreak and does so by implementing outbreak protocols ahead of a true outbreak. The trial of the Asepti-Sure system is under way, and it shows promise for cleaning. Audits and outbreak data are available at the unit level for front-line discussion and practice change where applicable. There is learner education for hospital students.

The committee meets regularly to action new plans, review data and modify approaches to gain maximum clinical spread. The IPAC team is engaged with the on-site physical plant teams as well as with external contractors. There is a robust plan for any construction on site and it monitors the work to completion. The team/committee have the authority to stop work until there is resolution for patient/staff safety. The maintenance team and IPAC team have worked closely on the new Canadian Standards Association (CSA) requirements for isolation room designation. The IPAC team supports food safety with the management of alerts, from apple slice contaminant recalls, to Listeria alerts in on-site purchased foods. In addition, the IPAC and occupational health and safety (OHS) teams work closely together to support such initiatives as flu vaccines, OHS identified hazards and patient/staff surveillance for illness and outbreaks.

There is a known process from environmental services for waste pick-up and disposals from the service areas. There is a trial in process concerning a blue box for non-sharps, to focus sharps containers for sharps only. Note is made of the organization's trial of hand hygiene products and on-body hand sanitizers for units that cannot have the standard system such as in mental health. There is both automatic and pump dispensers and a process for regular fills in public and on-unit areas.

Patient and families are engaged in IPAC practices and are educated as required. Family refrigerators have been added to the pediatric area in order that a common patient server is not used by parents of children with respiratory illness. There is a telephone message and signage to ask families not to visit if feeling ill and large posters that show patients and families how to put on PPE when visiting.

Environmental services staff members are trained and provided with cleaning protocols for every area to support full and part-time staff members that may be assigned to unfamiliar areas. This includes cleaning products to support terminal and regular cleaning. The IPAC team is starting to work on catheter surveillance with staff members and uses daily bullet rounds to review catheter use on the units. The IPAC team interacts regularly with patients and families to keep infection control practices top of mind.

2.2.8 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		
8.5	The team provides residents and families with information and education about how to recognize and report abuse.	
10.6	The team is aware of and follows the organization's strategy on preventing abuse.	!
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 interdisciplinary approach to patient-centred care and services is positively noted. Goals and objectives for this service are aligned with the corporate direction and progress towards attaining these goals is regularly monitored.
Priority Process: Competency
The interdisciplinary team is committed to providing safe, quality care and services to its patients.
Priority Process: Episode of Care
There is strong leadership and a sense of collegiality amongst members of the care team. The interdisciplinary approach to service planning and delivery is commendable. The organization of the service is strong with the principal focus of the team being care for the long-term patients. Wherever possible, patient choice is respected and input is sought for individual care and service delivery.

The team is strongly encouraged to develop a strategy to prevent patient abuse. This strategy may include developing a policy and an abuse reporting protocol; educating staff, patients, families; and establishing tools to identify patients at risk for abuse.

There is a need to review the process for advance care directives. Further, there is a need to ensure clarity of the orders so that there is no confusion in implementing the appropriate level of intervention.

Attention to patient safety is noted. Education is available for staff members to ensure that they maintain currency with respect to the needs of long-term care patients.

The recent addition of the behavioural supports transition unit (BSTU) is an exciting initiative for staff. Patients should benefit greatly from this program. The team is wished well as it proceeds with the opening of the final 10 beds in this unit, allowing it to operate at full capacity of 20.

Patient documentation is comprehensive. Encouragement is given for all physicians to use the electronic record to allow for a fully integrated record. It is recognized that currently, only some physicians are using this forum for documentation.

Priority Process: Decision Support

There are policies and procedures in place relative to the safeguarding, confidentiality and integrity of patient, staff information.

Priority Process: Impact on Outcomes

Good risk management processes are in place. Staff members receive training in safety-related patient care issues including but not limited to wound management, falls prevention, infection control, management of aggressive behaviour and infusion pumps.

Although there are currently no formal research projects being conducted, there are policies in place that support research.

2.2.9 Standards Set: Medication Management Standards

Unmet Criteria	High Priority Criteria
Priority Process: Medication Management	

The organization has met all criteria for this priority process.

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

The organization has an extensive antimicrobial stewardship program in place. This program was established in 2009, it is interdisciplinary, it includes lines of accountability, and it addresses all aspects of optimum use of antimicrobial drugs. An evaluation program is in place and in use.

The medication management system is fully developed across the hospital system of the organization. There is a policy in place for the management of high-alert medications. The policy identifies the responsible individuals that are members of the pharmacy and therapeutics committee, and also the names of the high-alert medications. All aspects of managing these medications are outlined in the policy.

Omnicell cabinets have been purchased and are distributed in patient care areas. Approximately 95% of medications are in these cabinets or in the pharmacy, with a small amount kept as ward stock. This has created an excellent and comprehensive medication management system.

Medication shipments are received directly into the pharmacy. This allows pharmacy staff members to ensure that no damage has occurred, such as freezing during the winter and so on.

2.2.10 Standards Set: Medicine 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 team has reviewed its client profiles to organize its services and delivery. The team's focus is on seniors' care, lung diseases, cardiac issues, and obesity and this reflects the community needs and services. The Belleville General Hospital (BGH) site is a dedicated tissue plasminogen activator (tPA) stroke site for stroke management. The team reaches out to community providers to enhance the process of clinical hand-off of patients

The team has used the organizational strategic plan to focus on system integration and seamless transition in care models. The team reviews its services and has reduced its acute length of stay (LOS) time. The team is looking this year to focus on ambulatory services for medicine services to support early discharges or to avert admissions. Team members are undertaking a trial on an admissions nurse assignment to support their accelerated bed turns.

The huddle board on the medicine unit supports falls management reporting, hand-hygiene compliance and other indicator monitoring. The incident reporting statistics on the pediatric unit at the BGH site for example, are posted and the team is initiating a focus on laboratory specimen management

The team has a combination of units, with a registered nurse (RN), registered practical nurse (RPN) and personal support worker (PSW) model, along with allied health team support. The staff members are continuing to work on patient assignments and care partnerships on the units.

Priority Process: Competency

The teams use their huddle boards to recognize and thank their colleagues. There are staff in-services to support new equipment on the unit. The registered practical nurses (RPNs) at Belleville General Hospital site are learning basic electro cardiogram (ECG) management on the tele-beds. As a result, staff members are now conducting on-unit ECGs as required. There is yearly re-training in workplace hazardous management information system (WHMIS), Emergency Measures and other clinical skills for work competency. During the survey the staff members indicated that regular in-services occur.

Priority Process: Episode of Care

There are opening visiting hours on the medicine units. Patient flow management and length of stay (LOS) monitoring support access to an ever growing need for medicine services in the area. The teams are supportive of patient and family needs both on the unit and at discharge. The teams support the circle of care in planning patient care and work closely with the Community Care Access Centre (CCAC) for discharge supports.

When necessary, patients are off-serviced to the surgical area however, surgical cancellation is rare to support medicine over-flow patients. The teams work to minimize alternate level of care (ALC) patients to support maximum patient flow. There is an ethical framework and consultation as required. Staff members understand how to access these services when required. There is a process for timely complaints resolution on the unit or with patient relations when warranted.

Open source order sets are embedded in the venous thrombo embolism (VTE) risk assessments on admitted patients and supports VTE management as required. The organization is strongly encouraged to have all physicians use these order sets, as free-text orders require pharmacist follow-up discussion with physicians where VTE management has not been considered and/or documented.

There is a process for medication administration at the bedside using client and medication record matching in the patient room. An intravenous (IV) to oral step-down reminder in the charts supports patient discharge planning. There is an on-call pharmacist for after-hours consultation as required. There is also a process for accessing medications from other units' stock. In some instances the patient will take their home medications when the drug is not accessible via the hospital pharmacy. These drugs and kept in the med-cart and managed by the pharmacists and nursing staff.

There are regular discussions with patient and family about care plans and a white-board at the patient bedside keep track of important information and questions. Bullet rounds support the patient plan and the organization of treatments and supports for patient discharge. There is a new process for 'faxing' information to the CCAC, which results in a telephone call or face-to-face meeting with the patient and family. This is a new process since January 2015 and evaluation in ongoing.

The pharmacists support best possible medication history (BPMH) with the creation of online medication lists for the day-to-day management of medications and prescription generation at discharge. At discharge, patients are also given a list of what medications to keep taking, stop taking and start taking.

Priority Process: Decision Support

The teams use clinical pathways and quality-based practice (QBP) handbooks to support best practice in selected case mid groups (CMGs) for example, for congestive obstructive pulmonary disease (COPD).

There is a combination of paper and online documentation of client information. Open access order sets are being implemented to support best ordering practices. Staff members indicate that once used to the electronic charting they like it and find it easy to use.

There is good communication in patient transfer and discharge planning with ongoing conversations with community providers and agencies and among staff members using the situation-background-assessment-recommendation (SBAR) electronic reporting.

Priority Process: Impact on Outcomes

The teams conduct initial and ongoing falls risk assessment and use safety crosses on their huddle boards to monitor their progress. They have post-fall huddles to review, reinforce and determine new plans, as required. Room signage and other visual cues support patients at risk for falls.

There is an incident reporting system that captures adverse events. These are reviewed and followed-up with unit staff members for learning across all sites. They are continuing to work on a solid feedback loop for staff.

The teams create their objectives every year to support the strategic plan and corporate planning directions. Seniors' care is an ongoing focus for the organization. The team identifies their targets based on prior year data and from benchmarking data.

Unit huddle boards are accessible to patients and families. Where required, data can be uploaded to support Quinte Health Care Corporation and ministry reporting.

2.2.11 Standards Set: Mental Health 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 mental health team is supported by strong leadership. Directions are clearly defined and staff members are supported and encouraged as they strive to maintain their high standard of care and service delivery.

Goals and objectives have been established for mental health services, which are in alignment with the corporate strategic plan. There is documented evidence of progress in meeting these goals.

The interdisciplinary team's commitment to recovery oriented patient-centred care is commendable.

Priority Process: Competency

The team members are dedicated to their roles in mental health services. There is a strong sense of professionalism and team compatibility in this team.

Priority Process: Episode of Care

It is apparent that safety was considered a priority in the design and physical layout of the renovated mental health unit. This is also noted in the selection of patient furniture and equipment.

There is evidence of a strong interdisciplinary team approach to delivery of care and services. A comprehensive interdisciplinary assessment is completed for all in-patients on admission including such aspects of care as risk assessment, suicide risk assessment, and risk for falls. Patient goals and a recovery oriented plan are developed with input from the patient.

The interdisciplinary team is fortunate to have four psychiatrists that are dedicated to providing a high standard of care. All four physicians are familiar with all in-patients and their treatment plans thus, enabling continuity of care when covering for each other. These physicians also provide consultation services and pride themselves on maintaining a two to three-week wait time. This is impressive.

A least intrusive and least restrictive care policy is in place. The team is commended for its commitment to implementing this policy. It was noted by a team member during the survey that: "the use of restraints is a sign of failure for us."

Attention to safety for patients and for staff members is a priority for the mental health team. In addition to comprehensive patient risk assessments, staff members are trained in non-violent crisis intervention training. Additionally, duress bracelets are worn by all staff. Security guards are in place and work closely with staff members in management of aggressive behaviour. The mental health team responds to all ‘Code Whites’.

There is a good process in place for reporting and follow-up of sentinel and adverse events. An employee assistance program, as well as peer support, is available to staff members in the event of major events.

There are avenues in place to address stigma associated with mental illness. Staff members are respectful of patients and their rights. They see their role as that of advocacy and whenever possible, take action to educate and minimize potential discriminatory situations.

It is noted that medication reconciliation is being done on admission. This process is clearly defined. There are plans to continue with this process at transfer and discharge. It is noted positively that the psychiatrist follows up with the family physician after a patient is discharged from the hospital. Plans to implement a patient consent form which will give the psychiatrist permission to contact the patient directly by telephone following discharge is now being explored.

Priority Process: Decision Support

The members of the interdisciplinary team work well together and there is evidence of support for each other's work.

Staff members are aware of the corporate strategic plan, and priority goals for this service have been developed in alignment with the strategic direction.

There are many avenues for sharing patient care information with all members of the interdisciplinary team. Some examples include, but are not limited to bullet rounds, interdisciplinary rounds, case conferences, bed scrums and educational rounds. Patients are encouraged to be involved in their care.

There is a policy in place on safe and appropriate use of cellular telephones and wireless devices. The organization is encouraged to expand this policy to include all forms of social media.

Priority Process: Impact on Outcomes

Indicators have been established for care and service delivery. There is documented evidence of tracking, trending and analyzing these indicators for identification of quality and risk management initiatives.

Best practice guidelines are used to develop mental health services.

2.2.12 Standards Set: Obstetrics 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

Goals and objectives of the obstetrics services are in place and are updated and changed as new targets emerge. The team is aware of the demographics of the population served. Ethical considerations arise for this team and processes are in place to manage these.

Priority Process: Competency

The team receives ongoing training in the use of infusion pumps that are used for intravenous therapy, and separate pumps are used to manage epidural anaesthesia. Performance appraisals are done annually. Of note is that team member contributions and achievements are recognized as 'kudos' during the huddles.

Priority Process: Episode of Care

There is a well-organized team for obstetrics services with adequate nursing, medical and midwifery staff. Students and residents are accommodated by the care team. The space is set up with rooms for labour and delivery and adjacent rooms for postpartum care. The equipment is good. A central monitoring system is in place however, staff members currently prefer to spend time in the room with the labouring mother rather than at the desk.

The nursery can care for infants from 35 weeks gestation. The demographics of the patients accessing the obstetrics services are carefully studied by the team and services are adjusted accordingly. There are some neonates that need treatment for Neonatal Abstinence Syndrome because of maternal drug use.

Priority Process: Decision Support

Care paths are in place for vaginal deliveries, elective cesarean sections and for post-partum care. These are used for 100% of these types of deliveries. This ensures consistent quality care.

Priority Process: Impact on Outcomes

The obstetrics team has good resources and the necessary equipment.

Care paths are in use for vaginal birth and for cesarean section deliveries thus, ensuring consistent quality care. Patient safety is a constant focus and high-risk activities are carefully managed.

The team is at year four of the managing obstetrical risk efficiently (MOREob) program and commended for this achievement. The team has seen a beneficial effect from participation in this process.

Midwives deliver patients at the Belleville General Hospital site. It is understood that care is transferred to a physician if the midwife's patient requests an epidural, and this is not standard practice at other hospitals in Canada. Perhaps a consultation might be an adequate arrangement.

Patient feedback is uniformly positive perhaps with the exception of concerns about the food and the cost of parking.

2.2.13 Standards Set: Point-of-Care Testing

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

The organization has met all criteria for this priority process.

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

Point-of-Care Testing (POCT) is done at the three smaller hospital sites and supports the emergency departments as well as the other patients served. There is equipment to offer a wide range of tests, and some more sophisticated tests need to be sent out. Nursing staff members are responsible for the daily operation of the testing equipment. The Laboratory manages quality control and maintenance.

2.2.14 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

There is evidence of strong leadership in the rehabilitation services. The commitment to realizing individual patient goals for care and service delivery is noted with approval.

Huddles provide regular opportunity for mitigation of risks and identification of continuous quality improvement initiatives in patient care and safety.

The interdisciplinary team includes all health care professionals involved in patient care. These team members work well together.

Priority Process: Competency

The current staffing model for rehabilitative services is registered nurses (RNs) and registered practical nurses (RPNs). There is a plan to include personal support workers (PSWs) to this model in September 2015. This plan, to move to an inter-collaborative care approach to patient care is being slowly introduced across the organization.

Credentialing for professional staff is done annually. Attention to ongoing training and education requirements is noted. Ensuring that staff skill set is current and assessing the need to build capacity is a high priority for this service. Training on use of specialized equipment such as infusion pumps is noted with approval.

Students are a relatively new and welcome addition to rehabilitation services. A student was present during this survey and expressed enjoyment with her placement here.

Priority Process: Episode of Care

Staff members are commended for their commitment to enhancing care and service delivery for rehabilitation services. There is a strong patient-centred interdisciplinary approach to care and service delivery. This is evidenced by the commitment to working with patients to meet their individual goals, and in the subsequent realization of a decrease in length of hospital stay.

Huddles, which occur three times per week, are used as a form of debriefing and problem solving. These ad hoc meetings are interdisciplinary and have proven to be an effective way to develop corrective action plans for adverse events. A more formal meeting occurs weekly and this provides opportunity for interdisciplinary team members to review progress in care and changes in patients' conditions. Sharing of observations and offering input and feedback is part of this process.

Medication reconciliation is done on admission, transfer and discharge. There is a comprehensive interdisciplinary admission assessment process in place. Emphasis on pain management assessment and evaluation of effectiveness of interventions are noted.

The attention to hand hygiene is applauded. Other patient safety measures include but are not limited to, falls prevention, infection control practices, staff education and training, and skin and wound management.

Staff members have access to necessary equipment for the provision of quality patient care. Outcomes of individual patient care goals are evaluated regularly in team meetings which include the patient and family whenever possible.

The merger of acute and slow-stream rehabilitation services approximately two years ago has been identified as a challenge for the team and for some of the patients. The team is working diligently to address the needs of both levels of service and is supported in these efforts.

Priority Process: Decision Support

The team has ready access to interdisciplinary e-health records via Meditech. Records reviewed during the survey were found to be up-to-date and comprehensive. There is evidence that the care plans are reviewed regularly and revised as necessary with any change in the patient's condition or treatment plan.

It is noted that a paper record still exist. This file contains consults, physicians' orders, some medication order sheets, admission referral information received from referring unit, and various other pieces of information. While it is recognized that some of these forms are generated and received in hard copy format, encouragement is nevertheless given to have all disciplines, including physicians, chart in the electronic record.

Microsoft Outlook is used as the email venue, and all staff members have access to the internet and intranet.

Current information that is pertinent to rehabilitation services is available and easily accessible.

Priority Process: Impact on Outcomes

There is strong and visible teamwork and mutual respect among and between the teams.

There are formal goals and objectives for rehabilitation services which are aligned with the strategic plan. The goals are realistic and measurable. Progress towards attainment of these goals is monitored regularly. Results are prominently displayed in the patient care area.

Team members receive training in how to identify, reduce and manage risks to patients and staff. Training is provided during orientation as well as during employment. Some methods used are in-service sessions, presentations, posters, and reminders during staff meetings, newsletters and the intranet. Topics include hand hygiene, infection control precautions, and falls prevention, among others.

2.2.15 Standards Set: Transfusion Services

Unmet Criteria	High Priority Criteria
Priority Process: Transfusion Services	

The organization has met all criteria for this priority process.

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

While there is no problem in the laboratory, there are occasional problems with the labelling of samples drawn by the nurses in the emergency departments (ED) for blood products. There are specific requirements for the labels and this can be problematic. The EDs and the laboratory are aware of the issue and are working to resolve it.

Home transfusion services are not provided by the team.

2.2.16 Priority Process: Surgical Procedures

Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Like other surgical programs in Ontario hospitals the political and funding landscape is changing with the introduction of quality-based service (QBPs), wait-list management and other hospital annual planning submission (HAPs) agreement parameters. The Surgical Program Advisory Committee (SPAC) is well-positioned to discuss the issues and develop solutions that can support the necessary changes that support the community needs. The indicators have positive results and there is commitment to understanding quality-based practice (QBP) handbooks and case costing which are key drivers in this time of change. The physicians are an engaged group and are working to maximize the funding for their patient needs.

The operating rooms (ORs) have stratified their work between the sites to maximize day surgery opportunities while continuing to support patients that require major surgery and inpatient stays. The Quinte Health Care Corporation (QHCC) is in the process of implementing a more comprehensive and efficient model for pre-admission management and has developed internet videos to support patients in understanding their surgical visit, along with their pre and post education and exercises.

The OR and surgical unit model supports registered nurses (RNs) registered practical nurses (RPNs) as well as RN first assists and allied health. The staff members speak of a team approach to patient care and speak of ongoing training and in-services to support their care. The surgical safety checklist and surgical pause are used in the ORs and can be seen in other areas where invasive procedures are occurring. The approach to pediatric surgical checklist review is commendable.

As the care model continues to evolve encouragement is offered to look at the fracture clinic area for redevelopment for its volume of patients and to work with the local health integrated network (LHIN) to create post-operative rehabilitation services as part of the QBP funding model for end-to-end care. The new cysto area at the Trenton site is an example of a re-development to support a better patient and staff experience in care.

There is review of indicators and other program metrics. Staff members indicate there is a need for greater and regular focus on their morbidity and mortality rounds/reviews as well as for a corporate committee for key cases to ensure their care is best in class. There is a robust incident management program, with case reviews as required. There is disclosure to patients quickly and efforts to keep them informed of the progress on the review, outcomes and recommendations.

Throughout the surgical program there are huddles and performance boards where staff members exchange information and create solutions to create positive and sustainable outcomes. The staff members are positive about the work they do to support their community's care needs.

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: April 22, 2014 to May 9, 2014**
- **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.	11	0	89	92
2 Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	0	11	89	94
3 We have sub-committees that have clearly-defined roles and responsibilities.	0	0	100	95
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.	11	22	67	92
5 We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decisionmaking.	0	0	100	89

		% Disagree	% Neutral	% Agree	%Agree * Canadian Average
		Organization	Organization	Organization	
6	Disagreements are viewed as a search for solutions rather than a “win/lose”.	11	0	89	92
7	Our meetings are held frequently enough to make sure we are able to make timely decisions.	11	22	67	95
8	Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	0	11	89	94
9	Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	0	0	100	93
10	Our governance processes make sure that everyone participates in decision-making.	0	11	89	91
11	Individual members are actively involved in policy-making and strategic planning.	0	0	100	88
12	The composition of our governing body contributes to high governance and leadership performance.	0	0	100	92
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	11	89	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	97
16	We have a process to set bylaws and corporate policies.	0	0	100	93
17	Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	97
18	We formally evaluate our own performance on a regular basis.	11	0	89	82
19	We benchmark our performance against other similar organizations and/or national standards.	13	38	50	66
20	Contributions of individual members are reviewed regularly.	22	11	67	62

	% 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.	11	11	78	79
22 There is a process for improving individual effectiveness when non-performance is an issue.	11	44	44	56
23 We regularly identify areas for improvement and engage in our own quality improvement activities.	0	22	78	79
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.	11	33	56	80
25 As individual members, we receive adequate feedback about our contribution to the governing body.	22	11	67	66
26 Our chair has clear roles and responsibilities and runs the governing body effectively.	0	11	89	94
27 We receive ongoing education on how to interpret information on quality and patient safety performance.	11	0	89	81
28 As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	93
29 As a governing body, we hear stories about clients that experienced harm during care.	0	22	78	81
30 The performance measures we track as a governing body give us a good understanding of organizational performance.	11	0	89	91
31 We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	0	0	100	85
32 We have explicit criteria to recruit and select new members.	0	11	89	78
33 Our renewal cycle is appropriately managed to ensure continuity on the governing body.	0	0	100	85

		% 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	11	89	91
35	Clear written policies define term lengths and limits for individual members, as well as compensation.	11	0	89	91
36	We review our own structure, including size and subcommittee structure.	0	11	89	85
37	We have a process to elect or appoint our chair.	0	0	100	88

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2014 and agreed with the instrument items.

3.2 Canadian Patient Safety Culture Survey Tool

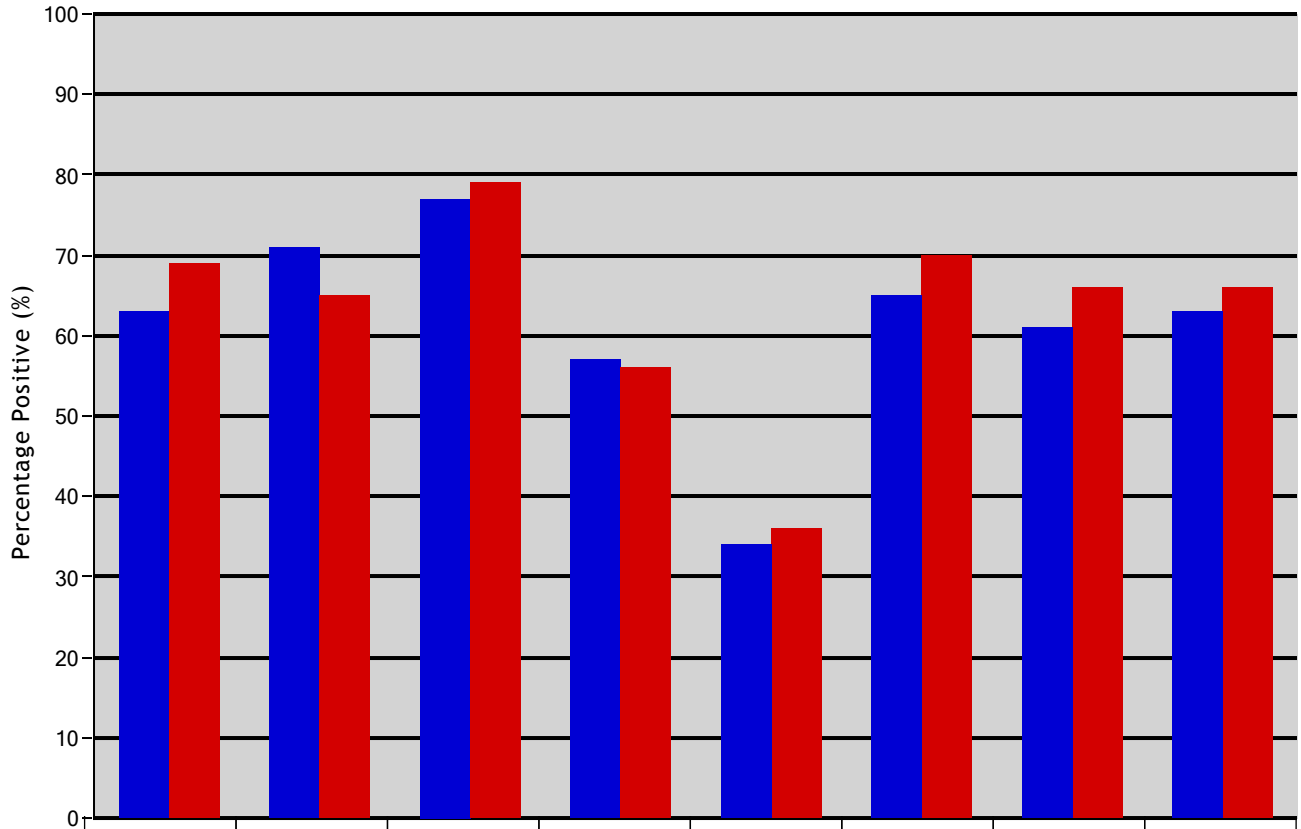
Organizational culture is widely recognized as a significant driver in changing behavior and expectations in order to increase safety within organizations. A key step in this process is the ability to measure the presence and degree of safety culture. This is why Accreditation Canada provides organizations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

Results from the Patient Safety Culture Tool allow the organization to identify strengths and areas for improvement in a number of areas related to patient safety and worklife.

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

- **Data collection period: June 1, 2014 to June 13, 2014**
- **Minimum responses rate (based on the number of eligible employees): 287**
- **Number of responses: 441**

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



	Organizational (senior) leadership support for safety	Supervisory leadership for safety	Unit learning culture	Enabling Open Communication I: judgment-free environment	Enabling Open Communication II: job repercussions of error	Incident follow up	Stand-alone items	Overall Perceptions of Client Safety
	63%	71%	77%	57%	34%	65%	61%	63%
	69%	65%	79%	56%	36%	70%	66%	66%

Legend

Quinte Health Care Corporation

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2014 and agreed with the instrument items.

3.3 Worklife Pulse

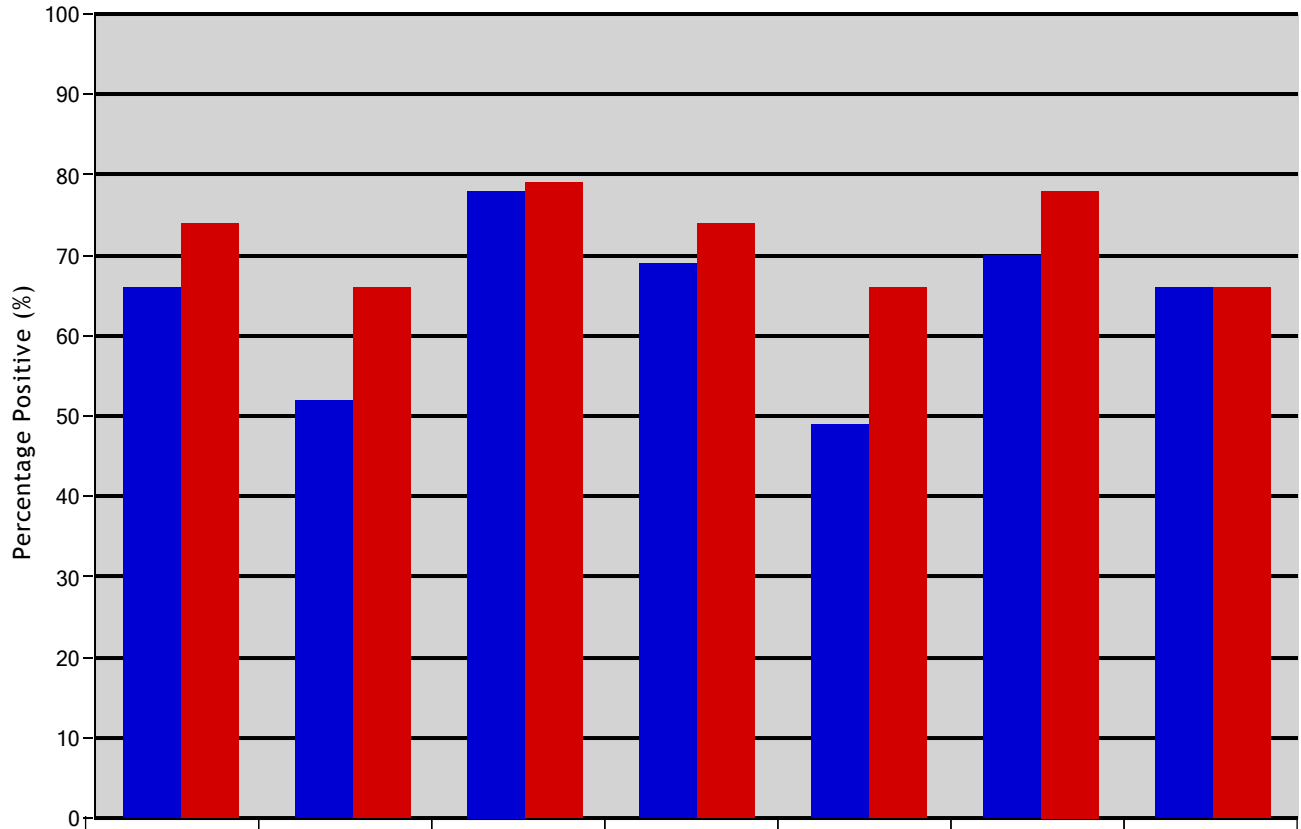
Accreditation Canada helps organizations create high quality workplaces that support workforce wellbeing and performance. This is why Accreditation Canada provides organizations with the Worklife Pulse Tool, an evidence-informed questionnaire that takes a snapshot of the quality of worklife.

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

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

- **Data collection period: September 18, 2014 to October 26, 2014**
- **Minimum responses rate (based on the number of eligible employees): 308**
- **Number of responses: 384**

Worklife Pulse: Results of Work Environment



	Job	Training and Development	Coworkers	Immediate Supervisor	Senior Management	Safety and Health	Overall Experience
	66%	52%	78%	69%	49%	70%	66%
	74%	66%	79%	74%	66%	78%	66%

Legend

Quinte Health Care Corporation

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2014 and agreed with the instrument items.

3.4 Client Experience Tool

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

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

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

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

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

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

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

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

Appendix A Qmentum

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

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

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

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

Action Planning

Following the on-site survey, the organization uses the information in its Accreditation Report and Quality Performance Roadmap to develop action plans to address areas identified as needing improvement. 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
Public Health	Maintaining and improving the health of the population by supporting and implementing policies and practices to prevent disease, and assess, protect, and promote health.
Surgical Procedures	Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge